ADVANCING PRIMARY CARE DELIVERY
Practical, Proven, and Scalable Approaches

UnitedHealth Center for Health Reform & Modernization
Why Focus on Primary Care?

Primary care is the foundation of the U.S. health care system
- 55% of over 1 billion physician office visits annually
- 6% – 8% of national health care spending ($200 - $250 billion annually)
- The ACA could generate 25 million additional visits each year

High value of primary care
- Central to effective treatment and efficient care delivery
- Emphasis on preventive services
- Core element in advanced care delivery models

Accessing primary care is a major challenge for many individuals
- Lack of capacity and access in rural areas and low-income communities
- 70% of ER visits by commercially insured individuals are non-emergencies

Practical, proven, and scalable solutions exist in the marketplace to advance primary care delivery

Read the Complete Report at unitedhealthgroup.com/modernization
Assessing Value and Capacity

A higher concentration of primary care physicians is related to:

- Lower rates of mortality
- More effective preventive care
- Fewer avoidable admissions
- Fewer avoidable emergency department visits
- Less use of costly and often not more effective high-technology diagnostic imaging

Demand for primary care is growing due to:

- An aging population
- Increases in chronic conditions
- Reduction in uninsured population
- Consumers looking for more convenient ways to access care, including extended office hours and electronic communications

Avoidable Hospital Emergency Department Visits and Primary Care Physician Supply

UnitedHealth Center for Health Reform & Modernization
Assessing Value and Capacity

Some areas of the country, including the West and the South, face greater challenges in ensuring primary care capacity in the coming years.

Primary Care Challenge by County, 2014
Primary care physicians are more concentrated in areas with higher household incomes and lower uninsured rates, while nurse practitioners and physician assistants are more concentrated in these underserved areas.
# Building Blocks for Bolstering Capacity and Quality

## Diverse Workforce
- Over 190,000 nurse practitioners (NPs), as well as other clinicians, can increase primary care capacity
- Evidence indicates high quality of primary care delivered by NPs

## Multi-Disciplinary Teams
- A primary care physician with a panel of 2,000 patients would need to spend 17.4 hours per day providing recommended care
- Integrating NPs and other providers into team-based care can allow practices to double the number of patients they see
- Practicing in teams increases the satisfaction of primary care physicians

## Health Information Technology (IT)
- Broader implementation of Health IT, including Electronic Health Records (EHRs), increases system-wide quality and care coordination
- Lack of interoperability prevents effective data sharing
- Cost of adoption and ongoing support is a challenge for smaller practices
Advanced Service Delivery and Payment Models

Paying for value incents higher quality care instead of a greater volume of services

Fee-For-Service (FFS)

- Encourages providers to deliver a greater volume of more costly services
- Fails to promote high-quality services and care coordination across providers
- Contributes to failures in care delivery, including overtreatment and wasteful health care spending

Models using FFS rather than value-based payments have struggled to achieve success

Value-Based Payment

- Shifts away from payments based on the quantity and intensity of services delivered
- Rewards high-quality and effective care rather than higher volume of more complex services
- Includes multiple approaches that allow payments to be tailored to the diverse capacities of providers

Advanced Service Delivery Models

Medical Homes and Accountable Care Models:
- Multi-disciplinary care teams
- Health information technology
- Focus on care coordination
- Treating the whole patient
Advanced Service Delivery and Payment Models

Medical homes that transform care delivery and pay for value have improved quality and reduced costs

Medical Home Outcomes in Arizona, Colorado, Ohio, and Rhode Island*

- 6 to 1 return on investment for care coordination activities
- Improved diabetes management
- 6.2% net savings on third-year medical costs
- Improved patient satisfaction
- Reduced avoidable hospital stays
- Increased care coordination

Medical home models don’t always succeed. A common factor in many successful models is paying for value through measures of quality, outcomes, and appropriate utilization

*UnitedHealthcare Medical Homes
Driving Consistency in Quality and Cost Effective Care

- **Level of Financial Risk**
  - Capitation + PBC
  - Shared Risk
  - Shared Savings
  - Condition or Service-Line Programs
  - Bundles & Episodes Service Line Programs
  - Managing a specific CONDITION or SERVICE LINE
  - Managing entire POPULATION HEALTH

- **Degree of Care Provider Integration and Accountability**
  - Fee-for-Service
  - Performance-based Programs
  - Primary Care Incentives
  - Performance-Based Contracts
  - Achieving specific METRICS
  - Accountable Care Programs

---

- **Achieving specific METRICS**
- **Performance-Based Contracts**
- **Primary Care Incentives**
- **Fee-for-Service**
Components of Value Creation

**Multidisciplinary Team**
- Primary Care Led
- Clinical and Non-clinical Resources

**Clinical Transformation**
- Population Health
- Practice Transformation
- Advanced Data & Analytics
- Care Transitions
- Value-based Compensation

**Connections**
- Medical, Behavioral, Social
- Community-based Resources

Proprietary Information of UnitedHealth Group. Do not distribute or reproduce without express permission of UnitedHealth Group.