Because democracy is a work in progress and requires constituent participation, we invite your collaboration in developing and refining our plans. We have added comments in areas where we have identified that we need specific questions and welcome your input.

Healthcare Plan

A note to the Reader:

The construction of the areas of need and proposed solutions outlined in this document will require interconnected and concurrent development of multiple solutions at the same time. Maximizing the effectiveness of the goals we have outlined here necessarily requires that we work together in a coordinated, non-linear manner.

Since multiple directives will be working together at the same time and not specifically in the order they are laid out within this document, it is important to understand that interconnectedness of resources will be needed to facilitate the identified solutions and that stakeholders from multiple areas of healthcare will be needed to provide insight and guidance as to how to best develop and apply our collective solutions. We have endeavored to construct the document according to this goal.

Medical Care for Individual Health in a World Facing a Continued Probability of Pandemic

In America, our current structure of meeting healthcare needs has been developed directly from our founding principles. The freedom of choice, the need for individual responsibility and the opportunity to solve a problem are all consistent threads that weave through the organizations, providers and patients within our system.

As such, improvement of our system lends itself well to positive iteration on the basis of increased knowledge of our humanity, economic and finance principles, and behavioral psychology.

As our country has grown, we have increasingly seen participation and success in our society as a result of increased awareness of community. Civil rights legislation stands as a primary example, but any number of laws have increasingly sought to make our population more equal, such that each person can contribute economically to the person next to them at a higher level. In short, increasing breadth and depth of our community is facilitated via the economic system.

In a community, human capital capacity is equivalent to the support that one gives to another and receives in some equivalent kind. In healthcare, this principle is explicitly definitive of both the demand and supply for that care. When this principle is explicitly built into our system, safety in our existence results at increasing levels, because our bodies can more effectively sustain the process that life requires to contribute to others in society. Put differently, we must stabilize human health before we can build capacity for the experience and realization of its product.

In so many conversations regarding participation in democracy, we often hear or state some version of the phrase, "they should be doing this" or "they should be doing that". Healthcare is no exception. When we think about what caring for the health of ourselves and others should look like, we often forget that we are "they."

More directly, whenever we seek healthcare, each of our bodies is the product of someone else's efforts in addition to our own. Seen this way, "We are they" is an overarching concept that catalyzes the principles that we can use to improve on our current system of healthcare. Doing so necessarily allows us to explicitly account and provide for "kinder and gentler care", such that we solve for the improvement of human capital for both the patient and the provider.

The experience of healthcare under these terms is kinder because there is mutual interest in participating in the conversation that determines the course of the care. The experience of healthcare is also gentler because it's more targeted rather than the broad-based, differential diagnosis approach that treats each person as an amalgam of symptoms as opposed to a human. The difference is important because care can be very invasive, and "gentler" care means providing the appropriate level of medical services as a goal equal to and indivisible from the more quantifiable health outcome. When we adhere to our responsibility within "We are they," it results in acknowledging the boundaries of what is good care, directed by and for the patient, which is each of us, even if we are the provider of that care.

As patients, it is demonstrably true that if we don't contribute to our own health, we are guaranteed not to get the outcome for which we hope. Yet our incentives, individually, and absent another person's consistent support, are to assume that our health is a given and only respond to our bodies' healthcare needs when they are unavoidable. This perspective often informs a conclusion that the only positive healthcare actions we can take occur under the threat of an outcome that appears negative in both the short-term and the long-term. We only react by consuming healthcare in negative situations, such as getting sick or injured, and this perspective makes us feel helpless in the provision of our own good health. Under this construction, we miss that the product that healthcare

is trying to supply, and the product that we truly want to consume, is the maximization of our health at every point in time. We miss it if, even in severe cases where the skill of specialized medical professionals is demanded, we can act to prevent the downward spiral in our health from being less extreme. Our own acute efforts obscure the reality that needing specialized medical care was necessary as a result of previous action not being taken by us. In contrast, doing our part in healthcare means that our intentional actions buy time for the contributions of others to be included in our outcomes, explicitly experienced in the health of our bodies.

By identifying the hole in our perception of healthcare outlined above, we can define a community structure that helps us understand why and how each person's contribution is necessary. For example, one person can't stop the slide into poor health alone - they can only slow it; but a group of people can not only stop the slide, but can reverse it. Conceptually, this is how we want our healthcare to function and how we want to understand our emotional and intellectual experience of it.

Summary of Concept

We submit that individual pieces of the healthcare economy should be considered and solved for as a whole, even if they are not directly tied together in the form of a program. The human body works as a closed system, with each part of the body affecting or being affected by another. Conceptually, this framing works well for considering the function and improvement of healthcare in America.

Each of us as patients needs our system to reconcile to itself, such as ensuring that pandemic response has been considered in conjunction with preventative health, even if these individual pieces of need seem far apart. In the plan below we have considered delivery mechanisms for ongoing healthcare that integrate with an acute strategy for circumstances like pandemic threat. Specifically, we have addressed solutions that we believe provide the best long-term outcomes, consistent with reducing cost and improving individual outcomes, that allow our system to evolve over time, without losing opportunities for innovation growth, or reducing healthcare providers to order takers, rather than elevating them to decision-makers in conjunction with their patients.

Primary care, and the patient-provider relationship is at the core of the intellectual framework we envision. Long-term health is strongly correlated with knowledge, and most of us, as patients, do not have primary education in the inner working and care of our bodies. We need that information transferred to us by our providers. The more effectively our system facilitates information transfer, the higher likelihood that we reduce the incidence of illness and chronic conditions. Concurrently, usage of healthcare will decline and with it cost.

Declining usage of healthcare presents real challenges for both businesses and employees in the future. It directly implies that either wages or jobs or both will be lost to the future. We fully expect, and as a society, should intend for this to be the case as long as we understand the full meaning of this reduction in cost. First, the reduction is relative to trends, rather than necessarily an absolute drop in cost, although both are ideal. Given the age of our population, the current shortage of providers both currently and graduating from medical school, and the level of existing healthcare needs, it will be many years before the payoffs, in terms of reduced cost in the system, will be realized. Paradoxically, this means that we have a great opportunity to plan for the future, because we need every healthcare worker available and more in the near term.

We envision primary care providers re-established as advisors of health, incentivized to advise a patient on their health needs, rather than to be a gatekeeper, directly motivated to keep payor (insurance company) costs down. As a society, we bear the direct cost of our healthcare sooner or later. We all age, and because we all age, sooner or later, our children are paying for us, or more hopefully, we have already paid our future costs forward.

Commented [1]: We need more information from medical and scientific experts to further develop this concept. We believe that there is a space here for nurses to play a key part in the provision of healthcare, in an expanded role compared to the role they currently play.

We propose building out Medicare, as a multi-faceted program, offered as an option for achieving this goal:

a. We propose that Medicare plans be made available, as an option, to patients of all ages, and to employers as a choice for covering their employees, such that every provider will be required to accept Medicare plans and that individual Medicare reimbursement rates be made public.
b. Medicare already has a social incentive towards cost control and an equal market-based incentive for improving outcomes.
c. If we ask it to compete more directly in the healthcare space, we believe that we will see a trend towards more price transparency on the part of commercial insurers and an increase in quality.
d. We also believe that we will see more patient-centered service. We want the market, and human innovation to drive these changes in participant action, rather than making them directly prescribed via legislation.

By expanding Medicare's scope of delivery, while making primary care primary, we believe that we can provide an ongoing mechanism for management and delivery of pandemic response. Without a vaccine for any pandemic, we necessarily will need a constantly capable testing protocol and a central database to track incidence, response and scope of the problem regionally. We believe that primary care and localized

resources can be fused to provide this response, and that Medicare can provide the operational structure to link these pieces together.

We also believe that this particular moment in time requires taking extra measures to ensure that our existing healthcare infrastructure survives this pandemic intact. We are currently seeing significant stress in many sectors of healthcare, not just in hospitals, but also with providers and surgical centers that are not able to continue providing care to patients who need it.

As such, our plan also includes triage responses for the healthcare system itself and for the healthcare workers and entities that make up that system. We are convinced that the costs, however large and uncomfortable to consider, will be much larger in the future if we do not take these steps. As with the economy as a whole, we consider the choice as all or nothing. Every part of the healthcare system is interconnected, by virtue of our human interconnectedness and unless every part of our system is stabilized, no part of our individual health will continue without negative effects.

These negative effects are most obvious through less healthcare available, less access than we currently have and less sophistication in the capability that we can provide. This results in less productive capacity as individuals, because we are sicker, more actual healthcare costs to the system in the future and far more rationing in areas where we should be expanding care.

However, if we use our best information, applied consistent with our principles, we believe that a path exists where the future holds the hope of better care, more care and healthier Americans, overall and individually.

Governing Principles

We have listed governing principles, sometimes referred to as first principles, in our economic document and we have done the same here. Without first listing the concepts that universally apply, we cannot ensure intellectual consistency within our solutions and we cannot effectively facilitate constructive conversation about how and where to build these plans to make them fully operational or to accommodate additional perspective, expertise and data. The most effective problem solving begins when everyone is made aware of the goal and the underlying elements to which each solution must reconcile. Doing so ensures we incorporate the most opinions most effectively. This approach also demands more responsibility on the part of each of us, as Americans, to admit to the scope of the problem and our own ability to contribute to its solution.

Solving problems in this way isn't easy, it's just the only way to actually fashion and apply solutions.

Governing Concepts for Healthcare in a Market Economy

Economic

We need to price actions in the healthcare economy based on the honest attempt to help another person.

a. The price would then result as the result of purposeful actions defined within structures that enable people to contribute their efforts to the health of another person. The compensation for taking these actions would be referenced by the person receiving the benefit, in the form of a value-added transaction which could include, but might not be limited to financial remuneration, since so much of healthcare is experienced and the benefit is conveyed within a human interaction.

In a competitive market, competition is seen as an endogenous effect that incentivizes innovation in the creation of a good or service. The benefit of such innovation is conveyed on both the consumer, in the form of a higher value product, and on the producer as the increase in knowledge, driven by collaboration towards a goal, that generates increased capability for future innovation.

a. For a market to be competitive, the consumers need a clear and verifiable price signal
b. For a market to be competitive, the consumers need a clear and verifiable quality signal
c. For a market to be competitive, prospective participants must have a personal and internal awareness of the need that a product or service can address
d. In a competitive market, reinvestment of revenues will be used to develop processes or services that enable providers and patients to generate and respond to increased knowledge of their relative responsibilities in the healthcare system

Conceptually, healthcare is uncompetitive by its construction, as it fails to a large degree on each of the above accounts. Yet, the "market" for healthcare still benefits directly from ensuring that competitive principles are included in the set of foundational ideas that form updates to our healthcare system.

Human Capital

a. The approximate current size of the United States Healthcare economy is $3.6 trillion. Within this section of the overall economy, every person contributing to that number is performing some function for which they are compensated.
b. Human capital is most effectively deployed when the incentives for its use are driven by value creation, seen equally from the perspective of individual suppliers and consumers as well as the market in aggregate.
c. Changes in deployment of human capital, in all of its facets and products, need to be consistent with the flows of supply meeting existing and future need, incentivized by shared returns under the "We are They" construct for understanding healthcare.
    i. We have formulated a question and answer model generally that, when applied to healthcare in patient-provider engagements across the spectrum, gives people the ability to link their future goals for enjoyment of life and what they need to do for their health to accomplish these goals.
        1. Healthcare providers can spend increased time interviewing their patients and finding the relevant variables to address their health needs effectively
        2. Initial questions are framed to open a space for the patient to provide their full story
        3. The direction of the ensuing questions is flexible depending on the the answers given by the patient and allows the patient to lead the session
        4. This method is designed to find what is important to individuals and the related steps that can be taken to meet their personal goals.
        5. Identify other people or resources whose additional information or support is required for meeting the goal
        6. Elicit healthy behavior changes as all involved parties come to a realization that their vision of the goal can be achieved by combining it with another's vision, information, support and effort contributed
    ii. Human capital has the potential for exponential returns when reconciled to the network effects implicit in economic participation.
    iii. The functional process by which these returns are probabilistically possible must be explicitly identified.
    iv. The locations of these returns must be acknowledged as existing (defined through the lens of human need) and unknown, as the future has not yet occurred.
    v. The context for generation of exponential returns must be constrained against the context within which the economic solution is being applied
        1. Human body
        2. Environment on the planet

Iteration as an Economic Event

a. Macro-level economic shifts involve massive displacement of workers and the income stream that they rely on to fund their daily lives.
b. For economic growth to continue, explicit accounting of the process and solution for allocating human and financial capital to new areas of the economy must be implemented into any solution
c. Capitalism and democracy, combined, form a shared understanding of the explicit role, albeit undefined, of the human capacity for innovation in generating value into the future
d. Functionally sound and economically positive policy must account for both the need for individuals and groups to bear explicit risk and the time it takes for investment and reinvestment to generate success, defined as the creation of a good or service which solves a problem more efficiently than an existing solution. Policy as constructed must also account for the time needed for a successful solution to return income streams that replace those lost from the transition from an existing process to the newly created solution
e. Group-level solutions, such as companies, must exist within a broader framework of expectations and rules that are codified in policy prescriptions, promulgated into law.
f. Broader frameworks, such as laws, must explicitly account for mechanisms that further human growth without hindering those mechanisms
    i. The frameworks are permitted and, in fact, encouraged, to disincentivize negative actions taken in direct opposition of the stated purpose of the law.
    ii. Construction of these disincentivizing actions are always and everywhere more effective when framed in terms of the types of actions that are allowed, rather than describing the nature of things that are penalties
g. Solutions that flow from adherence to the principles above will explicitly be defined by an awareness of the necessarily likely, but not directly controlled results of market participants
    i. The healthcare market is defined by consistent, similar needs for every member
    ii. The incidence of need occurs at each moment over the span of a lifetime, individually
    iii. Solutions flow directly as a result of market participants recognizing cause and effect, in both their actions and the results of the actions of those around them, and their intentional, coordinated response to improve on those results.

Hospital Financial Support

a. Government to provide up to $1 trillion in grants to hospitals with requirements for how the grant money can be spent
    i. AHA recently estimated that the US hospital system lost ~$50 billion per month between the months of March and June 2020; given the recent acceleration in the spread of the pandemic, we believe that nationwide losses could increase from this pace
    ii. Losses stem from:
        1. Losses on COVID-19 patients
        2. Reduced overall patient count, as patients defer hospital visits out of fear of contracting COVID-19
        3. Reduced or eliminated elective procedures, which are the single most important revenue stream for hospitals nationwide
    iii. Government grants pay for all wages of non-administrative hospital employees until the crisis is put under control
        1. Health expenses for hospital employees who fall sick
        2. Health expenses of family member of hospital employees who fall sick
    iv. Government grants pay for any incremental, ongoing expenses related to equipment needs for the hospital
    v. Government grants pay for employees who can be redeployed to other healthcare settings
b. Pay coronavirus expenses on behalf of the patient
    i. Hospital would have to apply for the benefit
    ii. Contingent on making the payment/cost public
c. Issue all of the payments through the Medicare structure
    i. Have patient apply and then the hospital verifies
d. Hospitals that can't survive become part of a national network that communities can buy out for local management
    i. Hospital provision of services should be defined by community need, and funding should flow according to how well proposed solutions generate returns to public health
        1. In rural settings in particular, public funding may be needed to support communities where private reimbursements and capital markets don't allow adequate provision of healthcare services essential to the communities they serve
            a. During the 1940s and 1950s, a significant number of rural hospitals were built with financial support from the Hill-

Barton act. Today, there are ~2,500 short-term, acute care community hospitals in rural areas
        b. Since these hospitals were mostly built without an underlying analysis of the health needs of the communities they were meant to support, these hospitals struggle financially and are generally underutilized, with an average daily inpatient census of 7 patients against a median of 25 beds per hospital
        c. Rural health continues to struggle today because the medical resources available don't always match community needs
    ii. Government supports running with current management and employees left in place until Community Needs Assessment process can be completed and FOIF funds are allocated
    iii. Becomes a Community-dedicated hospital supported by FOIF and Medicare
        1. Micro-level, community
        2. Micro-hospital
        3. ER - rigs in the community and urgent care to triage
e. Example:
    i. Community hospital that has a cash flow crunch
        1. Non-profit
        2. Receive taxpayer funds and fundraising
        3. Insurance reimbursement
            a. Contract dependent
            b. Payor mix
        4. Dependent on requirements for taking patients
        5. Current reimbursement AR is between 4 - 6 months
    ii. Pandemic reimbursements are not enough to cover the costs of the treatment

Applications of Medicare

Medicare as a Vehicle for a Competitive Healthcare Market

a. Medicare will be allowed to provide various insurance products to any person seeking insurance in the market
    i. Private insurance will continue in its current form as a provider in markets
b. Medicare will be accepted by every provider in the market
    i. Creates a price marker that signals a competitive price level

ii. Acknowledges that Americans, as a group, all will experience similar healthcare needs along an age chronology
    1. Determines that iteration of solutions results in a chance at more competitive markets in healthcare over time
iii. Medicare currently sets market prices based on the costs of healthcare to its population base and can update actuarial tables to account for members of the broader population
    1. Medicaid already possesses partial information availability for use in this build-up

c. Medicare will make its prices paid on all services public knowledge and update annually.
    i. Individual providers will not initially be required to provide their prices
    ii. It is expected that those who choose to do so will see higher incidence of patients, as a result of the appearance of greater service for patients
        1. Results in a more specific, intentional incentive for overall patient-centered care improvement
    iii. Creates an explicit reference for consumers on quality, as price and quality can now be directly correlated in decision-making, even if the quality markers remain vague.
        1. In healthcare, it will be days, sometimes weeks, often much longer, before a patient may know or even be able to evaluate the quality of the services they receive
        2. In some cases, the patient will never directly be able to formulate a conclusion as the quality of a medical intervention, because they have neither the knowledge nor the perspective to understand how and why an intervention was chosen.
    iv. This result makes the premium for insurance explicit in the market-place, because of the downward pressure exerted on the Medicare budget by voters interested in minimizing the cost but maximizing the quality of their healthcare outcomes.
d. By using Medicare to generate an explicit price signal and a far more useful quality signal, we, as consumers, will increase visibility on the next set of challenges, such that our knowledge expands to provide additional legislative ideas, while coordination and technology becomes available to support it.

Provider-Medicare Operational Functions as Constructed Above

Ongoing interaction with patients has always been a definitive healthcare action, but in the age of pandemic, when individual health actions affect group outcomes in a way that presents more definitive, but solvable challenges, the role of the primary care or general practice provider as an information resource for maximizing “healthspan” throughout

the life of each patient is increasingly important as a way to foster consistent, improved health outcomes.

General practice providers are the human interaction links to community health. They are the connective tissue of the vast network of specialists who support every facet of human health.

The outline that follows highlights the interactional definition of a primary care provider within the space of Medicare as a competitive market mechanism. The application of this outline would apply only to patients covered under Medicare.

a. Patients and providers of all types would receive incentives for compliance with legislative guidelines for care
    i. At minimum, incentives would account for basic quality control.
    ii. Additional incentives will be built in to drive improved outcomes for both the patient and the primary care provider.
    iii. Providers who perform well will receive higher reimbursement than equivalent treatment reimbursement for private insurance
b. Each subsequent engagement by a patient with providers beyond the general practice provider would constitute a tri-party set where each member (patient, general practitioner, specialist) contributes to the overall outcome, measured in terms of patient health.
    i. This cycle would be repeated over and over throughout the patient's lifespan.
    ii. Conceptually, a patient's health over his or her lifespan must be constantly evaluated both experientially, by the patient, and medically, by a medical professional.
        1. This tri-party construction facilitates this by positioning the general practitioner as the central repository for a patient's medical data over his or her lifespan.
c. Linking patients to a center of information reference would make the patient journey seamless, creating an unbroken health record
    i. Functionality to achieve this goal, at minimum, would link each patient and primary care provider in a central network housed at Medicare.
    ii. Individual EMR's can plug in and become a mechanism for aggregation
        1. Time limit will be specified for full linkage from EMR's to upload.
    iii. Any care provided in an urgent care or specialist setting must be communicated back to the patient's GP for review.
        1. The additional communication back to the GP, over time, ensures that information is not lost, which pays off in higher probability of improved long-term outcomes.

2. Self-referrals (which are encouraged) require a reference back to the GP for review, updating of the record, and a determination on the part of the GP whether a subsequent visit (whether with GP or specialist) is required.

d. Primary care providers will utilize a set of questions and patient responses to begin a conversation (the "Q&A") regarding the provision of necessary care, including potential referrals, for the patient
    i. Patient responses to the set questions and throughout the conversation will feed back into the decision mechanism that Medicare uses to evaluate coverage quality and level of reimbursement that confirms the outcome of the interaction for the interested parties.
    ii. Medicare will work with GPs and other medical providers to determine a set of questions that apply across the spectrum of human need over the course of a lifetime
        1. Medicare and GPs are required to share the set of questions with patients so that everyone has the same set of information
    iii. GPs will be incentivized to follow up with patients via improved reimbursements if the patient responses during the Q&A trigger a signal that follow-up might be merited
    iv. Patients who follow GP recommendations are eligible for rebates on premiums, copays and other healthcare costs
    v. Patients who complete a course of care with a specialist / GP have a 6-month follow up requirement with the specialist / GP to thank medical providers / show them the results of their work in the form of improved patient health
        1. Q&A in online setting - patient can record video and send securely to doctors
    vi. Referrals to specialists will be facilitated through the primary care providers if patient responses during the Q&A trigger a signal.
        1. Technology can help facilitate referrals and differentiate between specialist providers who are performing the necessary services per the patient Q&A
        2. Specialists will follow the Q&A model laid out above (between the specialist and the patient) to determine the level of care necessary.
        3. Specialists will be incentivized to provide a certain level of care for a patient based on the patient's responses to the Q&A.
            a. If the specialist follows through with appropriate care, they will receive a better reimbursement rate
            b. If the patient follows through on the specialists' recommendation, they will be eligible for rebates on premiums, copays and other healthcare costs.

4. Primary care providers, specialists and patients will have a confirmation call prior to the patient undergoing the recommended procedure/treatment from a specialist to ensure that there is tri-party agreement on the recommendation and the justification for doing so, as well as buy-in and understanding from the patient regarding its need.

e. Employer-provided insurance through Medicare (where the employer would pay the premium for Medicare) would form another way in which patient collaboration with the primary care provider would be incentivized
   i. The employer will receive premium reductions if its employees realize better health outcomes relative to a baseline as a result of active engagement with their general practice doctors
   ii. The employee will receive a portion of the premium reductions on their insurance as well
      1. Medicare will have visibility on the outcomes themselves and can disburse the credits equally and accurately.
   iii. In order to be eligible for premium rebates, employers would be subject to a number of conditions:
      1. Employers would be required to activate employee benefits available from Medicare within 90 days of enrollment or they would become ineligible for any incentives
      2. Employers would be subject to rules regarding activation and access on the part of employees.
   iv. Structures against abuse between employer and general practice provider
      1. Collusion between employer and general practice provider
      2. Ensure providers are incentivized to adhere to lower cost options for healthcare outcomes rather than over-testing / over-prescribing
f. Incentives for employers to offer a Medicare-sponsored option
   i. Employers receive a tax benefit / incentive for providing the program to employees
   ii. Employee participation benefits the employer via reduced premiums and improved outcomes
   iii. Both the employee and the employer benefit if the health outcomes are better

Products and Services Procurement

a. Every company/entity willing to participate in a market has to produce a good that solves a personal need/problem in the healthcare space.

b. Medicare evaluates the best tool for the job and sets the price level (and therefore the quality) baseline at that point based on an analysis of the cost for the producer to produce the product.
c. Medicare orders x number of these items for distribution via the government plan and as such, sets the price for this product in the market.
d. We expect that this explicit price setting-mechanism, derived from market principles drives quality up and overall price down.

Long-term, this approach will allow policy-makers, patients, providers, insurers and suppliers of support services to the industry to explicitly identify where discontinuities in care, reimbursement and access are occurring and to formulate a solution.

Medicare as a Government Entity in the era of Pandemic and ongoing health needs

Pandemic response will increasingly become an accepted, long-term health risk that will need to be addressed to the same extent as all other health risks of which we are broadly aware. To do so requires planning, process and explicit delivery of services through a network of providers, insurers and suppliers that will interface directly with the aggregate social needs at the public health level.

Because of the need to deploy resources immediately in response to the pandemic, the application of Medicare as a broader institution for execution of ongoing healthcare needs will need to be considered in crafting pandemic response legislation but process requirements for general practice/patient portions of the Medicare capabilities may be implemented in parts to allow providers and other stakeholders to adapt their processes to the new healthcare landscape.

a. Medicare's responsibilities will be expanded to include operational management of provision of pandemic response services
    i. Ongoing improvements in healthcare are increasingly predicated on efficient collaboration between private and public entities, such that innovation and efficiency grow commensurately with accessibility and outcomes.
b. Medicare will touch each person's healthcare journey one way or another, and using it as a central repository for information and analysis should ensure that our economy and our interconnectedness remains a strength, not a weakness in our ongoing approach to any pandemic.
c. In this initial wave of pandemic, we are asking our healthcare providers, first responders and public servants such as law enforcement to exert enormous effort. They are sacrificing at levels that are unsustainable and we must ensure

that they don't have to do so again. We need our healthcare providers to be providing care for many years in the future.

Constant Pandemic Readiness Program

We will define the measure of success in each community as the number of lives saved. We explicitly define the importance of people being cared for by loved ones, even during a situation where one passes away and how valuable it is to individuals caring for their loved ones in need to be able to be close to them, consistent with the healthcare needs of each. Our goal is to both reduce the acute stress on the healthcare system from pandemic response and to provide more structured opportunities for families and communities to care for one another.

a. Create a public ledger of a set of preparedness and execution questions that are asked by the program of each community and answered by the city officials and community leaders tasked with their execution of coronavirus readiness
    i. Reinforces responsibility for cooperation on the part of Administration at the Federal level, Administration at the local level and the community to answer a battery of questions to ensure operational functionality of care provision
    ii. Outline each step that the community will take, such that their residents are aware of the scale of the response
b. Criteria for evaluating success of the program - When a person becomes sick, and if a person lives, their survival has substantiated that society has provided them the value exchange that they desire from being a member of that society.
    i. If they live, and they are insured by Medicare, they get to pay the same Medicare rate, including Pandemic preparedness costs, prior to sickness, as long as some action is taken to compensate their humanity received with humanity given
        1. Could be in the form of thank you cards, flowers, etc, with the goal of supporting providers' mental health, and some submission of the verification for their Medicare file
            a. Medicare is already building files for these patients and would have the ability to cross verify
            b. The costs for administration would be justified by the investment into the people who are providing the care
            c. Ensures that providers are able to continue to provide care in the future
            d. This minimizes the government's long-term costs via loss of providers and its effect on the overall health of the population

ii. Returns to these processes can be framed through the concept of reciprocity, as described in point i. above, and the responsibility it engenders. For those who are being cared for, there is a higher likelihood of adherence with prescribed behavior, and, for those who are caring, there is a stronger belief that their efforts will be acknowledged. This reciprocity ensures higher effort given on both the part of the patient as well as the provider of the care.
    1. Reciprocity drives cost savings to each engagement as it drives more focus and targeted investment in finding a solution to each problem
    2. Those people who do not fall sick due to the Pandemic would pay any rate increases in Medicare collectively, incentivizing us to become more healthy and to plan for future pandemic outbreaks, since response and prevention is a community-based concept.

Deployment of the Pandemic Readiness and Response Program

Rural

Distribution of tests and materials for testing would be made available through the local post office, DMV, or community facilities such as civic groups and churches. We will ask the civic groups and churches to coordinate their resources and make calls for volunteers.

Commented [2]: Please see page 24 for further information on pandemic response supply distribution.

a. In Rural Areas this is an especially effective way to reach members of these communities
b. Each person would receive notification by mail of the opportunities for pandemic response in their community and be notified that community organizations are tasked to provide support
    i. Sample questions from the administrative questionnaire referenced above will be listed in the mailer to every person
    ii. Everyone with an address will receive a mailer
        1. Use libraries for everyone who isn't reached by mail
            a. Technology will be made available for use of the questionnaire
    iii. Alerts will be published through utility companies, cell phone companies
        1. Message that says you will be hearing from your local community leaders to build an ongoing response structure
    iv. Church, communities organizations are central hubs for information dissemination
c. Local community leaders and tribal organizations

i. Organize collaboration between various community organizations
    1. Requires them to hold the meeting
        a. Take volunteers and assign responsibilities in public
        b. Recorded so that people can view later

ii. Triage protocols
    1. Community Health organizations and Social organizations
        a. Interface with the churches, religious groups, and not-for-profits for information dissemination
        b. Social Distancing and communication processes to keep everyone involved and linked
            i. Each organization provides direct information to its constituencies
    2. Self-tests - pickup or delivery to homes
    3. Triage Portal for every American
        a. Includes access to a distributed online questionnaire
            i. Something like coronavirus.gov
            ii. Determination of symptoms or contact
            iii. Instructions for self-quarantine process
            iv. Submission of the online questionnaire begins the tracking process of the case
        b. The online questionnaire determines whether there is a need to test
            i. Self-test administered
                1. Online or call-based support for people with needs
            ii. Results distributed to their local community organization
    4. Tests or options distributed through the churches and the local organizations where the tests have been made available, public libraries
        a. Local stocks of tests will be based on geography and level of population density
    5. Provide for additional licensing options for test-reading technology to private companies to build the latent capacity during surge events
        a. Regional incentives for participation on the part of companies
        b. Could provide support through colleges and universities with labs
        c. Provided by the Federal government
    6. Ongoing testing should not function only as a matter of capacity

Commented [3]: Is there also a role for insurers here in informing their patient populations of new triage and testing protocols as well?

Commented [4]: What will our test selection criteria be for infection, immunity, and genomic mutation tests?

a. For those that test negative initially, we will continue to offer tests and shorter intervals than those who have not yet been concerned about infection

7. Assuming test comes back positive
    a. Patient goes back into the triage portal
        i. Internet
        ii. Smartphone
        iii. Telephone
    b. Log symptoms and verification of test
        i. Given info of closest location, tasks etc
    c. Transmitted to community-based hub
        i. Made aware of contact location if necessary
    d. Hospital is plugged into the portal
        i. If someone comes into the emergency room with Coronavirus symptoms
        ii. Stabilized
        iii. Re-routed to an outside location
8. Segmented based on severity of care needed
    a. Non-MD that have been repositioned to support
        i. Could be dentists, etc. who are on call on a rolling basis
    b. Centralized group of people
    c. Allocate reserves to that pool in hard-hit areas where there are no additional medical professionals

d. Process
    i. Our Administration communicates the level of physical assets that would be required for the triage
        1. Rooms, PPE, ventilators, etc
    ii. Distribution is determined based on tiered levels of need
    iii. National Guard to help set up as many of these locations as possible
        1. Pop up rooms
        2. Volunteer locations
        3. Options for tasking hotels
            a. Eminent domain concept applied in a way that supports the industry while providing care options to the local communities
    iv. Ensure providers don't drop from exhaustion - administrators must provide for appropriate scheduling that ensures time off for front-line providers
    v. Information Portal for Training new providers

Commented [5]: New York City can serve as a case study for how we should construct non-hospital treatment centers and permit less-stringent transfer and admittance criteria.

1. Will be for both existing healthcare providers and prospective volunteers who want to support the needs
2. Something like a Khan academy for medicine such that lay-people can provide basic medical care

vi. Care can be provided for people with non-severe conditions that are self-quarantined at home with families / other people
   1. From repository of community organizations and their list of volunteers

vii. Build out contact tracing section to account for cell phone technology that automates warnings and tracking

viii. National guard can support communities in the execution of plans - centralized training can be provided to National Guard / Army regarding construction of facilities and coordination of local resources in concert with community leaders, etc.

Commented [6]: We need information from epidemiologists and medical professionals to develop a reopening plan in the context of having a vaccine in 2021

Urban

Distribution of tests and materials for testing would be made available through the local post office, DMV, or community facilities such as civic groups, gyms, schools, employers, and churches. We will ask the civic/business groups and churches to coordinate their resources and make calls for volunteers.

e. In urban areas the reach of organizations will need to reflect more common touchpoints and diverse distribution channels
f. Each person would receive notification by mail of the opportunities for pandemic response in their community and be notified that community organizations are tasked to provide support
   i. Sample questions from the administrative questionnaire referenced above will be listed in the mailer to every person
   ii. Everyone with an address will receive a mailer
      1. Use libraries and social service providers for everyone who isn't reached by mail
         a. Technology will be made available for use of the questionnaire
   iii. Alerts will be published through cable/internet/utility companies and cell phone companies
      1. Message that says you will be hearing from your local community leaders to build an ongoing response structure
   iv. Churches, community organizations, schools, gyms, unemployment offices, and local businesses are central hubs for information dissemination

g. Local community leaders and tribal organizations
    i. Organize collaboration between various community organizations
        1. Requires them to hold the meeting
            a. Take volunteers and assign responsibilities in public
            b. Recorded so that people can view later
    ii. Triage protocols
        1. Community Health organizations and Social organizations
            a. Interface with the churches, religious groups, not-for-profits, schools, local businesses, and internet/cable/utility companies for information dissemination
            b. Social Distancing and communication processes to keep everyone involved and linked
                i. Each organization provides direct information to its constituencies
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Committee created to construct guidelines and execute on solutions for all Pandemic and Public health-related Federal Government Actions

a. Governors, CDC, NIH, FDA, National Institute for Allergy and Infectious Diseases, HHS, DOD, FEMA, HUD, CBO, Treasury, Medicare, State Department, industry execs, hospital administrators, practitioners, patients, supply chain and logistics, together to hammer out guidelines and create oversight structure
b. Ideas and think tanks requested to propose new solutions
    i. Licensing, legislative and procedural
c. Put together financing and development mechanism
    i. Bid or opt-in function
    ii. Price controls
d. Prepare for another 12 - 18 months and multiple waves
    i. Consider future annual needs and anticipate now
    ii. Reevaluate timing and long-term planning as new data becomes available (i.e. timeframe for vaccine development, manufacturing, and widespread distribution)
e. Create Subcommittees to manage the processes identified below

f. Providing funding to proposal-based think-tank for scientists not directly involved to earn grants for solving problems that are asymmetrical but directly related to long-term solution of similar, anticipated problems

Healthcare Districts created to organize and conceptualize each community's actions supporting community health

a. Individual District Boards staffed from members of the community
    i. State and Federal participation in the community boards
    ii. Link funding mechanism to ROI via prevention of Pandemic costs
    iii. Need to make the concept of responsibility explicit through the discussion as well as the construction

Healthcare Credentialing across state lines

a. Allows for redistribution of healthcare professionals to the areas with the greatest need
b. Optimizes deployment, speed of application, and utilization of healthcare resources

Hospital Management

a. Get data and project every at-risk hospital's needs over the next 12-18 months
    iii. Identify possible impact of treatment and incidence rate, actively infected
    iv. Standardize the pricing and account for regional variance in items like staffing, etc
        1. Block grants for expenses
    v. Oversight and validation process from former managers with track records of prudent financial management
    vi. Opt-out structure
f. Bankers have to be involved in the process
    i. They are already looking at financial statements/projections and can identify areas of lock-up and issues in the daily cash flows
g. Identify reimbursement updates to current models, delivery of emergency funds, usage availability of earmarked funds
h. Specific financial solutions based on the following types of hospitals
    i. Non-profit/foundation-based and insular hospital
        1. All reimbursement, grants, fundraising, payor contracts
    ii. District Hospital
        1. Tax support, reimbursement, donors
            a. Restricted and Unrestricted funds

2. Required to report community benefit dollars
    a. To ensure access to care
3. Required to spend their funds within the district
4. Can access the bond market for funding
    a. General obligation bonds

iii. Non-profit hospitals
1. Reimbursement, donors
    a. Restricted and Unrestricted funds
2. Required to report community benefit dollars
    a. To ensure access to care
3. Required to spend their funds within the district
4. Can access the bond market for funding
    a. General obligation bonds

iv. For-profit
1. Reimbursement and favorable payor mix, fundraising

v. County Hospital
1. Funded by local governments

Testing / Vaccination Regime

a. Hub and spoke mechanism regionally
b. Link to city, county, schools
c. In-home tests preferred for both infection and immunity
    i. Create a national database within Medicare
    ii. Seller of test requires uploading the sale to Medicare site
    iii. User of test requires verification of result on Triage Portal
d. Consistent testing requirements
    i. At home tests free to consumer
    ii. At periodic intervals
    iii. Allows for improved knowledge of population susceptibility and informs the rate and locations in which reopening can occur
e. Minimum thresholds before tests go to market
    i. False negative/positive results posted publicly for each test
f. Stabilizing supply chains and delivery to those in need of supplies, know-how, etc.
    i. Testing supply chain input sourcing
    ii. Logistics and distribution network support
    iii. Laboratory supplies and capacity
g. Allocate testing and vaccine supply over effective regions until supply is high enough to keep up with demand

Commented [7]: Consider virus genomic testing to track macro-level mutation/transmission trends, too.

i. Correct for current imbalances in supply and demand and create a process by which these imbalances can be sorted out without creating unnecessary bottle-necks
ii. Address the need for regional and rural hospitals who will experience Covid-19 effects later in the calendar will have the supplies they need if they have sent their existing supplies to locations that had demand earlier
iii. Reallocate laboratory capacity and create regional surge capacity such that laboratory capacity is not a bottleneck to implementation of testing programs

h. Portal that formalizes the supply chain analysis for medically necessary products
   i. Take a series of bids from prospective bids
i. Stabilize the demand for products that are essential supplies or are still in development
   i. Account for the increase in demand that is taking these products from existing patients who have a current need
   ii. Regulated by FDA guidelines
      1. Clear standards for development and quality assurance
      2. Quality controls drive approval and resource allocation
   iii. Govern the use of these prescriptions by healthcare priority, rather than access
j. Establish protocols for vaccine development, approval, manufacturing, and distribution
g. Publish data for lack of inventory across regional spectrums
   i. Methodology for transfer of inventory
   ii. Linked to the committee efforts below
h. Look for alternative suppliers for moments of surge
   i. Companies contact Administration to pitch their capacity
   ii. Administration equally to reach out to prospective companies
      1. Proposals to be reviewed and cost agreements negotiated
   iii. Possibly a 3rd party licensing agreement with 3M and other providers to allow people to construct the masks, gowns, ventilators, etc
   iv. Need industry (manufacturing) experts to help identify qualified producers and substantiate predicted output times

Commented [8]: Where are our essential supply chains hindered by poor quality or unclear standards/quality assurance?

Commented [9]: We need more information from epidemiologists, scientists and medical professionals to determine the optimal set of protocols

Healthcare reinforcements

Ensuring people remain as healthy as possible, continuing testing and efficiency of long-term testing sites (one year or longer) and building capacity by pulling in idled workers to begin support and replacement of providers who are exhausted.

a. Recruit remaining secondary healthcare providers to fill in need, train with retired front-line healthcare workers

i. Level of aid they receive in their business would be some link to their participation
ii. All doctors trained, rotated and served
1. Dentists, Veterinarians, etc

b. Enlist retired healthcare workers to train those who would go into the front-lines from jobs. - Anyone who wants to volunteer
i. Licensure registration updated to allow people to cross state lines to support
c. Final year medical students pulled into the support force or primary care force
d. Hospital Foundations (Non-profit)
i. Need to determine what they need for support
e. Physical locations and equipment remain (no evictions, foreclosures, loan calls, etc)
f. Funding and training cost methodology

Telehealth support

a. Use existing telehealth nurses to answer questions for patients who aren't yet at the Hospital
b. Use existing telehealth resources from other regions to support other and ongoing health needs of the population base in hard-hit areas.

Support for first responders and fire departments

a. Equipment for them to prevent transmission
b. Training for how to use it

Caregiving for Caregivers

a. Healthcare workers
i. Healthcare workers will need support for their children and support if they fall ill
1. Life insurance in the event of loss while treating pandemic victims
ii. Check with the Unions
iii. Paid Time Off
iv. Access to Mental Health services
b. Law Enforcement
i. Hazard Pay increases
ii. Life insurance in the event of loss due to pandemic
iii. Family fund for those who lose a family member in law enforcement to pandemic

c. First Responders
    i. Hazard Pay increases
    ii. Life insurance in the event of loss due to pandemic
d. Those who are sick with from pandemic
    i. Home health resources activated and deployed
e. Food relief for affected families over and above food bank support outlined in Economic plan if primary wage earner falls ill and doesn't have paid leave or sick time.

Incentives for volunteers

    i. People who support triage and care for people turned away from the hospital to other community-based situations
    ii. Program is structured for compensation if a volunteer wants that option, they can accept it or they can specify where they want it to be delivered, or they can just decline

Transfer Hospitals for Patients who have non-pandemic Emergency procedures

a. Create regional support hubs to assign beds for medical care to generate excess capacity
    i. Local hospitals not utilizing all of their capacity can contract with other providers to support at their locations

Stakeholder preparation and training

a. Information delivery coordinated by Committee, driven by agreed upon rules from main committee
b. Requires explaining the links for each entity in the process
c. Each has information requirements themselves that tie into the other actions that everyone else will take
d. Centralized reporting of testing
e. Hub and spoke method
f. Link to FEMA as a way to provide one system for tracking reporting of need

Manufacturing and long-term supply management of resources

a. National Stockpile rotates supply periodically back to on-the-ground resources
b. Minimum manufacturing supply quantities based on population statistics and probabilities of need

Information security

Commented [10]: What can we do to ensure adequate reserves in federal government resources to minimize the compounding risk of overextension during the pandemic response?

Commented [11]: Consider a "backing pool" to manage supply between hot spots and cool spots as described in this article:

https://www.rand.org/pubs/perspectives/PEA187-1.html?utm_campaign=&utm_content=1587071428&utm_medium=rand_social&utm_source=twitter

a. Ensure safety of patient data
b. Account for increased hacking that is occurring during these periods of stress to our healthcare system

Refurbish existing sites and build new healthcare sites

a. In densely populated areas, repurpose existing space and turn it into capacity
b. Deploy pop-up hospitals
c. Army Corp of Engineers

GP and primary care testing (urgent care)

a. Set up consistent and stable testing capabilities, and funding of resources, support
b. Directed by Medicare, even for non-Medicare insured patients

Data collection and tracking (centralized - hub and spoke for regions)

a. Begin building the infrastructure
b. Example: Work with existing EMR's with substantial reach to build a portal for protocols to facilitate national triage for pandemic
    i. Tech companies to develop a secure channel access for medical workers to utilize shared information and data
c. Shared data from various agencies into a central repository
    i. Facilitates inter-agency cooperation
    ii. Initially, something like an inter-agency need board
        1. Long-term build in a formal structure

Repurposed building and clinic cleaning

a. HAZMAT and FEMA process for verifying that buildings that were used to create supply are ready and able to begin their normal use, such as dormitories, hotels, etc
b. Ongoing process for additional waves in the future

Idleness during waves

a. Surge capacity structure constructed
b. Secondary providers can opt back in as the surge occurs again
    i. Potentially some sort of reimbursement for doing so to compensate

c. Help from outside areas in terms of personnel, equipment, etc
    i. Potentially some sort of reimbursement for doing so to compensate

Vaccine funding and research

a. Process for making sure money is available for future pandemics
b. Return-on-investment is significantly positive, based on reasonable probability of another pandemic and associated costs of lack of vaccines available

Insurance markets

a. Propose Forbearance Policy for Insurance
b. Recapitalize some portion of losses
c. Insurance companies can't raise rates related to Coronavirus
d. Insure that testing is covered through commercial insurance plans

International Efforts - ties to Foreign policy

a. Requires leadership of coordinated responses on the part of every nation to address a global pandemic

Medical school

a. free medical school if students choose roles in the mental health profession
    i. Role is underserved and needs will increase exponentially over the coming years

Next Steps

Conversations with members of American society, to build out the practical applications of these concepts and to ensure completeness to the stated goal

Community Needs Assessment

Because of the environment in which we find ourselves, the Healthcare Plan above serves to address the immediate needs of the U.S. healthcare system. In support of longer-term, community-specific needs, we've developed a Community Needs Assessment process that will include questions related to the healthcare needs of individual communities to help us identify where additional resources are needed.

1. In order to move the conversation forward and make it practical, we're going to start engaging with communities and representative healthcare providers that serve their communities.
2. We'll need to see how the plans intersect with the problems they're facing and solicit their input in areas where we don't have primary knowledge.
3. The goal will be to develop policy proposals and case studies that we can roll out to communities whose healthcare providers are dealing with similar challenges and that will serve as the basis for future legislation.