THE KECKLEY REPORT

Primary Care 3.0: The Front Door to Health System Transformation

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There's strong evidence that investments in accessible and effective primary care result in lower health costs, fewer hospitalizations and emergency room visits, lower mortality and higher patient satisfaction. But in the U.S. system, primary care has taken a back seat to specialized care. That's changing:

- Employers see investments in on-site and near-site primary care clinics as keys to employee productivity and lower health costs. Today, a third of companies with 5,000-plus employees host primary care clinics. Innovative primary care solutions are certain to be central to the Amazon-JPM-Berkshire Hathaway venture and CVS-Aetna combination expected to be approved by the Department of Justice any day.
- Investors like primary care models that leverage technologies and operational efficiencies to reduce unnecessary hospital use and costs associated with chronic diseases. They are betting on digital technologies, nurses and mid-level practitioners to coordinate care for consumers based using customized cognitive learning tools to improve patient lifestyles. Iora, One Medical, and Paladina have attracted more than $600 million from venture capital and private equity backers in the past 18 months to expand their primary care clinics nationally.
- States see strong returns on investments in primary care clinics. Rhode Island and Oregon passed legislation to double funding for expanded primary care after seeing dramatic savings. California and Colorado are considering legislation to add capacity in their Medicaid, CHIP and school clinic programs. Most states are embedding medication management, behavioral health, alternative therapies and screening for social determinant risks in their primary care programs as avoidable costs associated with addiction, social isolation, food insecurity et al. are better understood.
- Consumers are receptive to new models of primary care. Concierge medicine, retail clinics, direct primary care and other forms of primary care have gained widespread acceptance, especially in urban markets and among commercially insured consumers. More than 3,000 primary care practices now offer alternative payment models and 1,900 retail clinics now operate. Surveys indicate consumers like their convenience, predictable costs and online scheduling and have no qualms about the quality of care they provide.
- Federal policy makers see the value. Two alternative payment models, the Patient Centered Medical Home and Medicare Shared Savings Programs, predicated on

primary care coordination are featured in the Affordable Care Act. A four year pilot, the Comprehensive Primary Care Collaborative begun in 2012, resulted in 1% lower Medicare spending by paying PCPs a per-patient management fee; its sequel, Comprehensive Primary Care Plus, started in January 2017. Medical student loan forgiveness has expanded. Funding for federally qualified health centers, primary care access for Veterans and community health centers have expanded. Residency programs in primary care, which have not been expanded since 1997, received approval for 3,000 new slots annually for five years. And slowly, Medicare payments to PCPs were enhanced as part of the health reform and more. Recent pronouncements from HHS Secretary Alex Azar promising "bold" changes to alternative payment programs is certain to include a larger role for primary care in population health.

Indeed, the stars are aligning for primary care, but it's not a slam dunk. There's a shortage of primary care physicians—as many as 20,000 more are needed by 2030 to accommodate our aging population and burgeoning lifestyle-related maladies. Plans to add 3,000 primary care medical residency slots annually for the next five years will help, and shortages of nurses loom large in assessing the healthcare workforce….but there's a bigger challenge: Compensation.

Compensation for most specialists is considerably higher than primary care. Like every profession, compensation is a way of keeping score. But unlike other professions, medical training carries enormous debt: in 2018, 75% of the newly minted docs will start their careers with average medical education debt of $190,694 and all will be $228,000 behind in career earnings compared to their peers who were working while they were in training. So, the differential between compensation for primary care physicians and specialists weighs heavily in a medical student's decision about their clinical focus and the lifestyle it might afford.

Median Compensation for Select Specialties 2016-2017

Specialty	*Range ($000)*	*% Change 2016-2017*
Orthopedics	$501K to $679K	-14.4 to +10.6
Invasive Cardiology	$429K to $625K	+0.2 to +14.7
Anesthesiology	$371K to $493K	-1.3% to +22.8
Emergency Medicine	$317K to $386K	-0.4 to +13.0
OB-GYN	$277K to $368K	-5.2 to +3.6
Internal Medicine	$232K-to $279K	-0.7 to 3.0
Pediatrics	$213K to $264K	+1.0 to +24.9

Source: Modern Healthcare Physician Compensation Survey of 14 Leading Physician Compensation Firms 2018

Looking ahead, the evolution of innovative primary care delivery models and capabilities is likely the most significant trend impacting the U.S. health system in the next few years. Funding, at 4-8% of total U.S. health spending, will increase. Clinical models will expand beyond physical medicine to include behavioral health, dentistry, nutrition, and prescription management. Compensation will be based on management fees and savings from unnecessary tests, procedures and admissions. Digital capabilities that enable scheduling, virtual visits, telehealth and patient engagement will be features. Clinical decision-support tools linked to cloud-based clinical analytics will enable precision diagnoses, targeted treatments, and customized self-care management for patients.

Primary care relationships for patients will be with multi-disciplinary teams whose clinical performance is accessible and brand is recognized. Medical records will include patient signs, symptoms, medication history and lab values as well as social circumstances, habits and lifestyle preferences. And the costs associated with primary care recommendations—referrals, tests, medications, over-the counter remedies, lifestyle changes, et al—will be known in advance as the primary care team and the consumer share decision making about efficacy and affordability.

From Primary Care 1.0 to 2.0, changes were largely the result of technologies that made primary care more accessible. Retail clinics, expansion of scope for nurse practitioners in some states and the emergence of population health programs in hospitals were major advancements in the transition to PC 2.0.

But the transition to Primary Care 3.0 represents a monumental shift: employers are playing a bigger role. The clinical model is more sophisticated and complex. The focus is on the performance of a care team working in tandem with individual patients and populations. And compensation is more directly tied to management fees and incentives for savings and avoidable cost reduction.

At a high level, Primary Care 3.0 is likely to become the front door to the U.S. health system, tackling issues like drug addiction, loneliness and others head on.

	Primary Care 1.0 1995-2005	*Primary Care 2.0 2005-2015*	*Primary Care 3.0 2015-2025*
Clinical Focus	Physical Medicine	Physical Medicine with Growing Attention to Lifestyle-Related Risks	Physical and Behavioral Medicine, Nutrition, Prophylactic Dentistry and Lifestyle-Related

			Preferences and Values
Staffing	1-5Physicians + nurses + administrative support (5.5 FTEs/physician)	Physicians, Nurses, Allied Health Professionals + administrative support (4.5 FTEs/physician)	Physicians (Medical, Behavioral), Pharmacists, Nurses, Dentists, Nutritionists, Digital Specialists, Health Coaches + administrative support (4.5 FTEs/physician)
Compensation	Negotiated Fee for Service (FFS) Payments from Insurers, Medicare & Medicaid (90% 3rd Party; 10% Consumer	Negotiated Fee for Service (FFS) Payments from Insurers, Medicare & Medicaid plus shared savings from payers/alternative payment models (75% 3rd Party; 10% shared savings; 15% Consumer)	Negotiated Fee for Service (FFS) Payments from Insurers, Medicare & Medicaid plus shared savings from payers/alternative payment models (60% 3rd Party; 20% shared savings; 20% Consumer)
Emergent Models	Concierge Practices	Retail Clinics Virtual Care	Direct Primary Care Specialized Population Management i.e. Senior Care, Frail Elderly, et al
Differentiation	Physician Reputation Patient Experiences Insurance Acceptance	Team Reputation 3rd Party Contracts Digital Capabilities Locations Scale	Brand Pricing Digital Capabilities Locations Clinical Models Scale Specialized Services

Primary care 3.0 will dramatically alter what's included in primary care, how these services are provided and paid for and by whom.

It means needed changes in the training programs in our 147 accredited medical schools and 400 teaching hospitals to expand the clinical significance of primary care.

It means recognition by hospitals that investments in the PC front door are strategic to their long-term sustainability.

It means funding by state and federal policy makers to increase access to PC 3.0 services,

especially in the U.S. 93 communities where shortages are acute.

It means lawmakers must continue to merge health and social services programs so eliminate disparities in access and quality.

It means primary care providers must prepare to play a larger role on the healthcare stage, tackling touch issues like end of life care, disparities, mental health, unhealthy lifestyles and more.

It means primary care will be a major focus for disruptive innovation attracting strategic investors attracted to an opportunity wherein its customers are receptive to new models, new approaches and a clear value proposition.

Primary care 3.0 is the front door to health system transformation in the U.S. to allow our system to be accessible, affordable and equitable.

Paul

P.S. Watch for details about India's new program, Modicare, that provides free hospitalization to 500,000 of the country's 1.3 million inhabitants. Like China and other developing economies, lawmakers are attempting to create more access to healthcare for their underserved populations. In India, like the U.S., access to healthcare is a major issue in their forthcoming national elections. Prime Minister Narendra Modi announced the program this weekend.

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