PSA / IHPF STRATEGIC ANALYSIS

Top 12 Takeaway Ideas

The durable strategic concepts in Healthcare Vision 2.0

Derived from the 28-page Healthcare Vision 2.0 strategic reconciliation

EXECUTIVE READ

Preserve Gary's destination, but operationalize it through a person-directed, publicly accountable connective layer that closes agreed care next steps with paid humans, bounded AI, explicit financing and evidence-based stop gates.

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.

01 Gary supplies the destination, not the implementation blueprint

Gary's paper should survive intact as the opening vision because it states the 10-year destination with unusual clarity; it should not be treated as evidence that the destination will occur or as a deployable operating plan.

Why it matters. This distinction protects both Gary's authorship and PSA's judgment. The vision can remain stable and memorable while the strategy, evidence register, governance controls and pilot design continue to evolve. It also prevents later GPT-generated synthesis from being mistaken for Gary's personal views.

Evidence reading. Primarily vision and model-generated reconciliation. Confidence is high about document role and low about any implied forecast of adoption or outcomes.

Source anchors: §§1, 2, 18 and 19; pp. 4-5 and 19-20.

02 Person-directed healthcare is the governing commitment

Services should increasingly organize around the person's goals, permissions, preferences and acceptable burden, rather than requiring the person to become the project manager of disconnected institutions.

Why it matters. "Person-directed" is stronger than institution-centered care and safer than consumer abandonment. It preserves professional duties and institutional obligations while

giving the person a portable plan, meaningful choices, correction rights, caregiver delegation and non-digital routes to help.

Evidence reading. Strong conceptual agreement across Gary, PSA/IHPF and documented lived experience; the operating model remains a hypothesis to test.

Source anchors: Executive Vision; §§4, 5, 10, 16 and 19; pp. 2-3, 6-8, 12 and 17-20.

03 The neglected design object is the process of obtaining healthcare

Healthcare services and the work required to obtain healthcare are not the same thing. A service can exist and each institution can perform its local task while the person still lacks a coherent answer to what happens next, who owns it and whether it closed.

Why it matters. This reframes fragmentation as a concrete workload borne by patients and caregivers: interpreting records, arranging transport, reconciling tests, locating responsibility and chasing follow-up. It makes burden and continuity core outcomes rather than side concerns.

Evidence reading. Documented lived experience is strong design evidence about failure modes and burden, but it is not population-level proof of effectiveness for a proposed solution.

Source anchors: §§7 and 8; pp. 9-11; lived-experience sources L1-L2.

04 The connective layer is PSA's highest-leverage architecture

PSA should pursue a governed continuity layer that connects visits, homes, payers, pharmacies, community supports and caregivers without attempting to replace the EHR, HIE, clinician or institution.

Why it matters. The connective layer turns person direction into an operating model. It can maintain one permissioned plan, expose responsibility, adapt across existing systems and provide different surfaces for residents, caregivers, navigators, clinicians and stewards. Its purpose is to hold the seams accountable, not create another silo.

Evidence reading. A model-generated PSA/IHPF synthesis grounded in prior research and lived experience. It is a strategic architecture, not yet an empirically validated New Mexico intervention.

Source anchors: §§5, 14, 16 and 19; pp. 7-8 and 15-20; platform source P1.

05 Verified closure—not information delivery—is the unit of value

A referral sent, appointment listed, instruction delivered or task marked complete is only an intermediate state. Value is created when an agreed next step has an owner, due date, escalation path and evidence that the intended result actually occurred.

Why it matters. Closure creates a measurable target for navigation and exposes false completion. It distinguishes "test performed" from "intended measurement obtained and

interpreted," and "referral placed" from "appropriate care received." This gives PSA a practical outcome around which workflow, payment and evaluation can align.

Evidence reading. Strong conceptual development within later PSA/IHPF work; population benefit and cost effects remain empirical questions for a prospective pilot.

Source anchors: §§5, 8, 14, 16 and 19; pp. 7-8, 10-11 and 15-20.

06 AI abundance is selective and can intensify scarcity

AI can make first-pass summaries, translation, drafting, education, pattern finding and coordination suggestions inexpensive. It does not automatically make clinical judgment, trusted relationships, physical care, specialist capacity, clean interoperable data, review time, implementation capacity or financing abundant.

Why it matters. Cheap generation may produce more messages, flags and plans than competent humans can safely review. PSA therefore needs an operational definition of abundance: low marginal cost with acceptable quality and without transferring uncompensated work or risk elsewhere.

Evidence reading. Gary's abundance premise is a useful design hypothesis, materially qualified by current empirical evidence showing capability or documentation gains do not necessarily produce clinical outcome gains.

Source anchors: §§4, 9, 15 and 19; pp. 6-7, 11-12 and 16-20; external evidence E3.

07 Human accountability and review capacity are core infrastructure

"Human in the loop" is insufficient. Consequential outputs require a named, qualified and paid human with explicit authority, response standards, escalation duties and capacity limits.

Why it matters. A system that generates work without funding review merely shifts the bottleneck. Reviewer minutes, queue age, caseload, exception volume and authority must be measured before enrollment and during operation. Accountability must remain visible even when the AI itself recedes from the user's foreground.

Evidence reading. Strong agreement across PSA/IHPF and clearly attributable Kris-archive governance/workforce syntheses; actual staffing ratios and safe thresholds remain unproven.

Source anchors: §§5, 9, 13, 16 and 19; pp. 8, 11, 14-18 and 19-20; K1-K5.

08 Community must be plural, chosen and context-specific

"Geography should matter less; community should matter more" is directionally right only if geography is not wished away and community is not treated as one idealized thing.

Why it matters. Useful community may mean place, tribal nation, culture and language, family, socioeconomic circumstance, condition community, affinity network or individual preference. Information may travel; people, specimens, procedures, transport and specialist capacity often

do not. Design must ask each participant which communities are useful and respect privacy or refusal.

Evidence reading. Strong design principle supported by rural New Mexico realities and lived experience; transferability depends on local co-design and sovereign/community authority.

Source anchors: §§4, 6, 11 and 19; pp. 6-7, 9 and 12-13; E5-E6.

09 CHWs and promotoras are a paid meaning, trust and continuity layer

Community health workers and promotoras should not be treated as inexpensive substitutes for clinicians or as unlimited volunteer capacity. They are skilled human infrastructure with defined scope, supervision, integration and payment.

Why it matters. They can conduct teach-back, identify barriers, coordinate logistics, support caregiver delegation and verify closure in culturally and linguistically meaningful ways. Their workload, emotional labor, escalation access and reimbursement must be designed and measured.

Evidence reading. Supported by PSA/IHPF synthesis and external CHW implementation research; the exact New Mexico workflow, workforce availability and reimbursement path require validation.

Source anchors: §§5, 11, 16 and 19; pp. 8, 13 and 17-20; P2, P4 and E4.

10 AI should become ambient—not invisible

A mature service should be described in terms of understanding, completion and responsive human support rather than model brands or novelty. But AI must remain explicit in provenance, auditability, disclosure, performance monitoring, appeal and accountability.

Why it matters. This reconciles usability with rights. People should not have to navigate constant AI branding, yet consequential use cannot become opaque. The service needs logs of source, model/version, policies, overrides, incidents, subgroup performance and kill-switch authority.

Evidence reading. Strong agreement as a design and governance principle; the appropriate disclosure threshold by function remains an implementation question.

Source anchors: §§3, 4, 6, 13 and 19; pp. 5-7, 9 and 14-15.

11 The economic architecture is inseparable from the service design

PSA must answer who pays, who benefits, who saves, who loses revenue, who captures value and which incentives support or resist redesign before scaling.

Why it matters. Savings do not automatically accrue to the entity doing closure work, and the organization funding CHWs or review may not capture avoided utilization. Fee-for-service

volume, fragmented budgets, liability, procurement and vendor lock-in can defeat a socially valuable design. A grant-only operating model is not sustainable.

Evidence reading. A strong political-economy insight and a necessary planning condition. Savings, attribution and value capture remain hypotheses until measured and contracted.

Source anchors: §§3, 4, 6, 12, 16 and 19; pp. 5-7, 9, 13-14 and 17-20; E1 and E6-E8.

12 PSA should act as a learning institution: start narrow and scale reversibly

The correct first move is not a general healthcare AI platform or autonomous diagnosis. It is a staged, bilingual next-step-closure service for a defined New Mexico population, beginning with manual workflow and AI shadow mode.

Why it matters. A narrow wedge makes the causal hypothesis testable and exposes partner capacity, safety, burden, interoperability and financing before they are hidden by scale. Expansion should require meaningful closure gains, acceptable safety and equity, no material burden transfer, funded responder capacity and tested vendor exit.

Evidence reading. This is the report's integrated strategic recommendation and remains a proposed implementation hypothesis until Stage 0 and prospective evaluation are completed.

Source anchors: Executive Vision; §§14-16 and 19; Decision Appendix A-D; pp. 2-3 and 15-24.

Synthesis note

The 12 ideas form one chain of reasoning, not a menu of independent features. Gary's vision supplies the destination. Lived experience identifies the burden. The connective layer supplies the architecture. Verified closure supplies the unit of value. Paid humans, bounded AI, interoperability and economic design supply the operating constraints. Independent evaluation and stop gates supply the discipline required to learn safely.

Evidence note

This document analyzes Healthcare Vision 2.0 rather than conducting a new external evidence review. Evidence characterizations and source codes are inherited from the 28-page reconciliation. Conceptual convergence among GPT-generated documents is treated as triangulation, not independent empirical validation.