PSA / IHPF STRATEGIC ANALYSIS

Top 12 Takeaway Action Items

A sequenced 90-day board and implementation agenda

Derived from the 28-page Healthcare Vision 2.0 strategic reconciliation

EXECUTIVE READ

Do not authorize a broad AI platform. Authorize a bounded 90-day Stage 0 that produces the partner commitments, workflow definitions, safety rules, capacity evidence, financing pathway and independent evaluation plan required before any participant-facing pilot.

Ranking method: strategic importance to PSA/IHPF decisions, durability across the source analysis, and leverage over later design choices. Source section and page anchors are included for traceability.

Role note: proposed owners below are accountable roles, not assignments to named individuals. The PSA Board should name people only after confirming authority, time and resources.

01 Adopt “person-directed healthcare” as PSA’s governing term

Action. Approve a short board definition: the person directs goals, permissions, preferences and acceptable burden; professionals retain duties; institutions retain obligations; support may be delegated and must remain accessible without AI.

Why now. The term will shape partner selection, governance, product requirements and evaluation. Without a shared definition, “personalization” can leave institutional control and patient workload unchanged.

Required output. Board-approved definition and a one-page design-principles statement used in every Stage 0 workstream.

Proposed accountable role / timing. PSA Board chair with strategy lead; Days 1-14.

Gate. No partner charter or pilot specification advances if it conflicts with the adopted definition.

Source anchors: §§10, 16 and 19; Decision Appendix E.1; pp. 12, 17-20 and 24.

02 Settle the document architecture and provenance rules

Action. Preserve Gary's original paper unchanged and clearly attributed as the introductory vision; adopt Healthcare Vision 2.0 as the collective strategic and evidentiary reconciliation that follows it.

Why now. This protects authorship, separates vision from operating claims and prevents model-generated convergence from being mistaken for independent empirical validation.

Required output. Approved document order, editorial note, source/provenance register and version-control convention.

Proposed accountable role / timing. Board secretary or designated evidence steward; Days 1-14.

Gate. No public or partner-facing version is released without explicit attribution and evidence labels.

Source anchors: §§2, 18 and 19; Decision Appendix D and E.2; pp. 4-5, 19-20 and 23-24.

03 Authorize only a bounded 90-day Stage 0

Action. Authorize discovery, co-design, baseline measurement, workflow definition, partner negotiation and reversible diligence—but no participant deployment and no material vendor commitment.

Why now. The current unknowns are operating and institutional, not merely technical. Stage 0 should determine whether a safe, financed and measurable pilot exists before PSA builds software or enrolls people.

Required output. Stage 0 charter, budget, risk register, named workstream leads and a Day 85-90 GO / REVISE / STOP board meeting.

Proposed accountable role / timing. PSA Board sponsor and Stage 0 program lead; Board authorization now; work across Days 1-90.

Gate. No Stage 1 enrollment until every required Stage 0 output is approved.

Source anchors: Executive Vision; §§14-16; Decision Appendix B, D and E.4; pp. 2-3, 15-18 and 22-25.

04 Validate the first wedge, population and site before final selection

Action. Use Doña Ana post-visit, discharge or referral closure for a defined Turquoise Care diabetes/hypertension population as the presumptive wedge, then confirm it through baseline and partner discovery.

Why now. The first use case must have frequent, observable and consequential next-step failure, a credible comparison, reachable participants and partners able to respond. Presumption is not proof of fit.

Required output. Event/population/site selection memo with baseline 30-day completion, burden, volume, subgroup and feasibility data.

Proposed accountable role / timing. Stage 0 lead with clinical, payer and evaluation leads; Days 8-70.

Gate. Revise or stop if failure is too rare, closure cannot be measured or responder capacity is inadequate.

Source anchors: §§14-16; Decision Appendix B, D and E.5; pp. 15-18 and 21-24.

05 Secure the operating coalition and name accountable humans

Action. Conduct structured outreach to one Turquoise Care MCO, a provider/FQHC or hospital, a clinical sponsor, SYNCRONYS, pharmacy/transport partners, CHW/promotora organizations, rural/tribal representatives and an independent evaluator.

Why now. The connective layer cannot close tasks unless institutions commit response capacity and authority. General interest or letters of support are not enough; consequential questions need named owners and service levels.

Required output. Partner map, letters of intent, authority matrix, escalation routes and response-service-level commitments.

Proposed accountable role / timing. Partnership lead with Board sponsor; Days 8-28, refined through Day 90.

Gate. No enrollment without a named clinical backstop and funded, timed response routes.

Source anchors: §§5, 12 and 16; Decision Appendix D and E.6/E.11; pp. 8, 13-14, 17-18 and 23-25.

06 Co-design the service with residents, caregivers and plural communities

Action. Complete compensated journey interviews across language, rurality, disability, caregiver status, socioeconomic circumstance and relevant tribal/community contexts, using Gary's case as one exemplar rather than the population model.

Why now. The pilot must reduce—not reassign—the process burden of obtaining healthcare. Co-design should reveal preferred channels, useful communities, refusal/permission needs, caregiver capacity and points where the service itself could become intrusive.

Required output. Ten to fifteen compensated interviews, journey maps, accessibility requirements, caregiver-delegation rules and a plural-community segmentation.

Proposed accountable role / timing. Community co-design lead with paid CHW/promotora partners; Days 15-35.

Gate. Redesign if the proposed workflow increases contacts, confusion, surveillance concern or unpaid family work.

Source anchors: §§7, 8 and 11; Decision Appendix D; pp. 9-13 and 23.

07 Define closure semantics and prove the manual workflow first

Action. Specify what sent, accepted, scheduled, completed, verified and failed mean for each task type, then run the workflow manually before allowing AI to influence participant-facing work.

Why now. Technology cannot compensate for ambiguous responsibility or false completion. Manual execution reveals exception volume, response delay, missing data and actual labor before automation hides them.

Required output. Task-state dictionary, owner/due-date/escalation rules, closure evidence standards, manual scripts and a burden/exception map.

Proposed accountable role / timing. Workflow lead with clinical sponsor, navigator lead and evaluator; Days 36-65.

Gate. Do not automate a task whose meaning, accountable owner or closure evidence is unresolved.

Source anchors: §§5, 8, 14 and 16; Decision Appendix B and D; pp. 7-8, 10-11, 15-18 and 22-24.

08 Adopt bounded-AI, clinical-safety, privacy and governance controls

Action. Write the intended-use statement, allowed and prohibited functions, source controls, human review rules, disclosure, audit logging, incident process, correction/appeal rights, change control and kill-switch authority.

Why now. The recommended first pilot may use AI for drafting, approved translation, task extraction, barrier classification and nonclinical queue support—not diagnosis, prescribing, test interpretation, autonomous triage, denial or emergency-delay advice.

Required output. Governance charter, clinical escalation protocol, consent/proxy model, AI red lines, audit specification and incident/rollback drill.

Proposed accountable role / timing. Clinical safety lead and privacy/governance steward; Days 29-55.

Gate. Pause on serious preventable harm, delayed urgent escalation, material breach, untraceable output or inability to identify the accountable reviewer.

Source anchors: §§5, 13, 15 and 16; Decision Appendix B-C, D and E.8; pp. 8, 14-18 and 22-25.

09 Fund and capacity-test the human operating model

Action. Define paid CHW/promotora, navigator, supervisor, clinical backstop and reviewer roles; measure minutes, caseload, queue age, escalation slots, overtime, emotional workload and training needs.

Why now. AI output is not capacity. The pilot becomes unsafe or exploitative if review and coordination depend on uncompensated labor, heroic staff effort or an assumed able caregiver.

Required output. Role/authority matrix, staffing ratios, supervision plan, training package, capacity baseline and workload ceiling.

Proposed accountable role / timing. Workforce lead with clinical sponsor and finance lead; Days 8-70.

Gate. No enrollment if service levels cannot be met within funded workload limits; pause on unsafe queue growth or uncompensated scope expansion.

Source anchors: §§5, 7, 9, 11, 16 and 19; Decision Appendix B-C and E.6; pp. 8-13, 17-20 and 22-25.

10 Secure financing and value-capture terms before software build

Action. Map who pays, benefits, saves, loses revenue and captures value; negotiate a payer/provider term sheet covering CHWs, supervision, review, evaluation and ongoing operation.

Why now. A grant may finance discovery but cannot prove sustainability. Savings may accrue to a payer or provider while the community operator bears closure cost. Attribution and value capture must be contractual, not aspirational.

Required output. Full cost model, payer/provider value map, loss/resistance analysis, attribution logic and signed financing pathway.

Proposed accountable role / timing. Finance/economics lead with Board sponsor; Days 22-45, finalized by Day 90.

Gate. No build or scale without a sustainable payer and funded human/review capacity.

Source anchors: §§12, 14 and 16; Decision Appendix C-D and E.7; pp. 13-18 and 23-25.

11 Test minimum viable interoperability and vendor exit

Action. Determine what data can be accessed from providers, SYNCRONYS, pharmacies and payers; test minimum adapters, consent, latency, provenance, portability, rollback and vendor exit without waiting for perfect integration.

Why now. The connective layer should federate across incumbents rather than replace them. But weak data, semantic mismatch and lock-in can invalidate closure claims and transfer risk to staff.

Required output. Data availability map, adapter prototype, security review, semantic test, audit trail, portability package and demonstrated exit/rollback.

Proposed accountable role / timing. Data/technology lead with governance steward; Days 50-76.

Gate. Defer any function whose data rights, latency, provenance or rollback cannot be made explicit before exposure.

Source anchors: §§5, 14-16 and 19; Decision Appendix A-D; pp. 8, 15-18 and 21-24.

12 Pre-register independent evaluation and empower a stop decision

Action. Specify the comparison, power assumptions, primary completion outcome, safety and burden co-primary measures, subgroup plan, economic analysis, implementation fidelity and prespecified stop rules.

Why now. Engagement, model accuracy and enthusiastic anecdotes are insufficient. The pilot must show meaningful closure improvement without preventable harm, inequitable performance, burden transfer, unsafe queues or unsustainable economics.

Required output. Independent evaluation protocol, baseline, scorecard, safety-adjudication process, preregistration decision and Day 85-90 GO / REVISE / STOP board packet.

Proposed accountable role / timing. Independent evaluator with Board-authorized safety authority; Days 60-90.

Gate. Stop or revise if prespecified benefit, safety, equity, burden, capacity, auditability or financing conditions are not met.

Source anchors: §§14-16 and 19; Decision Appendix B-E; pp. 15-25.

Board decision at Day 90

GO only if the Stage 0 record shows a measurable closure problem, willing and accountable partners, a safe manual workflow, funded human capacity, explicit data rights, a credible financing path and a prospective evaluation capable of detecting benefit and harm. REVISE if the wedge or workflow is promising but one or more correctable conditions remain. STOP if accountable response, sustainable payment, acceptable burden, safety, auditability or a measurable primary outcome cannot be secured.

Sequencing principle

These actions should run as coordinated workstreams, but their gates are sequential: define the governing commitment; establish provenance and scope; validate the problem and partners; prove the manual workflow; secure people, governance, data and payment; then authorize limited AI shadow testing and prospective enrollment.