Training Primary Care Physicians in For-Profit, Value-Based Care Clinics

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Primary care is undergoing a paradigm shift to value-based care, a transformation increasingly propelled by for-profit entities such as healthcare payers, retailers, and startups backed by private equity and venture capital. By 2030, at least 30% of primary care may be delivered by non-traditional companies under value-based care arrangements.[1] Not only are these new entrants providing clinical care, but they are also now training medical students, residents, and clinical fellows in their own or affiliated primary care practices. This raises important questions about the future of primary care physician (PCP) training.

For decades, nonprofit academic health systems have been at the frontier of medical education. More recently, however, for-profit, value-based primary care companies are launching their own training programs (see Table 1) with the thesis that they have something unique to offer: tailored skill building in areas such as team leadership, population health management, and quality improvement to help clinicians succeed in value-based practices and expose them to alternative cultural and practice models in primary care.

Some organizations are partnering with traditional academic medical centers while others are forming their own programs. For example, Oak Street Health, a publicly traded care delivery organization, partners with medical schools across several states, including an Education Centered Medical Home for medical student continuity experiences with Northwestern's Department of Family and Community Medicine. Resident physicians also rotate through their clinics for experiences in population health and primary care redesign. Aledade, a care enablement company that works with physician practices to build accountable care organizations, allows family medicine residents to rotate at partner practices or community health centers. Both curricula offer training in primary care innovation and care management.

Post-residency training is similarly expanding. In 2014, Iora Health (now One Medical) launched its primary care leadership fellowship with Dartmouth's Master of Health Care Delivery Science program. The year 2022 marked the start of a similar two-year fellowship by ChenMed, a Medicare Advantage-focused primary care delivery company. In addition to substantive clinical work, such programs offer coaching and leadership training, experience working in cross-functional teams with senior clinical, operations, business, sales, and marketing leaders, and teaching on care delivery innovation among other topics.

It is yet unclear how these training programs may differ from existing innovative academic primary care residency programs or post-graduate fellowships. For example, Brigham and Women's Hospital and Duke Medicine both offer rigorous management and leadership training for internal medicine and primary care residents, and many other programs such as Kaiser Permanente, Cornell University, and Boston Medical Center offer one-year healthcare administrative and leadership fellowships. It is also unclear how—and if—these programs are utilizing established pedagogy[2] and whether the curriculum effectively prepares trainees to deliver value-based care.

Regardless, as value-based care continues to take hold, there is consensus that PCPs must be equipped with new skills. PCPs will need facility with working in interdisciplinary teams, focusing on addressing—and not solely identifying—health-related social needs, and seeing patients across virtual, home-based, and office-based settings. Familiarity with digital tools for chronic disease management, quality improvement, remote patient monitoring, and telehealth may also be necessary. PCPs in value-based care clinics may also need to be more attuned to operational costs, patient satisfaction, and healthcare outcomes, especially those in for-profit settings given the need for outsized financial returns.

Training environments significantly shape physician behavior, and it will be important to monitor how these new programs systematically affect clinician practices and patient outcomes.[3] On one hand, training PCPs under for-profit, value-based models could foster patient-centered practice patterns, proactive care planning, and greater attention to health-related social needs. On the other hand, an expectation for high financial returns to investors may entrench certain potentially harmful behaviors, such as avoiding referring patients to higher-cost tertiary and quaternary care facilities. Prior research has shown that compared to private, not-for-profit providers, private,

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Table 1 Examples of Primary Care Training Programs Led by For-Profit, Value-Based Care Clinics

Company	Partnership (location)	Description	Length of program	Participants per year	Level of training
Oak Street Health	Northwestern University, Feinberg School of Medicine (Illinois)	Medical students engage in 4 years of primary care precepting, clinical skills development, and quality improvement training	4 weeks	16	UME
	Northwestern Department of Family and Community Medicine and Department of Internal Medicine (Illinois)	2nd and 3rd year internal medicine, family medicine, and medicine-pediatrics residents, and geriatric medicine fellows receive value-based care training and support while rotating through Oak Street practices	2–4 weeks	50	GME
	Northwestern Kellogg Graduate School of Management (Illinois)	Residents, fellows, and early-career physicians rotate through management experiences and complete a Master of Business Administration (MBA)	2 years	4–6	GME
Aledade	Independent physician practices (varies)	2nd and 3rd year family medicine residents receive value-based care training and support while rotating through partner practice and community health center sites	2–4 weeks	20	GME
OneMedical/Iora Health	Geisel School of Medicine, Tuck School of Business (New Hampshire)	Residents, fellows, and early-career physicians receive population health training at clinic sites and complete a Master of Health Care Delivery Science	2 years	2–4	GME
	Electives with various academic partners (varies)	2nd and 3rd year internal medicine, family medicine, and medicine-pediatrics residents, and geriatric medicine fellows receive value-based care training and support at clinic practices during electives	2–6 weeks	25	GME
ChenMed	Florida International University (Florida)	Medical students rotate through ChenMed facility during their 1st or 3rd year of medical school	4 half days per year	20–50	UME

for-profit providers (e.g., primary care practices, hospitals, nursing homes) seem to have worse health and healthcare-related outcomes.[4] A more recent analysis found that patients enrolled in traditional Medicare were more likely to receive cancer care in the highest-rated hospitals compared to those enrolled in MA, a program commonly used to deliver care by for-profit, value-based care entities.[5] However, MA enrollees had higher use of preventive care and lower use of post-acute care. It will be important to understand whether training environments—not just current practice environments—result in such disparities. The Accreditation Council for Graduate Medical Education (ACGME) could commission a longitudinal study on PCP practice patterns and their relationship to quality based on training environments. More nuanced analyses of process and outcome metrics between PCPs with differing training environments but similar patient panels and current practice type should also be considered.

In addition, it will be critical to ensure these new organizations are offering high-quality training. To the best of our knowledge, no for-profit, value-based organization sponsors their own formal graduate medical education (GME) program. However, there is precedent for for-profit entities doing so to subsidize the costs—and ultimately profit off—of training residents; in 2021, HCA Healthcare offered nearly 2000 GME slots and became the largest GME provider in the country,[6] but its programs were mired in controversy as reports of poor trainee oversight and education emerged. Clear guidelines and oversight on the development and implementation of such trainee programs from the ACGME could help protect trainees and their patients. Incorporating a pilot program in the Advancing Innovation in Residency Education initiative led by the ACGME could inform such work, as could expansion of value-based care ambulatory experiences by residency review committees.

Finally, if these programs continue to grow, it will be crucial to ensure that resources are not diverted away from safety net providers, such as federally qualified health centers (FQHCs). Though FQHCs are the backbone of

the social safety net, they routinely struggle with staffing, finances, and overcapacity. Compared to FQHCs, for-profit, value-based primary care organizations are orders of magnitude smaller, but tend to feature better compensation, smaller panel sizes, and longer patient visit times.[7] This could be attractive to many physicians, offering an alternative to those who otherwise might consider working at an FQHC. The competition for talent will only increase as for-profit primary care practices expand their reach in underserved communities, which may fulfill clinicians' mission-oriented mindset. Enhanced loan forgiveness programs for trainees may be necessary to help practices serving highly vulnerable communities, both FQHCs and other actors, offer competitive positions in the limited physician labor market. Another opportunity exists in federal funding to support higher pay and better working conditions in FQHCs and to help FQHCs transition to full-risk and hybrid capitation models that may help mirror some of the most attractive features of value-based companies.

Ensuring our care delivery system successfully transitions to value-based care may require a reimagining of training programs for PCPs. Though for-profit, value-based companies offer unique opportunities, careful monitoring is warranted. This begins with publicly reporting details on for-profit, value-based care training arrangements. Understanding trainee experiences will be equally important as the corporatization of medicine may have contributed to the recent decline of medical school applicants to emergency medicine programs. It will be critical to evaluate the impact of training programs over time and better understand the practice patterns of this next generation of physicians.

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Declarations:

Conflict of Interest: *DV and KA have nothing to disclose. AK is an employee of and shareholder in Oak Street Health; a shareholder in One Medical Group; and a compensated board member of the American Board of Internal Medicine and ABIM Foundation.*

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