“Once detailed studies of the vast natural experiment provided by COVID -19 are analyzed in the post -pandemic period, thresholds for the treatment of a host of conditions are likely to be reconsidered.” Christakis, Nicholas “Apollo’s Arrow: The Profound and Enduring Impact of Coronavirus On the Way We Live,” p. 269 in Chapter ‘Things Change.’

> With respect to telemedicine, more was accomplished in two weeks than in five years. Brigham and Women’s found that only 5% of patients needed in -person visits.
>
> Pandemic highlighted how much care could be provided at home. Venues and type of providers who could offer various types of care.
>
> Iatrogenic illnesses perhaps as many as 50 to 100 thousand deaths. Overall, perhaps as many as 1% of patients admitted to hospital die from a medical mistake.
>
> Patients admitted to hospital for cardiology related diagnoses had better prognosis when cardiologists were attending national annual convention.

Time to consider non-traditional, innovative care. But what overarching standards must there be?

- Assess regional health and financial needs, with a focus on prevention, chronic conditions, equity

Sample measures

How many people in any given region have a Primary Care Physician, and have seen them?

> Detailed Medical History

Status of prevention, and baselines

Monitor if care for Chronic Care meets standards?

McGlynn standards of care?
https://www.nejm.org/doi/full/10.1056/nejmsa022615

Quality and Cost

There is the standard assumption that for medical care, better quality costs more money. That assumption is antithetical to broader understanding of quality and systems. A well developed and capable system leads to better quality AND to better outcomes, as well as lower costs.

This all ties inseparably to how many dollars will be provided to each of the regional entities, when those are determined.