A neurosurgeon on policy, technology, and the safety net

Take the brakes off

Why the people closest to the patient should shape the rules, what mandatory models get right and wrong, and what it would take to let physician innovation run.



Dr. Anthony DiGiorgio &
Ahmed “Eddie” Qureshi

Bringing the front line to the policy table

Dr. Anthony DiGiorgio is an associate professor of neurosurgery at UCSF and director of spinal neurotrauma at Zuckerberg San Francisco General Hospital and Trauma Center. He has spent his career in the safety net, works on health policy with organized neurosurgery, and hosts his own podcast on healthcare policy.

This guide distills his conversation with Eddie Qureshi on the Rainfall Health Podcast, recorded in San Francisco. It's written for health system executives and physician leaders weighing how policy, technology, and mandatory episode models will shape care — especially for safety net and rural hospitals.

Where he works

UCSF
Associate professor of neurosurgery

SF General
Director of spinal neurotrauma

Policy
Washington Committee, organized neurosurgery

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Dr. Anthony DiGiorgio
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Eddie Qureshi
Founder and CEO of Rainfall Health, host of the Rainfall Health Podcast

Too few people making policy have practiced under it

Everyone has opinions about healthcare policy. But DiGiorgio sees a shortage of front-line clinicians in the room — people who know what it's like to sit face to face with patients, work inside the system, and watch bad policy directly affect care.

That's what pulled him in, and what keeps him there: bringing that lens to policymakers so the system works a little better for everyone.

On the computer

~90%

Of his screen time, he estimates, goes to answering some kind of policy demand.

Where policy shows up in a physician's day

Administration
Emails and requirements from above

Payers
Ongoing battles over what's covered

Every decision
Each clinical choice shaped by some rule or another

> **“Everything I do as a doctor is influenced by policy in some way or another.”**
>
> Dr. Anthony DiGiorgio

As a resident, he says, he just wanted to take care of people and do what was best for each patient. It didn't take long to see how much of that was decided somewhere else.

Policy should be a safety net — then get out of the way

Eddie often compares healthcare to aviation: a 99% arrival rate would be a terrible metric for airlines, so healthcare needs a higher bar. DiGiorgio agrees the bar matters, but pushes back on the analogy.

Airlines

0% of planes should crash

Passengers board a working aircraft and expect to arrive.

Healthcare

100% of people eventually die

Clinicians take over a plane that's on fire and heading toward a mountain.

What good policy does — and doesn't

Acts as a safety net	Sets guardrails that protect patients.
Empowers patients	Helps people get the care they need.
Doesn't micromanage	Lets the patient-physician relationship drive what happens on the ground.

> “Healthcare is a little bit more bespoke than flying an airline. There's a lot more heterogeneity to it.”

Dr. Anthony DiGiorgio

A clean claim is not the same as good care

Electronic health records are bought by large health systems, not by the clinicians who use them. Their job is to capture every billing nuance — quality metrics, CPT codes, ICD codes — and to maximize reimbursement. Frictionless patient care comes second.

The two goals can run in parallel, he says. But they're distinct tasks, and the software is optimized for only one of them.

Medicare fee schedules

~1,500 pp.
Physician fee schedule

~1,000 pp.
Hospital fee schedule

~2,500 pp.
What the EHR is built around

The efficiency that never arrived

The 1990s promise

No more hunting through paper charts for labs or hanging films on light boxes in radiology.

—

The reality

Labs and imaging on a phone — and physicians turned into data-collection clerks.

Why not TurboTax?

Eddie compared fee schedules to the tax code: hugely complex, yet consumer tools make filing simpler. DiGiorgio's answer is the buyer. Tax software is sold to the person filing. EHRs are sold to the corporation submitting the claim.

> **“The end user is not the same person who is purchasing the software.”**
>
> Dr. Anthony DiGiorgio

The scribe took the typing. The clicking is still there.

Ambient AI has been the fastest-adopted technology in U.S. healthcare, Eddie notes, and one clinicians actually enjoy. DiGiorgio uses an ambient scribe in clinic. It has simplified things — and made some things more complex.

What it took away

Typing the note

What's still manual

Editing imperfect notes

Entering diagnosis codes

Order entry and visit billing

What slows adoption

Risk aversion	Large organizations are understandably cautious.
Information blocking	A dominant EHR may not let outside applications connect easily — not supposed to be allowed, but he believes it still happens.
HIPAA as an excuse	Privacy should be a priority, but it's often used as a reason not to adopt.

> “It's going to be these kind of smaller physician-led healthcare organizations that are going to be on the forefront of this, and then the big companies will probably come along later.”
>
> Dr. Anthony DiGiorgio

Grading outcomes can tempt systems to pick patients

CMMI's mandatory episode models — TEAM today, and CJR-X starting in 2028 — judge hospitals on outcomes. Eddie calls that common sense, and revolutionary for healthcare. DiGiorgio sees real room for unintended consequences in procedure-based models.

The biggest one is cherry-picking: declining to operate on high-risk patients to protect the episode's bottom line. That's why he's glad CMMI has been talking directly with physicians, including organized neurosurgery, to refine TEAM.

Mandatory models

TEAM
Transforming Episode Accountability Model

CJR-X · 2028
Comprehensive Care for Joint Replacement Expanded

The infrastructure ask, in two arms

1

After discharge

Few hospitals own their post-acute facilities. They lose track of the patient — or face building a post-acute operation of their own.

2

Documentation and coding

Risk-adjusted models reward capturing baseline risk. Without technology, that means hiring lots of people.

A cautionary tale

In early voluntary bundles, he recalls stories of a hospital spending about $30 million to participate and earning about $30 million back — hiring staff just to stay at baseline. Infrastructure that heavy makes it hard to come out ahead.

> “You can't do that surgery that you want to do because it is too risky for our bottom line.”
>
> Dr. Anthony DiGiorgio, on the downside he worries about

Plenty of data. No one synthesizing it.

A patient can arrive with imaging, labs, notes, and wearable data. Narrow tools flag sepsis or decompensation. But nothing he's seen pulls it all together to answer the question in front of him: how does this affect the problem I'm treating right now?

How dirt gets into the chart

In the ER
A scan needs a diagnosis, so “stroke” gets entered.

The result
No stroke. The diagnosis stays in the chart.

Years later
The patient shows up in a stroke database query.

Where AI could help most

Structure the unstructured	Turn notes and radiology reports into usable data.
Make data portable	A sodium trend from two health systems should land on one graph. He believes patients should own their data.
Follow recovery	After spinal fusion, wearables could track gait and physical therapy progress that's rarely captured today.

Eddie adds the stakes: only a fraction of what drives outcomes is clinical, and only part of that is captured in the EHR. In spine surgery, much of the episode's cost lands in post-acute care — where no single large EHR follows the patient. DiGiorgio's point: needing post-acute care often reflects the patient's baseline, not the quality of the surgery.

Spinal fusion, per Eddie

~60%

Of episode cost occurs in post-acute care

Innovation needs competition, not just incentives

San Francisco, per Eddie

30+
Systems in mandated sites

5
Procedures, judged head to head

Eddie asked whether the same financial incentives that built the EHR industry could drive the good. DiGiorgio would like to think so, but says top-down levers — bundles, AI incentives, information-blocking penalties — only go so far. Real innovation comes from hospital X competing with hospital Y on the best outcomes at the lowest price.

The Bay Area has plenty of large systems competing, he notes, but few small or physician-owned hospitals. And big systems can throw money at a problem, cross-subsidizing from other revenue streams if it doesn't work.

Who is in the room — and who decides

Wants the right thing	Pays	Controls
Patient and physician	**Medicare, insurer, or employer**	**Large health system**
Neither controls the resources.	The actual customer.	Administers care and makes the calls.

That's how something as intimate as the clinician-patient relationship turns sterile at scale. Patients want a doctor who knows them and their family, and end up in systems with no personal relationship to them at all.

> “You have these two small entities being controlled by these incredibly huge entities, and a lot of that gets lost.”
>
> Dr. Anthony DiGiorgio

“Doc, I live in my car. I don't have access to a shower.”

A patient at San Francisco General

Early at SF General, he performed a minimally invasive laminectomy he'd done hundreds of times. The patient went home the same day, came back infected, was treated, and came back infected again. In all those cases, he'd never seen two infections in one patient. Then he asked why.

Hard to capture, harder to risk-adjust

- Housing
- Regular nutrition
- Family support at home
- Trust in the health system

His view

Same high standard

Safety net hospitals shouldn't be let off the hook.

The catch

Don't penalize the uncontrollable

A shower isn't a surgical outcome.

The risk

Access shrinks

The easy way out is not operating at all.

He trained at Charity Hospital in New Orleans before his fellowship at SF General, and has treated safety net patients his entire career. Inefficiency that a large system can absorb hits the safety net an order of magnitude harder.

If you're not at the table, you're on the menu

Eddie's experience at Rainfall runs against the stereotype: safety net and rural facilities have been some of the fastest movers on new infrastructure, because they know their patients intimately. DiGiorgio agrees. Give physicians on the ground the ability to build, and innovation follows.

Physician innovators he points to

$75

Primary care visits

For a mostly Medicaid and underserved population.

Cash

Urgent care in Denver

Visits for less than an insured ER copay.

New

Financing models

Direct primary care, indemnity coverage, physician-led ASCs and hospitals.

How to give clinicians a seat

Physician leadership	Work with organizations that listen to physicians and put them in charge.
Concerns get heard	If patients lack a shower after surgery, someone notices — without 900 committee meetings.
Infrastructure to act	A social worker, medical respite, or a check-in arranged quickly.

> “If you let physicians be on that front line while also developing the policy, I think you're going to have a lot better outcomes.”

Dr. Anthony DiGiorgio

What he'd ask CMMI to test

The country produced a COVID vaccine at lightning speed. DiGiorgio wants the same urgency applied to care delivery: a CMMI model that picks a few markets and takes the brakes off physician innovation and new healthcare entities.

The test

- Access to care
- Patient care
- Cost of care

Brakes to lift in test markets

Certificate of need laws

Physician-owned hospital ban

Site neutrality, where it fits

His prediction: those markets would see an explosion of innovation, better patient care, and new access for safety net patients. More broadly, he's most hopeful about physician innovators building and competing with large systems — as long as policy cultivates them instead of restricting them.

> **“If we take the brakes off of physician innovation, what does that do for access to care?”**
>
> Dr. Anthony DiGiorgio

Infrastructure for mandatory models, without the headcount

Rainfall Health is an accountability and accessibility platform powered by AI, built for Medicare-mandated episode programs like TEAM and CJR-X. It's technology and services together — so hospitals can take on outcome-based risk without building it all themselves.

He said **Hospitals lose the patient after discharge**	One advocate follows each episode patient across post-acute settings and beyond the hospital's four walls.
He said **Nobody synthesizes the data**	Data from disparate sources brought together in near real time, so teams can act within the episode window.
He said **Infrastructure means hiring**	An end-to-end service that works alongside existing teams instead of adding headcount.
He said **Don't penalize the safety net**	Support for the patients with the fewest resources at home, so access doesn't have to shrink.

Measured on

Patient satisfaction | Quality of care | Outcomes | Cost management

Rainfall HEALTH

Get connected

Be ready for what's mandatory

If you lead a hospital or health system preparing for TEAM, CJR-X, or other episode programs, we'd like to talk. Rainfall is the end-to-end solution, technology and services, for hospitals and health systems.

Learn more
www.rainfallhealth.com

Start a conversation
sales@rainfallhealth.com

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