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COMMENTARY

The Case for Transformative Care

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The U.S. health care system's revenue structure includes payment models that are incompatible with each other and the needs of consumers: the transactional fee-for-service model and variations of value-based and outcome-based care models. While provider organizations struggle to function in these environments, physician leaders at ChenMed contend delivery systems can move beyond these confusing and ineffective models of care and embrace a transformative care model. Transformative care combines a capitation payment model and a primary care delivery approach that emphasizes care team accountability for patient care and requires care team members to develop the trust-building and influencing skills necessary to modify patient behavior and create better health outcomes. The success of the model is based on scaling and sustaining outcomes-based care and supporting clinicians in their mission to focus on quality patient care and positive health outcomes. Key components of the model include: robust data and technology to understand patient needs and to measure progress; prioritized physician/patient relationships and a mindset of accountability to ensure the necessary time and resources are invested in developing the trust and influence with patients required to improve outcomes; and personal development programs that start in medical school, continue at the clinic level, and emphasize self-evaluation, behavior modification, mentorship, peer-to-peer feedback, expanding care capacity through the development of others, and a daily commitment to maintain and pursue excellence.

Despite the widely acknowledged need for deep change in the U.S. health care system, moving from fee-for-service or transactional care to value-based care is not sufficient. America needs more — a vision for the future that moves past transactional care, and even beyond value-based and outcomes-based care to *transformative care*. We define transformative care as a commitment from clinicians and clinical leaders to influence patients toward better health outcomes. Despite the

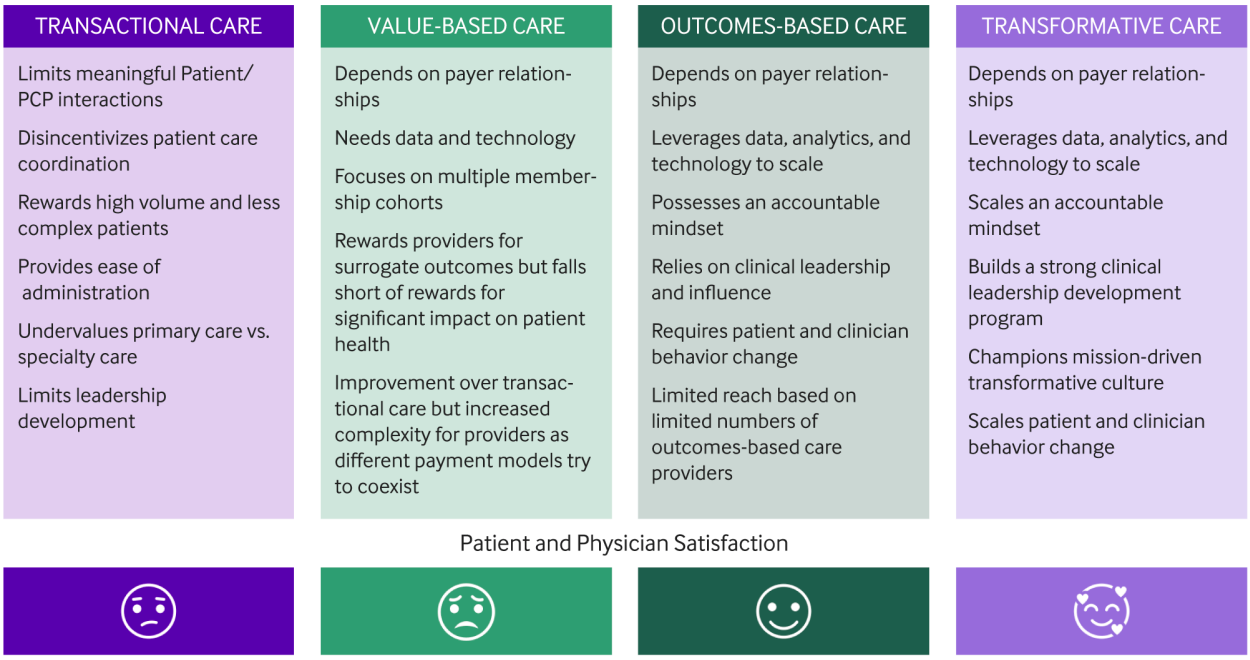
strengths and given the weaknesses of the existing American health care system, we must insist on a system that embraces a higher purpose, emphasizes superior outcomes, leverages state-of-the-art technology, and generates a leadership development culture to drive transformative care and create scalable change that will improve health for everyone.

ChenMed is a Miami, Florida–based privately owned health care delivery and technology company delivering high-touch and personalized primary care for Medicare-eligible seniors in underserved communities. Operating approximately 130 concierge-style centers across 15 states under its Dedicated Senior Medical Center, JenCare Senior Medical Center, Chen Senior Medical Center, and IntuneHealth brands, the organization is focused on expanding the transformative care model. We believe the broader primary care industry will need to move beyond the incompatible and often ineffective fee-for-service and value-based care models, and transition to a sustainable transformative care model (Figure 1).

FIGURE 1

Transactional Care to Transformative Care: Key Attributes

This figure summarizes the key aspects of the four models of care discussed. The essential distinction of the transformative model is that while it is rooted in a full-risk, outcomes-based approach, there are two additional pillars that make the care transformative: a mission-driven culture and a clinical leadership development program that both effectively scale. We believe professionals experiencing transformative care, as depicted in the satisfaction component of the figure, will change their lives, the lives of their patients, and the lives of their colleagues — replacing frustration, stress, and burnout with fulfillment, joy, and meaning.



PCP = primary care providers

Source: The Authors

Transactional Care

The U.S.–based transactional care system can work for patients who are sick and can afford it. These patients value flexibility and the ability to shop for the care they need. If their doctor cannot see them, they can see someone else. If they do not like their doctor's treatment recommendations, they can get a second opinion. These patients have the financial resources to choose the most prestigious and respected doctors and hospitals for their more serious health issues.

Unfortunately, many Americans have limited access to transactional health care because the local fee-for-service providers could not make their economics work in communities where most patients paid with government-sponsored care (Medicare and Medicaid). As a result, the providers moved to greener pastures in more affluent neighborhoods. For the Americans left without access, a lack of financial resources can further impact their access to quality housing, nutrition, transportation, education, and other social determinants that can combine to have a greater impact on health than family medical histories.[1] In fact, studies estimate that 70% of medical outcomes are based on patient lifestyle, behaviors, and social networks. Sadly, the well-meaning transaction-trained doctors who stay in these underserved communities don't have the time, training, or focus to address these social determinants of health and other nonmedical factors.

> *"We define transformative care as a commitment from clinicians and clinical leaders to influence patients toward better health outcomes."*

Health care disparities in America disproportionately impact marginalized and impoverished populations. For example, ChenMed's JenCare Senior Medical Centers in New Orleans, Louisiana, are in poor inner-city communities just a few miles from the expensive French Quarter. In these neighborhoods, however, fast food restaurants and convenience stores — not Michelin-star restaurants and fresh-food markets — crowd every corner. Patients in these communities are primarily Medicare- and Medicaid-eligible African American seniors on fixed incomes who live with multiple complex medical conditions. They die 15 to 20 years earlier than their white, financially secure counterparts living just a few miles away.[2]

Moving beyond transactional service and the issues inherent in that model is not for the faint of heart. Medical school and residency programs are built on the fee-for-service model. These programs focus on preparing doctors to work in inpatient and specialty care. Rare is a program that offers training in proactive, preventive care focusing on social and behavioral components of health and how to change the underlying behaviors leading to the disease burden. Equally rare is the program that encourages holistic, cost-effective, and less invasive approaches for disease management before ordering a prescription, an injection, or a procedure.

Medical schools and residency programs are not designed to prepare future primary care physicians for preventive care models. If they were, they would also focus on the relationship building, influencing, and coaching skills primary care clinicians need to drive behavior change and help their patients avoid the tests, procedures, and referrals that drive inpatient and specialty care. But

in a world where increasing economic pressures have led to more partnerships between health care systems and academic medical centers, a focus on the *soft* skills that lead to prevention is not aligned with the health care system's financial goals. Further, the system's payment model incentivizes primary care clinicians to treat illness, not prevent it. These incentives often deter overworked clinicians — who in some cases are paying off student debt — from developing the soft skills on their own.

There is, and always will be, a vital role for hospitals and transactional care. In an ER setting, doctors must focus on the chief complaint. A battery of transactional tests and procedures is the quickest and most effective way to identify an issue and address it appropriately. In these situations, there is no place for influence and behavior change. Reacting to the immediate chief complaint must be the priority because a failure to react could be the difference between life or death.

Transactional care, however, cannot be the only way. Doctors have become increasingly frustrated with this model of care. They went into medicine to heal people and make differences in the lives of others. They did not invest years in medical school to generate transactions that have limited impact on patient outcomes. Likewise, they did not think becoming a doctor would have an adverse effect on their own physical, mental, and spiritual health, but we are seeing doctors burn out and drop out of medicine at alarming rates.[3,4] Industry disruptors interested in better patient health outcomes and greater professional fulfillment for doctors are pushing hard for value-based care in primary care.

> *"Moving beyond transactional service and the issues inherent in that model is not for the faint of heart. Medical school and residency programs are built on the fee-for-service model."*

Value-Based Care

There is bipartisan support to move to value-based care because it is not financially sustainable to continue in the fee-for-service, transactional care model. Clinicians want to move to a value-based care approach, but a gradual move to value-based care from fee-for-service penalizes them by creating tremendous complexity for introducing anything other than a transactional care approach.

Value-based care models typically describe a practice with a multitude of value-based contracting and incentives on top of a predominantly fee-for-service model. This approach can be frustrating and difficult to maneuver, causing more stress for doctors and staff as well as the patients caught in the middle. Further complicating the move to a unified value-based care and payment model is the lack of price transparency, constant renegotiating of pricing, and pharmacy rebates.

It takes a different mindset and skills for clinicians to succeed in value-based care. Developing the influencing, trust-building, and coaching skills necessary to create better outcomes requires clinicians to develop emotional intelligence muscles they didn't need to excel in medical school or residency training. Better listening skills, more empathy, and understanding how others perceive

them are just a few of the soft skills needed to influence patients and change their behaviors. These skills take time to develop, and clinicians are hesitant to invest whatever discretionary time they have in developing skills that apply to their few primary care patients covered under a value-based care payment model. In addition, while many value-based care contracts reward clinicians for surrogate outcomes (e.g., process measures associated with blood pressure management, diabetes control, and preventive screenings), the contracts often fall short of rewarding them for more significant impacts on patient outcomes — like avoiding ED visits and hospitalizations through effective proactive, preventive primary care.

Provider groups must face the frustration and complexity that a partial or incremental move toward value will create, and they must appreciate that a full-time focus is required to motivate both the staff and their patients to change their behaviors. The coexistence of the competing fee-for-service and value-based payment models drives home the conflict: It is speed and quantity versus quality and cost. Both can work. It is difficult, however, for them to coexist in the same practice. The organization's business model plays a role. For example, the for-profit, publicly traded corporation HCA Healthcare relies primarily on transactional care and continues to grow and deliver strong financials, although they acknowledge that "the industry trend toward value-based purchasing may negatively impact our revenues."[5] Kaiser Permanente, a nonprofit integrated system that includes its own health plans, hospitals, and medical groups, relies on capitated payments to support its value-based model and continues to grow sustainably.[6] As the industry gradually shifts toward value over volume,[7,8] doctors and health care organizations must choose a side. Incremental moves toward value rarely work. Those who choose to go all in with the value-based care model will leave the transactional care world behind and move to an outcomes-based care model.

> *"A full risk, outcomes-based approach is the foundation of a transformative care model."*

Outcomes-Based Care

Without the confines of practicing in a fee-for-service transactional model, clinicians can focus on helping patients to achieve more healthy days by reducing their sick days. We define this practice environment as *outcomes-based care* with a simple definition of outcomes: The model requires full-risk capitation to incentivize preventive care, reduction of avoidable hospitalizations, and the early detection and management of high-risk conditions. Outcomes need to be the focus of care, calibrated by cost. While clinicians and experts can debate the definition of positive outcomes, extending life by promoting healthier days and reducing sick days is our most fundamental view of positive outcomes. Furthermore, achieving consistent positive results requires a singular approach to primary care delivery without switching back and forth between transactional and value-based care, which continues to be a flaw in many value-based care models.

For groups to financially sustain themselves in an outcomes-based model, they need to benefit when preventing hospitalizations, avoiding ED visits, and eliminating medical waste. This requires a full-risk capitated model where savings from prevention can apply to more primary care

capabilities, such as social and behavioral expenses covered by Medicare that drive better patient outcomes. Full-risk, or full-risk capitation, refers to a payment model in which private insurance companies partner with health care providers who will both take care of the patients while also assuming financial risk for those patients.

There are varying levels of risk-bearing. But for this discussion, let's assume full risk, meaning the risk for hospitalizations, professional fees, and drug fees for the group are transferred to the provider. These providers then pay for all aspects of the care, wherever it comes from — a hospital, a specialty group, or a pharmaceutical company. The providers are at risk if expenses exceed their budget, but they benefit from any savings they achieve by lowering the necessity for expensive medical interventions. In this model, preventing hospitalizations leads to direct savings that the provider can reinvest into primary care. This option gives providers the best chance to succeed financially while also serving the best interests of their patients. Because there is a risk of underutilization, it becomes critical to have an open and transparent forum that allows for peer-review of high-risk cases, dedication to appropriate guideline-based care, and a focus on patient outcomes over pure cost.

ChenMed is a full-risk primary care provider. A full risk, outcomes-based approach is the foundation of a *transformative care* model. ChenMed primary care providers (PCPs) and their care teams focus on prevention and wellness to improve outcomes. This focus reduces the need for specialty care, controls prescription costs, and lowers ER and inpatient hospitalizations among our Medicare-eligible senior patients from between 30% to 50% when compared to their counterparts in fee-for-service, transactional systems. We build our outcomes-based model on two important pillars: one information-based and one relationship-based.

The first pillar is having the right data and technology infrastructure. Great data enables the development of baselines, benchmarks, and attainable goals. This supports informed decision-making for the PCPs, helps them be more strategic with where to focus their time and efforts, and aids in identifying and rectifying potential issues in a patient's health. Simply put, technology and data empower outcomes-focused providers to reduce our patients' hospital sick days, drive more healthy days, and save lives. Our proprietary electronic medical record system that was custom built for a transformative care approach helps us identify and manage high-risk conditions. We can integrate data and information from hospitals, payers, pharmacies, and other medical clinics so our PCPs have the full picture of each patient's medical history and current state. We also have practice management systems that help us improve patient service and interact more frequently with patients in a meaningful way to drive better health.

> *"In pursuit of better outcomes, our PCPs take a holistic approach — examining all the factors contributing to a patient's health. Only then can they develop the influence they need to help patients change their behaviors."*

The second pillar is our relationships with our patients. Most ChenMed patients are lower income, i.e., Medicaid-eligible seniors on fixed incomes with multiple complex and chronic diseases in underserved communities. Recognizing that the ability to influence requires a close and trusted relationship, we have smaller panel sizes (approximately 450 patients per physician), about five times smaller than primary care physicians who have 2,300 patients per panel.[9] Lower panel sizes enable us to have frequent, often monthly, visits with our senior patients, which allows us to build trust. Seeing patients monthly — compared to the non-ChenMed Hispanic and Non-Hispanic Black patients aged 65-and-older who see their PCPs about two or three times per year[10] — also empowers our PCPs to make more timely and targeted changes to care, which drives improved medical optimization.

Simply put, our smaller panels and frequent visits allow our PCPs to prevent little problems from becoming big ones. The additional time also allows more focus on lifestyle changes, reducing polypharmacy, and establishing clear goals of care. Further, we schedule follow-up visits for 20 minutes. Over the course of 1 year, these visits total about 220 minutes per patient, exceeding typical primary care visits for those 65-and-older by 171 minutes for Non-Hispanic Black patients (about 49.1 minutes) and by 144 minutes for Hispanic patients (about 76.0 minutes).[10] And finally, smaller panels give us more availability to see patients whenever they have needs or concerns. Our PCPs are comfortable sharing their cell phone numbers with patients. Our patients know that when they have an urgent need, we can quickly and confidently address them. Our clinicians understand the full-risk environment and take time to understand and align with their patients to help them achieve their most ambitious health goals, such as longevity, mobility, and quality of life.

When doctors join ChenMed and begin working in our model, they do things differently. They begin every patient interaction with the same question to themselves, "*How do I help my patient get to better health?*" They spend time getting to know their patients and learning about their families, histories, social lives, and living conditions. In pursuit of better outcomes, our PCPs take a holistic approach — examining all the factors contributing to a patient's health. Only then can they develop the influence they need to help patients change their behaviors. They cannot get better outcomes without behavior change, and behavior change requires influence and trust.

PCPs who join ChenMed go through year-long intensive training to help them adopt a mindset of accountability. An accountable mindset means they take full responsibility for the patient's health, even managing the social variables outside the PCP's direct control. It also means taking responsibility for the care teams who support the patients. The entire team must focus on outcomes and develop the skills to select, train, and empower new team members to keep patients healthy. Finally, an accountable mindset means our PCPs continue to pursue different approaches to connect with and influence patients, including patients who may present as noncompliant. The ability to overcome traditional barriers to compliance and to achieve adherence to disease management strategies means the care team must go deeper to uncover the barriers that prevent that individual patient from doing the necessary positive things that could improve their health. This requires not only the expert clinical acumen developed through medical school and residency, but also developing the social and relational skills they may not have learned in their training. In the full-risk model, trust, coaching, and influencing skills determine success. These skills help clinicians lead with empathy, listen carefully, and develop trusting relationships with their patients

— the kind that you may see in a close-knit family. Without these relationship skills, a clinician's vast medical knowledge will prove insufficient.

> *"In the full-risk model, trust, coaching, and influencing skills determine success."*

There are little pockets of organizations across the United States that employ full-risk, outcomes-based champions to deliver primary care. It is important to note that this model is not transactional, nor is it a part-time value-based care component inside of a transactional system. And while the impact on individual patients can be profound, the overall impact of these innovative organizations within the nation's greater primary care system is limited. To improve health across America, starting with the neediest populations, we need more doctors in outcomes-based models where the incentives align with better health outcomes. The impact of scaling outcomes-based care would be transformative, and that brings us to transformative care.

Transformative Care

Sustaining and scaling outcomes-based care will create a new primary care model — *transformative* care — which champions health and wellness for patients and caregivers. The foundation of transformative care is a commitment from clinicians and clinical leaders to influence patients toward better health outcomes. While that may sound like outcomes-based care, in transformative care, there are two additional pillars that make the care transformative: a mission-driven culture and a strong clinical development leadership program.

The first pillar is a *mission-driven culture*. The mission is the*why*, and the why must be deep, meaningful, and aligned with a vision for transforming primary care. At ChenMed, our*why* is to fight for the forgotten communities, eliminate health care disparities, and create health equity for our patients. We stand up for the most vulnerable, forgotten, and marginalized senior citizens in America. Our mission is to honor them with affordable, VIP care that delivers better health. Other health care delivery organizations can develop their own*why* to address hurdles to better health that are unique to their patients.

The *why* is important because you are scaling a model that disrupts the existing primary care ecosystem through a preventive and outcomes-based approach. Anytime you do something so countercultural, you need a strong and clear*why* to generate the will to keep pushing forward. You need it to go into new geographies with champions willing to go against the current grain of primary care. You need it to attract those talented champions, like-minded clinicians, and leaders who embrace and share that mission. Most of all, you need a strong*why* when facing barriers, setbacks, and disappointments that inevitably come when pursuing a massive change to something as large and imposing as our current primary care delivery system. At the very least, the transformative care model is capital-intensive. At ChenMed, we invested in the technology needed to produce great outcomes with the intent to scale outcomes-based care and reach transformative care. We needed additional capital to build and maintain the training and education infrastructure necessary

to teach skills that medical schools and residency training didn't cover. Without a strong*why*, we could have given up the pursuit if money got tight. However, our clear, well-stated mission tells us it's worth sticking to that mission through difficult times because everyone will benefit when we achieve our vision of transformative care.

The second pillar of transformative care is a strong clinical development leadership program that inspires clinicians and physicians to lead each other, introduce the model to new doctors and clinicians, and drive transformative care into new communities. Developing and leading other leaders is how organizations grow, scale, and expand. It is also fun to watch. There is nothing as inspirational, influential, or meaningful as watching leaders create other leaders, and it happens in three steps.

> *"Sustaining and scaling outcomes-based care will create a new primary care model — transformative care — which champions health and wellness for patients and caregivers."*

First, aspiring leaders must evaluate themselves. Personality assessment tests can help. Coaching can help. Self-exploration or guided therapy can help. No matter what route leaders take, the journey to self-discovery will help them leverage their strengths, recognize weaknesses, and shift their mindsets to finding a greater purpose — something bigger than themselves and bigger than a desire to heal others. The greater purpose must align with a vision to transform health care.

Second, leaders must expand their capacity through others. When leaders invest in others, everyone wins. We learn more, stretch more, influence more, empower more, and build more capacity. Expanding capacity by investing in others is such an important element of leadership development that it is a formal part of our job descriptions.

Third, transformative leaders understand the pursuit of excellence. When anyone says they've reached excellence, they haven't. It's the pursuit of excellence that matters. Excelling is constantly asking ourselves, "What can I do better?" because we want to be intentional about what we want to create.

This is how accountable people create other leaders, scale transformative care, and improve health for everyone.

Looking Ahead

The secret to transformative care is remarkably simple. Accountable primary care doctors focus on improving outcomes through scalable data, driven by a *why* that is deep and meaningful, while working with mission-driven people and a world-class leadership culture. Simple, however, does not mean easy.

Fee-for-service, or transactional, care has been the reigning, undefeated, and rarely challenged primary care delivery system champion in the U.S. since before many of today's health care professionals put on their first pair of scrubs.

Primary care doctor-patient encounters are primarily focused on sick care. PCPs react to a chief complaint such as high blood pressure or a breathing issue and are paid for every transaction they generate in pursuit of a return to the patient's pre-complaint state.

> *"The secret to transformative care is remarkably simple. Accountable primary care doctors focus on improving outcomes through scalable data, driven by a why that is deep and meaningful, while working with mission-driven people and a world-class leadership culture."*

Hospital systems and primary care physician groups work the same way. They react to a complaint and every patient they see, every test that's done, every lab that's ordered, every referral made, is a transaction, which contributes to revenue. The CEOs and hospital administrators, the current leaders of for-profit primary care delivery organizations in America, were hired, in part, because of their expertise in generating revenue.

A transformative primary care model focused on a scalable, outcomes-based approach through full-cost capitation essentially eliminates multiple revenue opportunities for primary care physician groups and health systems. Eliminate the multiple revenue opportunities, and you eliminate one of the pillars of for-profit institutions — generating as much revenue as possible in pursuit of a favorable return on investment. A shift of this magnitude will challenge everyone in the health care ecosystem — not to mention higher education and communities dependent on the tax base primary care providers create — to reset their goals and expectations for primary care.

Primary care clinicians and clinical leaders who dedicate themselves to transformative care will discover more developmental opportunities, reduced payment model complexity, fewer but more in-depth interactions with specialty care and pharmacology professionals on critical cases, better data and technology, and a greater ability to positively influence patient behavior — all resulting in better health care outcomes. They will spread better health to some of the unhealthiest, most-forgotten corners of the United States. They will eliminate health care disparities and improve the lives of people who otherwise would receive expensive, confusing, and ineffective care at best and little to no care at worst. They will change their lives and the lives of their colleagues, replacing frustration, stress, and burnout with fulfillment, joy, and meaning. Most of all, professionals who embark on a transformative care journey will transform primary care by pursuing health and wellness for everyone involved.

Reaching a critical mass of influence, according to a University of Pennsylvania study,[11] will require at least 25% influence penetration as a practice in the transformative care model. If 25% of the providers are practicing in the transformative care environment and they are focused on the 5% of sickest, most complex, patients, they can achieve 30%–50% reductions in hospital rates

compared to the status quo. They will also generate a continuous cycle of development and renewal that creates leaders and improves the health of one patient, one doctor, one community, and one generation at a time; and American primary care will be transformed.

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