I appreciate the attention you are paying to this important issue. However, there is no single “quick fix” and I fear that if we try to invent one, things will only get worse. We have doubled down on care rationing via “managed care” over the last several decades. Our system is bloated and weighted heavily towards documentation rather than true patient care. It is more expensive and less effective than ever.

EMRs not only do not live up to their promise, they add a host of administrative tasks to physicians’ day that have little if anything to do with patient care. Institutional networks and systems are fragmented and getting real time access to crucial information from multiple institutions is more difficult than ever because of security concerns. EMRs contain proprietary information that makes the goal of “interoperability” unattainable. The cost and complexity of EMR system maintenance and exponentially increasing regulatory requirements force doctors into large groups where we are relegated to data entry and coding tasks rather than the patient care we trained for. We are clearly expendable. Physician burnout and suicides are at an all-time high.

I agree that everyone needs to work together to build a health care system that makes sense, is cost effective and equitable, takes advantages of existing strengths and creates centers of excellence for high intensity / low incidence conditions. Such “Model Systems” were created by the Federal Government in the 1970’s to manage spinal cord injury and that model can still work today with some modifications.

I recommend the following:

1. Create a central database for health information like the IRS data base for financial information. Such databases already exist through insurance claims data and can be made interoperable and secure using existing technology.
2. Assign each person who seeks health care in any setting in the country a “Health Security Code” or similar secure portal so that all progress notes, lab results, imaging studies and advance directives are accessible **to the patient.** In turn, the patient can authorize access to their information for **any treating** health care provider in real time. This approach allows EMR companies to retain proprietary material and takes the onus of data protection off individual practices and institutions. It also removes the need for restrictive “networks” based on costs and / or geography. It protects existing relationships between patients with multiple chronic conditions and their care teams, including PCPs, home care staff and specialists. It allows for the fact that people move and switch employers frequently.
3. Assign each person a “core team” consisting of a midlevel provider and a physician. One should be a generalist and the other should have relevant specialty skills depending on what conditions the patient is dealing with. This team becomes the primary liaison between the patient and the system. They should have access to behavioral health and specialist care, including the ability to consult via videoconference with distant specialists who have experience with the specific condition(s).
4. Hire adequate support staff, such as medical coders, administrative assistants and medical assistants for data entry and coding rather than burdening clinicians with this task. This frees up doctors and nurses to do the actual work. It may seem costly in the beginning but will save resources and improve outcomes in the long term.
5. Train and hire nurses, NP’s, PA’s, physical, occupational, speech and respiratory therapists to provide hands on patient care and maintain lines of communication. Social workers, case managers and other clinical personnel can help ease transitions between different care venues, including home/community, urgent care, emergency rooms, acute hospital, LTAC and SNF facilities that may not have access to real time information. Over time, these teams can develop special expertise in low incidence / high intensity conditions.
6. Assign each specialty society the task of developing “Best Practice” protocols for conditions they typically manage and use these as a starting point for patient care. Specialties could work together on certain conditions, including multiple trauma, childhood onset illnesses that persist into adulthood, pain management and obesity related illnesses. Ideally, the protocols would start with the least invasive treatments and allow enough time for them to bear fruit. The protocols should clearly have scientific evidence to back them up, but they should also include common sense approaches that should be a given, such as hand washing, clean instruments, appropriate equipment and universal precautions. They should also consider the need for human contact, which has been all but lost in our current system.
7. Create a modular system of care that can be adapted easily for specific conditions. For example, home based care, outpatient care, urgent or emergency care, minute clinics, day hospitals, inpatient rehab and skilled nursing facilities all have their place. Educate patients and families regarding where and how to access care. For rare and complex conditions, designate regional centers to provide care across the continuum and allow them to interact with local primary care staff.
8. End direct to consumer advertising for medications and durable medical equipment. Support smaller, more nimble companies that can develop a specialty area and make sure there are enough to cover existing patients.
9. End “competitive bidding” rules that select for low cost, low quality equipment and supplies. Preventive care works, but only if there is access.
10. Prior authorization practices have gotten out of control. Allow clinicians to talk to a clinical peer to explain their treatment and cite relevant evidence.

I realize that these guidelines are rough, general and will require some investment. However, many of these scenarios already exist in some form. Several have been used routinely in the past and proven their worth many times over. After throwing billions of dollars down the rathole of EMRs and managed care, isn’t it worth a try?