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Value-Based Care

The Missing Link to a Better Patient Experience

When care is designed for relationships, trust becomes possible, and better health outcomes tend to follow.

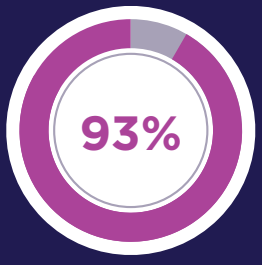
Patient experience improves when the delivery model makes follow-through a regular part of the day.

A patient is discharged on a Friday afternoon with three medication changes and a note that says, “Follow up with PCP.” By Monday, he feels lightheaded. His daughter is not sure whether the dizziness is due to the new diuretic or the new blood pressure medication, and she does not want to “bother the office.” She tries calling anyway. The phone tree is long. The callback does not come until the next day. By then, the patient had fallen in the kitchen.

In a fee-for-service model, this story is treated as bad luck. It is not. It is what happens when the most important work, like education, medication reconciliation, early outreach, and rapid access, lives outside what the system reliably pays for. Value-based care does not remove complexity. It changes what the system can afford to do about it.

Patient experience is what happens across the care continuum: access, communication, coordination, and respect. Patient satisfaction is how patients evaluate their experience against expectations. Health outcomes are results over time: symptoms, function, avoidable hospitalizations, and disease control.

> **New doctors don’t get a chance to practice what we do, which is relationship-based care, and follow patients for months and years. It’s simply not possible to do that in a residency environment, at least not today. - Christopher Chen, MD**



In 2023, **93.0% of adults age 65 and older reported at least one chronic condition,** and 78.8% reported multiple chronic conditions. For seniors, patient experience is often defined by whether care is coordinated enough to handle complexity safely.

This paper will discuss:

1. How patient experience is shaped more by care design than by hospitality tactics
2. Why fee-for-service makes continuity, access, and coordination harder than they need to be
3. How value-based primary care supports better communication, follow-up, and health outcomes
4. What primary care providers can borrow from value-based models to improve patient experience for seniors

Patient Experience

AHRQ defines patient experience as the range of interactions patients have with the healthcare system, across clinicians, staff, and settings. That definition is intentionally broad. Patients do not experience "a visit." They experience whether the visit is connected to everything that came before it and everything that follows it.

The Three Pillars of Patient Experience

When clinicians talk about the pillars of patient experience, it helps to keep them grounded in practice. In primary care, patient experience consistently rests on three things patients can reliably report: access, communication, and coordination over time. Access is the ability to get timely appointments, help, and information. Communication is how clearly the care team listens, explains, and confirms understanding. Coordination is whether care connects across clinicians and settings so the patient is not forced to carry the story alone.

Ordinary Moments Define Patient Experience

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There is a reason patient experience belongs in quality conversations. A widely cited systematic review in BMJ Open notes that **patient experience is increasingly recognized as one of the three pillars of healthcare quality**, alongside clinical effectiveness and patient safety. That framing is essential for primary care providers. Experience is not a separate domain that competes with clinical work. It is one of the factors that determine whether clinical work succeeds or fails over time.

Patient-Centered Care

Patient-centered care is not a slogan. It is a set of conditions that enable a team to understand what matters to a patient and respond consistently. In a value-based system, CMS notes that clinicians deliver high-quality care using a person-centered approach, contrasting it with fee-for-service patterns where care is often siloed across multiple specialists focused on single issues.

Patient-centered care becomes difficult when the model forces the day into a rapid series of transactions. The intent may be good, but time is still finite. Seniors rarely present with one problem. They bring multiple conditions, complex medication lists, functional limits, caregiver dynamics, and symptoms that do not fit neatly into one code.

The 4 Ps of Patient Experience

When discussing patient experience, it can be helpful to borrow language from **"proactive P4 medicine."** The literature describes care that is predictive, preventive, personalized, and participatory. In day-to-day primary care, that idea translates into what patients feel when a system is working: proactive outreach, personalized planning, predictive attention to rising risk, and precise follow-through. "Precise" here is not about perfection. It is about delivering the right intervention at the right time, with clear communication and reliable execution. That comes down to system design, not individual style.

Value-based primary care makes these habits feasible. It supports the staffing and workflows for proactive outreach, medication checks, and early follow-up. With smaller panels and more time, care teams learn what "normal" looks like for each patient and can respond early when the story begins to change.

Fee-For-Service Care

Payment follows volume. The visit becomes the unit of work. The time between visits is often clinically meaningful but not financially supported, so follow-up and coordination compete with the subsequent scheduled encounter.

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Value-Based Primary Care

Payment is tied to outcomes and total cost. Teams can invest in prevention, outreach, and coordination because those activities protect patients and support better health outcomes over time.

Example of Value-Based Practice

A value-based primary care practice typically operates with a smaller panel, more extended visits, a primary care provider-led team, and proactive follow-up between visits. Success is measured by outcomes and avoidable utilization, not by visit volume.

Patient Satisfaction

Patient satisfaction is not the same as patient experience and is often used as shorthand for patient experience, but the two are not identical. Patient satisfaction is a measure of how a patient feels about what happened and is strongly influenced by expectations. Expectations are shaped by culture, prior experiences, fear, and the clarity with which clinicians explain what to expect.

In research on patient perspectives, expectations are described as anticipations that certain events are likely to occur during care or as outcomes of care.[4] When expectations are unclear, satisfaction becomes volatile. Patients may be dissatisfied even when care is technically appropriate, or satisfied even when the process was fragmented, because their expectations were low.

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Patient satisfaction reflects whether the care matched a patient's expectations. Patient experience reflects what actually happened across the care continuum, including access, communication, and coordination.

The Goal Is Engagement, Not Ratings

The goal of patient satisfaction is not to chase ratings. The goal is to reduce friction so patients can engage in care that works for them. When a patient trusts the team, they call sooner. They disclose sooner. They follow through more consistently. The care plan becomes something shared, not something assigned.

Satisfaction rises when patients believe the team will show up for them, especially between visits.

Reliability Is What Patients Notice

In inpatient care, organizations sometimes use a "5 Ps" mnemonic to standardize rounding and reduce preventable needs. One standard version includes pain, position, potty, periphery (needed items within reach), and pump (checking IVs and devices). Primary care does not need to borrow the mnemonic. It can learn from the underlying logic. Satisfaction rises when patients experience reliability and responsiveness, especially when they are vulnerable.

In fee-for-service primary care, reliability is often undermined by throughput pressure and fragmentation. Callbacks become delayed. Appointments become scarce. Continuity breaks when patients cannot get in and take whatever slot they can find. The patient's satisfaction is then a reasonable response to a system that does not feel dependable.

Value-based care does not make patients easier. It makes dependable care more achievable. When the model pays for preventing avoidable hospitalizations and complications, it becomes rational to build systems that patients experience as respectful: timely access, clear communication, and a team that knows them.

Care for Seniors

The stakes of patient experience rise sharply with age. Seniors are more likely to live with multiple chronic conditions, polypharmacy, cognitive change, and social vulnerability.

They are also more likely to experience the harm created by gaps: missed follow-up after hospitalization, medication confusion, delayed symptom response, and uncoordinated specialty care.

Adults age **65 and older** frequently live with multiple chronic conditions. In this population, minor coordination failures can become major events.

This is where the limitations of fee-for-service become visible. The model was not built around continuity or proactive relationship-based care. It was built to reimburse discrete encounters.

Even RVUs, introduced initially to standardize reimbursement, can end up rewarding volume over outcomes when productivity becomes the central measure of a primary care provider's value. **Dan McCarter noted** that RVU incentives can be "perverted to incent volume of services delivered, rather than health outcomes achieved." RVUs do not reflect important efforts such as understanding patient values and communicating with family members.

For seniors, the work between visits is often what **prevents the next hospitalization.**

Health Outcomes

Health outcomes describe what happens over time: blood pressure control, diabetes control, symptom burden, functional status, falls, avoidable admissions, readmissions, and quality of life. Outcomes are shaped by biology, behavior, and environment. They are also shaped by the system's ability to follow through.

What Determines Health Outcomes

Social determinants of health matter here. The CDC describes social determinants of health as nonmedical factors that influence health outcomes, including the conditions in which people are born, grow, work, live, worship, and age.

For seniors, these conditions often make the difference between a plan that looks good on paper and one that can be followed at home.

Examples of Patient Outcomes

Examples of patient outcomes include fewer avoidable hospitalizations and readmissions, better symptom control, improved functional status, fewer falls, better chronic disease control (such as blood pressure or A1c), improved quality of life, and more time living independently.

Better health outcomes often mean

fewer crises and more stability:

fewer avoidable hospitalizations, better symptom control, and more time living independently.

Why Value-Based Care Changes the Conditions for Outcomes

Value-based care creates space to address these realities by tying success to outcomes rather than the number of services delivered.

A 76-year-old woman with heart failure and diabetes keeps returning to the emergency department with shortness of breath. Her weight fluctuates. Her diuretic changes. Her A1c drifts upward. In a traditional model, each event becomes a separate visit with separate instructions. In a value-based setting, the team treats the pattern as the problem. A nurse calls to review weights and symptoms. A pharmacist helps simplify the regimen.

The primary care provider adjusts diuretics with a clear plan to manage new symptoms, especially dizziness or lightheadedness. The team learns that she has been rationing food at the end of the month, and “diet nonadherence” becomes a social support plan. The following month is quieter, not because she became a different person, but because the system around her life became more coherent.

Clinical Outcomes

Clinical outcomes are the measurable health metrics clinicians track: blood pressure, LDL, A1c, kidney function trends, vaccinations, depression screening follow-up, medication adherence, and post-hospitalization reconciliation. These measures matter because they often predict what happens next.

Why Clinical Outcomes Matter

Clinical outcomes give teams early signals. They show whether a plan is working, where risk is rising, and when follow-up is needed before a small change becomes a hospitalization.

Clinical Outcomes Improve When the Model Supports Three Practical Capabilities

1. Time for clinical decision-making. Value-based care supports more time per patient, improving history, medication review, and shared planning.

2. A primary care provider-led team. Seniors need an interdisciplinary team to coordinate referrals, follow through between visits, and close loops after hospital events.

3. Continuity over time. Care becomes safer when the patient is known. Longitudinal relationships make it easier to recognize subtle changes early, including confusion, frailty, or weight gain, before they become crisis-level harm.

In value-based care, these capabilities are built into the day, not treated as extras. The model aligns patient experience with clinical practice, enabling the delivery of care that restores dignity for patients and purpose for primary care providers.

Improving Patient Experience in Value-Based Primary Care

- ✔ Make access a clinical tool, not a scheduling problem.
- ✔ Build continuity so trust does not reset at every visit.
- ✔ Use proactive outreach to catch risk early.
- ✔ Coordinate care as a standard workflow, not a heroic effort.
- ✔ Measure outcomes to learn, then return the learning to the relationship.

Patient Feedback

Patient feedback is often treated as an administrative obligation. In practice, it is one of the clearest ways patients show where the system is fragile. The CAHPS Clinician & Group Survey measures patient experience across domains such as timely appointments, care, and information, and the quality of provider communication. This is where patients feel the system is working, or not.

Patient Feedback Works Best as a Clinical Signal

Feedback becomes most useful when teams treat it like a clinical signal. A recurrent delay in callbacks. A pattern of confusion after specialty visits. A weak handoff after hospitalization. Repeated reports that medication changes were not understood. These are not isolated complaints. They are clues about where care is breaking down.

CAHPS surveys capture patient experience information that providers can use to improve the care they deliver. That framing matters. Feedback is not a score to defend. It is data that points toward redesign.

Why Value-Based Care Makes Improvement Possible

In fee-for-service environments, redesign is difficult because the day is already overfull. Even when teams see the problem clearly, fixing it can feel like unpaid labor.

Value-based care changes the equation by funding improvement work as part of the mission of keeping people well. When the model rewards prevention and follow-through, it becomes rational to build reliable systems for callbacks, transitions, medication reconciliation, and coordination.

Patient experience improves

when the team can keep promises: calls returned, care coordinated, transitions managed, medications reconciled, and questions answered before fear turns into an emergency visit.

Patients feel the difference quickly.
Seniors feel it even faster.

A better patient experience is not just a softer waiting room. It is a care system that does not ask patients to carry the burden of coordination while they are sick. It is a model that gives clinicians enough time to listen, enough team support to follow through, and enough continuity to build trust.

Value-based care does not make medicine easy. It makes effective medicine more possible. When outcomes and experience are treated as inseparable, the work that happens between visits, such as phone calls, medication reconciliation, family conversations, and proactive outreach, becomes part of the standard work of care.

In that shift, patients are not the only ones who benefit. Primary care providers regain the ability to practice with steadiness and dignity. The day becomes less about surviving the schedule and more about keeping faith with the people who depend on us.

At ChenMed, we practice medicine the way it was intended, by investing in primary care and empowering physicians to build meaningful relationships with our senior patients. An enhanced patient experience is how we pursue more good days and better health outcomes for our patients. Learn more about **ChenMed's practice model here.**