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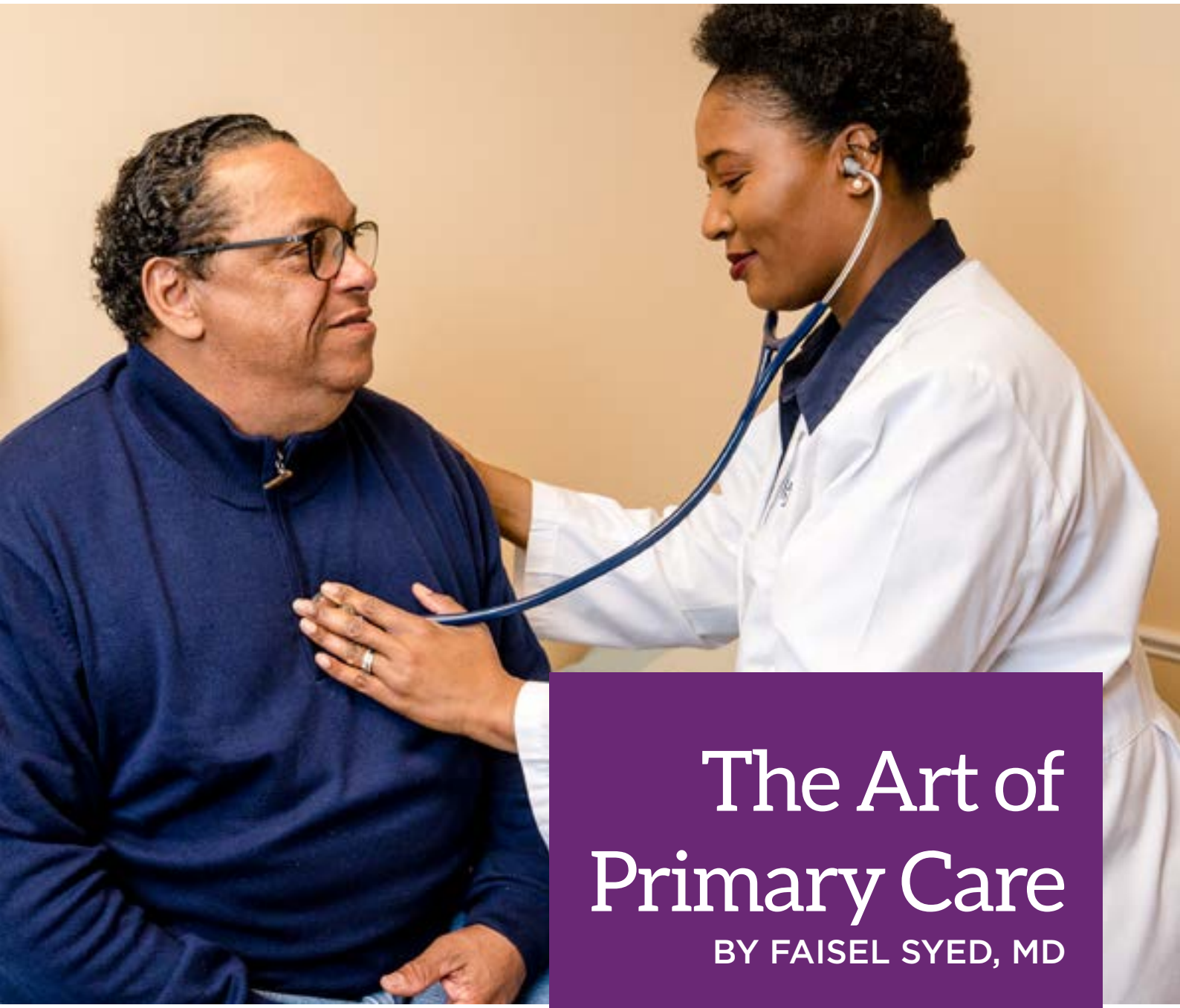

The Art of Primary Care

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The early days of primary care in the United States began in small towns and farming communities. In these settings, doctors traveled in circuits, paying frequent house calls, ready to perform almost any medical service. They treated infections and injuries, set bones, performed surgeries, attended to the dying, and delivered new babies.

"Many were astute clinicians, with great knowledge and capabilities; they were very committed to serving their people," a research paper published by the American Academy of Family Physicians (AAFP) explains. Those skills were borne from clinical experience and the powerful bonds doctors formed with their patients — relationships that often began at birth and continued through adulthood into elderhood.

The art of primary care stems from this sacred bond. The patient is an individual who thinks, feels, responds to their environment, learns, works, and experiences success, conflict, adversity, and loss. A person who changes over time due to myriad factors influencing physical and emotional growth, stability, and wellness. To forge a strong bond, the provider must bring his or her authentic self to patient interactions and listen and respond to the whole person.

Although the traveling family doctor has become a relic of the past, current research shows that good provider-patient relationships contribute to better functional health. Unfortunately, The US healthcare system, dominated by the fee-for-service (FFS) reimbursement model for decades, has become entirely inhospitable to forge meaningful bonds between patients and primary care providers.

Re-centering primary care and the sacred bond can help move American healthcare forward. Integrating the art of primary care with advanced medical science and technology offers a path to better health outcomes and health equity for US individuals and families.

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This white paper will discuss:

Barriers to Whole-Person Primary care

The FFS system has effectively replaced genuine primary care with a profit-driven healthcare funnel. Incentivization based on relative value units (RVUs) rather than care quality forces providers to escalate medical services. Patients move quickly from the initial complaint to diagnostic procedures, specialist referrals, and interventions that aren't always medically necessary. The result is a national healthcare landscape characterized by skyrocketing medical costs and poor clinical outcomes.

The Association of American Medical Colleges (AAMC) estimates that by 2033, the US will reach a shortage of 21,000-55,200 primary care physicians. In its report on the family medicine results of the 2022 National Resident Matching Program, the American Academy of Family Physicians (AAFP) included a call to action:

"...Healthcare, education, and societal systems need to incentivize, recruit, and support a more diverse medical student population that better represents the U.S. population and those who are more likely to choose primary care careers and practice in underserved areas."

As ChenMed's National Director of Primary Care, I've worked to make the art of primary care central to our value-based, transformative healthcare delivery model. The success of our model demonstrates that practicing the art of primary care can lead to positive change for medical care in the US.

Practicing the Art: Skills and Tools

The art of primary care relies on communication to build unique relationships. PCPs need specialized tools, knowledge, time to forge sacred bonds with patients, and supportive infrastructure.

Evidence-based communication skills

First and foremost, PCPs must have enough time to talk during visits to get to know the patient and become familiar with their needs and circumstances. But achieving productive communication with different individuals also requires skills.

Just as physicians rely on medical science for good clinical outcomes, evidence-based techniques result in more productive patient conversations. Examples of techniques include motivational interviewing and active listening.

Knowledge of complex health influences

The conventional FFS approach places responsibility for personal health entirely on the patient, assuming that behaviors and non-adherence result from conscious refusal. In fact, research shows us that many factors can influence health behaviors and choices. These include social determinants of health (SDOH), such as race, gender, and income levels, as well as psychological, biological, and environmental factors.

The provider-patient relationship requires PCPs to look deeper into the cause of health-limiting behaviors to address them more effectively.

Smaller patient panels and purpose-driven infrastructure

On average, people in the US see their PCP just 2.6 times each year; the average office visit lasts only 18 minutes. Healthcare models that facilitate smaller patient panels allow for more extended and more frequent visits, which, in turn, support relationship-building. They also provide more patient education opportunities, resulting in greater self-agency around personal health decisions and behaviors.

Infrastructure that positions the PCP as the leader of a skilled care team and makes it easy for providers and patients to stay in touch is essential for comprehensive, coordinated care.

Prevention: Connecting and Encouraging

A transformative approach to health promotion focuses on disease prevention and early, effective intervention. When those tactics don't stop disease progression, we must turn focus to the easing of suffering.

By prioritizing prevention, PCPs can help patients avoid health complications that often lead to greater suffering, expensive treatments, and hospitalization (and, critical to the full-risk model, lower the practice's expenses.) But prevention will only be effective if the patient is entirely on board.

Many providers have no training in speaking to patients who are resistant or ambivalent to making preventive health choices. Influenza vaccination rates illustrate this point. Despite incentives like gift cards and easy access at grocery stores and pharmacies, the US flu vaccination rate in adults over 18 was only 50.2% over the 2020-2021 flu season.

The art of primary care could potentially turn flu vaccines into a success story. At ChenMed, we train our teams in evidence-based communication strategies. Our PCPs use motivational interviewing and find joy in understanding each person's internal drivers towards behavior change. We've found this positively impacts our patients' trust in preventive care services like flu vaccines and ultimately leads to higher vaccination rates.

The Art of Engaging

There's no such thing as a difficult patient.

My years in community health have taught me that the most challenging patients aren't simply "being difficult." When people respond with negativity or hostility, it usually indicates they're experiencing hardship or distress. Despite unpleasant behavior, these patients desperately need compassion, kindness, and to be treated with dignity.

Instead of lecturing hesitant patients, I encourage PCPs to ask more questions and to listen carefully to the answers. When the person has finished speaking, use empathy and respectful, supportive language to address concerns gently. Then let them make their own decision.

Curing: Knowledge and Collaboration

In our current healthcare system, providers are conditioned to start with symptom relief strategies and move quickly to intervention when those strategies aren't successful.

In contrast, transformative primary care approaches curing by identifying and addressing the underlying cause of illnesses. This typically results not only in symptom relief but also in condition improvements and positive changes in overall health, reducing the need for interventional procedures. Because PCPs have extensive knowledge about all organ systems, they're well-equipped to treat many acute and chronic conditions.

Patient empowerment fosters compliance

The art of primary care involves treating patients as equals. While the PCP has medical knowledge, the patient is the expert regarding their personal experience and identity. This includes their individual experience of health-related changes or symptoms. By working collaboratively with the patient towards a better outcome, PCPs can improve patient education, medication adherence, and compliance with treatment and health management programs.

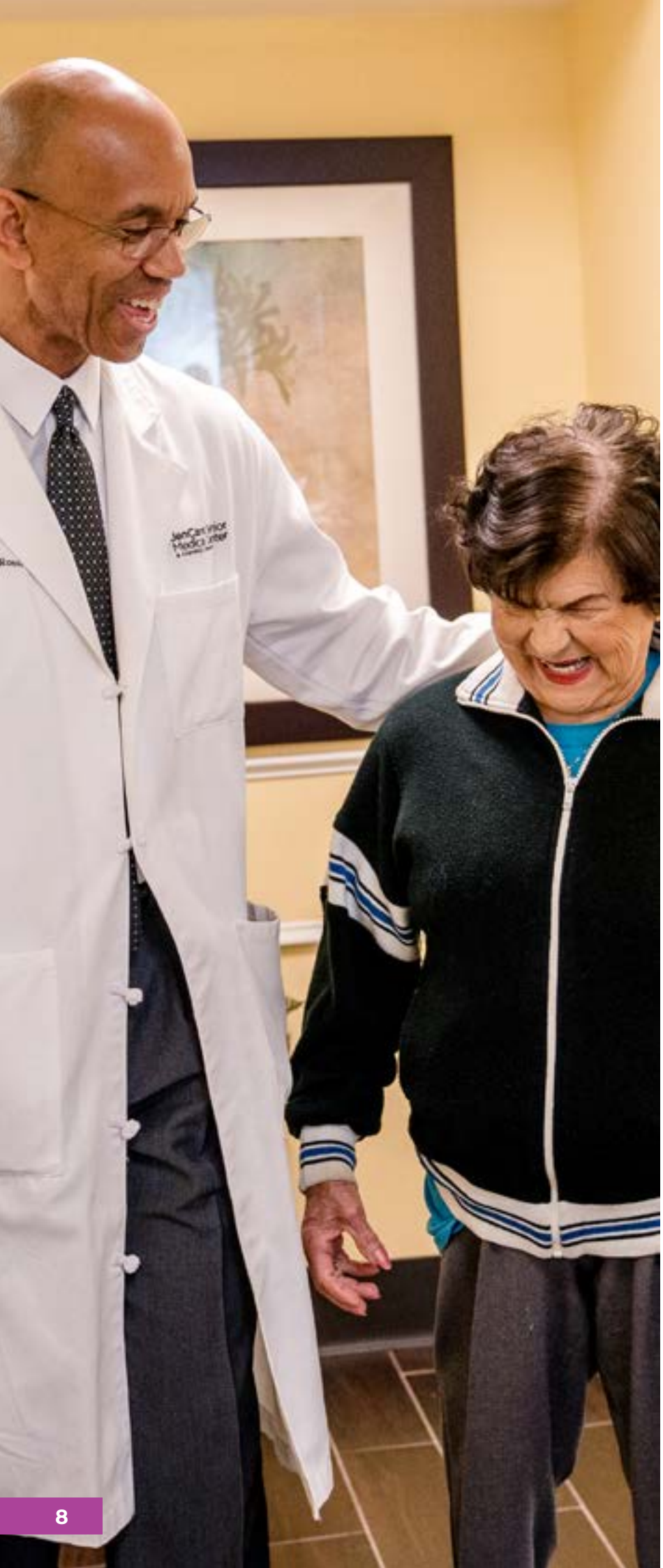
Primary care providers lead effective care teams

In a multidisciplinary approach, the PCP leads a team of experts, including case managers, social workers, care coordinators, and family and community members. The team works to identify any SDOH or other factors influencing the patient's health. The PCP then guides the team in addressing these issues with medical and non-medical resources.

Primary care is specialty care

The authors of Curing and Caring: The Work of Primary Care Physicians With Dementia Patients, a 2011 qualitative study of PCPs, assert that since FFS became the norm in the mid-1960s, primary care "has moved toward triaging and resource coordination, focusing mostly on common illness treatment and leaving the 'fancy' stuff for specialists."

In reality, PCPs have training and expertise in diverse areas, including internal medicine, geriatric and pediatric care, adolescent care, and hospital-based treatment. Additionally, primary care clinics typically have the technology and supplies to address many urgent and emergency conditions.



The Art of Acute Care

Language choices can keep us all connected to our capacity for empathy.

The model we use at ChenMed allows us to respond attentively to people with acute complaints. Instead of walk-ins, we refer to them as patients in need. This simple change reframes how we perceive our patients and encourages us to relate to them as individuals.

Our staff has training in communication around unexpected clinic visits. When we let other patients know that a person has an urgent need, most pre-scheduled patients respond with care and flexibility. We've engaged their own empathy, and they trust our providers will give them their full attention as soon as possible.

Easing Suffering: Attending and Responding

According to "Responding to Suffering," a medical research article published by JAMA, "suffering" refers to severe distress affecting an individual's physical, social, emotional, spiritual, and financial domains. The authors write that suffering "calls on us as physicians to address our patients as whole persons," which is "particularly challenging in our age of specialization and automation in medicine."

Practicing the art of primary care allows PCPs to address suffering both medically and with non-medical resources. The sacred bond plays a central role in managing all aspects of suffering, as does strategic leadership of the care team.

Easing suffering by addressing SDOH

Patients living with severe chronic illness or nearing end-of-life may experience extreme suffering daily. PCPs can harness multidisciplinary care to alleviate their distress. This could mean asking the care team to arrange transportation to and from physical therapy appointments, arranging a payment plan to keep utilities on, making sure someone has enough to eat, or connecting the patient with faith-based services of their preference.

End-of-life care

Although most people would prefer to die at home, 30% of deaths in the US occur in hospitals, 20% in nursing homes, and just 31% in homes.

The art of primary care brings comfort, compassion, and dignity to the end-of-life transition, allowing patients to maintain their personhood during their final experiences. The sacred bond offers a safe space for patients nearing death to express their personal and cultural needs. They trust the provider to invest in fulfilling their wishes to the best of their ability.

Using cultural sensitivity and approaching care decisions from a place of empathy and respect can reduce physical and emotional suffering for the individual and those close to them. Allowing loved ones and community members to guide the actions of PCPs and their team members helps make difficult conversations with patients and families less distressing.

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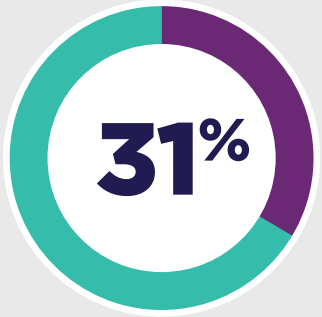
In nursing homes.



In homes.

"...Physicians can learn to be more attentive to suffering, act with compassion, and develop more fulfilling relationships with patients. Turning toward suffering and helping patients refocus and reclaim their lives can also help physicians to reconnect with a deeper sense of purpose and meaning in their own work." –"Responding to Suffering" JAMA, December 2015

These two evidence-based approaches complement medical care for suffering patients. They align with the art of primary care and the ChenMed approach to caring for older adults.

Turning toward:

Providers should remain present in the face of suffering, no matter how painful. It requires the clinician to learn about the experience from the patient, bear witness, and stand in solidarity with compassion and humility.

Refocus and reclaim:

Providers can gently challenge self-perceptions and assumptions and encourage patients to connect deeply to their core values. They can encourage the patient to stop self-identifying with suffering and to continue to play an active role in their own lives, including the end-of-life experience, when possible.

The Full-Risk Model: Reclaiming the Art of Primary Care

Most providers, including myself, became doctors because they felt a powerful desire to help people. But the current US healthcare system isn't working for physicians or their patients. PCPs need to know that value-based care models can change how we practice and enhance the impact we can make on our patients.

Keep patients out of the hospital

In a fully capitated system, the practice becomes financially responsible for all the patient's healthcare, including specialty and hospital costs. This may sound intimidating, but the wonderful thing about capitation is that the practice is incentivized to keep patients out of the hospital and avoid escalating service costs. As a result, a focus on improving health and reduction of unnecessary specialist referrals, diagnostics, and interventions drive financial health–not RVUs.

The PCP's salary and bonus become tied to good outcomes and performance rather than how quickly they can turn patients around or how many tests they can order. And this can work to **equalize the pay gap between PCPs and specialists.**

Support solid relationships

Full-risk models facilitate smaller patient panels, more frequent visits, longer appointment times, and an infrastructure that supports those relationships with follow-up calls, weekly texts, check-ins, patient education, and other services.

Limit non-interventional specialists and hospitalizations

Full capitation means the practice assumes the responsibility for all care, including urgent and emergency care, specialist care, and hospital services. That incentivizes PCPs to provide quality acute and urgent care, exhaust all other options before referring to a specialist, and resort to hospital care only when medically necessary. Patients experience less interruption in their daily lives, remain in their homes, and avoid the pitfalls of conflicting opinions and interventions.

Capitation supports primary care that improves patient outcomes, giving providers a renewed sense of passion and purpose.

Leverage the art of primary care for health equity

The US healthcare system is often called the "best in the world." Unfortunately, care access and quality vary widely depending on social factors such as race, economic status, and education levels. When access to personalized care, healthy lifestyles, nutritious food, and other contributing factors are beyond the patient's reach, it's challenging to improve pathophysiology.

A fully capitated approach can make exceptional primary care available to vulnerable and underserved communities.

Increase provider satisfaction

Under a full-risk model, PCPs can experience the art of primary care in action. Physicians and staff can take pride in knowing they're making a holistic impact on patient health and contributing to positive change for US healthcare delivery.

The ChenMed Full-Risk Model

ChenMed's high-touch preventive model **lets PCPs practice medicine the way it was meant to be practiced.** Our work at ChenMed demonstrates that the art and science of primary care can provoke transformational healing in a vulnerable and medically complex population.

Working with Medicare Advantage, ChenMed's physician-led care teams and network of supportive specialists use a hybrid approach, improving clinical outcomes and quality of life through in-clinic and telehealth services. Our collaborative infrastructure keeps providers, patients, care team associates, and family members connected.

Provider education

ChenMed provides extensive training and mentoring to physicians entering our network; we offer a fellowship for transformative care leaders and conduct workshops for providers outside our network who are interested in transitioning away from the FFS model.

Conclusion

Refocusing primary care on relationships, patient trust, and the provider's passion for healthcare is critical to attracting more doctors to the practice and addressing burnout among current providers, improving health outcomes, and working toward health equity.

A transformative care delivery model elevates the art of primary care and empowers PCPs to contribute significantly to the goal of value-based care by restoring equity and integrity to the US healthcare system.

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For more information, visit www.ChenMed.com