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The Primary Care Infrastructure Alliance

What Healthcare Can Learn From OneWorld

By Mike Eaton
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Primary care has an access problem, but we keep trying to solve it as an ownership problem.

Demand exceeds supply, so health systems add clinics, medical groups recruit more physicians, urgent care operators open another site — and everyone builds more capacity inside their own walls.

Much of that assumes patients care who owns the exam room, but most do not.

They care whether they can get the right care when they need it, whether the person seeing them knows enough about them to make a good decision, and whether someone remains accountable after the visit.

The airline industry figured out a version of this years ago.

As 4sight Health's David W. Johnson discussed in, "Healthcare's One-World Solution," OneWorld is a global airline alliance that connects independently owned carriers such as American Airlines, British Airways, Qantas and Qatar Airways into a shared network. Each airline keeps its own fleet, brand, employees, economics and operating system, but members agree to common rules that let travelers move across their combined capacity with a more connected experience.

The alliance does not create one airline. It makes separate airlines work like one network.

Healthcare should pay attention.

The next primary care network may not be a bigger medical group. It may be an alliance. And the structure underneath it may look like a new kind of clinically integrated network, a super CIN built not simply to organize physicians, but to organize access, information, clinical decisions and accountability across independently owned capacity.

That is the Aggregators' Advantage, coined by 4sight Health's David W. Johnson and Paul Kusserow in The Coming Healthcare Revolution — when it stops being a market idea and becomes an operating model. In the book, they say care is moving out of traditional institutions, consumers expect easier access and more care is being delivered by different kinds of clinicians in different settings. The organizations that matter most will increasingly be the ones that can make fragmented capacity usable.

A super CIN could be the infrastructure underneath it.

Start with a simple premise. If a network is accountable for 100,000 attributed lives under a value-based contract, it does not need to own every place those patients receive routine care. It does need to know what happened, how the decision was made, what happens next, and whether that decision raised or lowered the risk of a bad downstream outcome and higher cost.

That is a different definition of control.

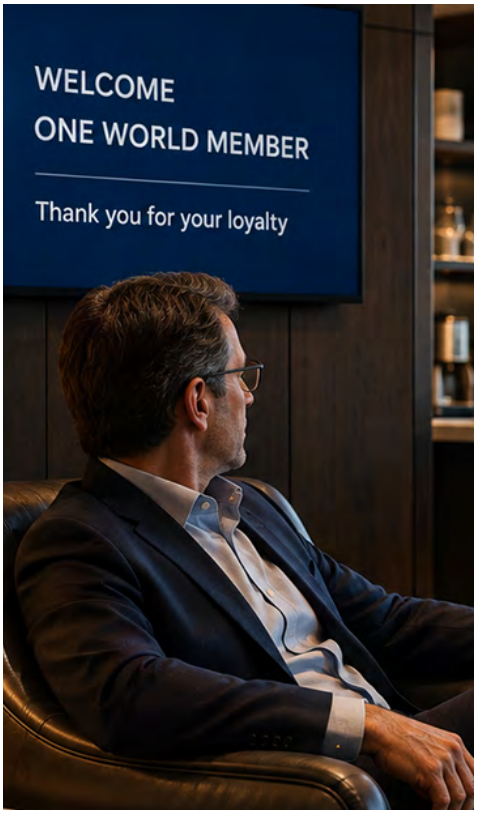
The old model says control the asset.

The new model says control the integrity of the decision.

A super CIN built around shared primary care access could connect health systems, independent practices, advanced practice clinicians, urgent care sites, pharmacy-based care, behavioral health providers, virtual platforms and other trusted access points. The organizations remain independently owned but operate under a common clinical compact.

Patients remain attributed. Risk remains attributed. Longitudinal responsibility stays clear.

Access becomes shared. That only works if the alliance has real rules.



RULES OF ENGAGEMENT

The network must agree on what can move freely across the alliance and what should stay with the longitudinal care team.

Start with high-volume conditions where the clinical pathways are well understood:

- **Uncomplicated respiratory illness**
- **Urinary symptoms**
- **Hypertension follow-up**
- **Diabetes monitoring**
- **Medication management**
- **Musculoskeletal complaints**
- **Preventive gaps**
- **A handful of common behavioral health needs**

This is not about turning medicine into a script. It is about acknowledging that much of the variation in routine care has little to do with good judgment.

A traditional CIN already tries to reduce unnecessary variation inside a defined network. A super CIN extends that discipline across organizations that may not share ownership but do share clinical standards.

Empactful Studio's Mike Eaton *has spent his career operating at the intersection of strategy, finance, operations and healthcare transformation. He understands that the forces reshaping healthcare are not isolated trends to monitor individually. They are interconnected structural changes that are collectively redefining how healthcare organizations create value, deploy capital, manage labor, adopt technology and compete for consumers.*

INFORMATION FLOW

You cannot call something a network if the clinician receiving the patient has to start over every time the patient changes sites.

The treating clinician should see the medications, allergies, conditions, recent results, care gaps, risk signals and enough longitudinal context to make a safe decision. The encounter then must flow back into the attributed patient's record without someone faxing a note three days later and hoping the primary care provider (PCP) sees it.

This is where the OneWorld analogy is useful. The aircraft remain separate. The information cannot.

The same is true in primary care. If the access point changes and the information breaks, the alliance has failed.

ESCALATION LOGIC

The alliance has to know when routine care stops being routine.

A third respiratory visit in a month is different from the first. A blood pressure of 168 over 100 is not just another hypertension follow-up. A patient with diabetes and worsening renal function has crossed into a different kind of decision. A refill request may be routine until the data say it is not.

Those signals should trigger the attributed team automatically.

Not because the PCP needs to approve everything, but because longitudinal accountability has to reconnect with episodic access the moment it matters.

This is where the super CIN becomes more than a convenient access network.

It becomes a network of governed decisions.

THE ECONOMICS

If the attributed organization bears responsibility for total cost of care, it should be willing to pre-fund access infrastructure that keeps people out of more expensive and less coordinated settings.

That changes the conversation.

We need to stop asking whether every primary care encounter generates enough fee-for-service revenue to support the site delivering it. The better question is what reliable access is worth across the population.

Avoiding an unnecessary emergency department visit matters. Catching deterioration early matters, so too closing care gaps. Resolving a problem today instead of letting it turn into three encounters over the next two weeks can spell the difference between a bad outcome and a delighted customer.

That is how value-based care should think about capacity. Not as inventory to monetize, but as infrastructure to deploy.

THE FUTURE OF CAPACITY MANAGEMENT

The strongest primary care organization may eventually be the one that owns less capacity than its competitors but can reliably reach more of it.

That is the Aggregators' Advantage. The super CIN gives that aggregation clinical teeth.

As care moves out of traditional sites, healthcare needs a distributed supply strategy. The aggregator makes that supply accessible. The super CIN governs how it gets used.

The attributed organization keeps accountability while the alliance expands access. Common pathways govern routine decisions and shared information keeps encounters connected. Escalation logic catches the edges while the economics reward resolution rather than ownership.

That is not loose affiliation nor a preferred provider directory. It is certainly not just a more sophisticated version of urgent care.

It is a clinical operating system across independently owned capacity. That matters because vertical integration has trained healthcare to equate ownership with control.

But ownership is not control.

You can own hundreds of physicians and still have poor access, uneven clinical decisions, duplicate testing, missed escalation and fragmented patient journeys. You can own the building and still lose the decision.

A well-designed super CIN can create more functional control with less ownership because it governs the things that actually drive outcomes and cost: Who gets seen, by whom, with what information, under what pathway and what happens next.

OneWorld made a traveler's usable network larger than any single airline. Primary care can do the same thing.

AUTHOR

Mike Eaton is Vice President of Health System Strategy and Design at Empactful Studios, where he advises healthcare organizations on transformation strategy, operating model redesign, physician alignment, and value-based care innovation.

Mike is widely recognized for his ability to help boards and executive teams navigate periods of disruption and change. He has successfully brought two healthcare IT companies from concept to market exit and is a frequent advisor to organizations exploring new operating models, digital health strategies, AI-enabled care delivery, and consumer-centered transformation.