More Advanced Practice Competencies Are Required to Achieve Value-Based Care Alignment

Part 3 of a study exploring how PCPs are positioned to deliver against a value-based care mandate

In our 2 prior reports examining our national survey of primary care physicians (PCPs), we segmented the landscape of value-based care PCPs into Leaders, Experimenters, and Abstainers based on their degree of alignment with value-based payment models. We further explored how these 3 cohorts differed across several dimensions, including panel characteristics and clinical decision-making. We found that Leaders were more likely to have larger and more senior patient panels, see greater volumes of patients, and be more willing to grow. Leaders were more likely than their peers to be compensated on performance-based metrics, be more engaged in managing referrals, and make specific health plan and product recommendations that better aligned with their practice goals.

We hypothesize that the foundational infrastructure of the practice itself has a considerable impact on the ability of PCPs to manage in a value-based environment. This infrastructure is complementary and facilitates effective compensation approaches, referral management, and enrollment management decision-making discussed earlier. The infrastructure includes capabilities to support overall financial performance management; risk adjustment activities and processes that enable appropriate coding and therefore optimized risk-based revenues; and a clinical support model that allows PCPs to work at the top of their licenses. Strong capabilities in each of these domains should translate to an ability to manage financial performance against value-based contracts.

Key Takeaways From This Analysis:

01 **The gap in practice capabilities to deliver against value-based care is significant overall and wider between cohorts.** Utilization reporting (+20 percentage point gap), out-of-network care reporting (+25pp gap), and adjacent on-site clinical services (+39pp gap) represent the greatest gaps in capabilities between Leaders and Abstainers.

02 **In general, PCPs believe they capture codes correctly, but leading risk adjustment practices differ between cohorts.** 68% of PCPs across cohorts uniformly believe they capture the right codes. However, 82% of Leaders ensure they see their patients annually, compared to 73% and 74% of Experimenters and Abstainers, respectively.

03 **Advanced practice provider (APP) utilization improves with greater alignment to value-based care.** Leaders utilize APPs the most, with an APP-to-PCP ratio at 1:2, as compared to 1:3 among Abstainers.

04 **PCP workload and satisfaction are affected by degree of value-based care alignment.** Leaders work an average of 48 hours per week—3 hours fewer than Abstainers—and spend only 44% of their time on direct patient care, compared to 49% and 47% for Experimenters and Abstainers, respectively.

05 **PCPs are optimistic about the future of practice capabilities to manage value-based care.** 71% of PCPs believe their capabilities required to deliver on value-based care will improve over the next 5 years.

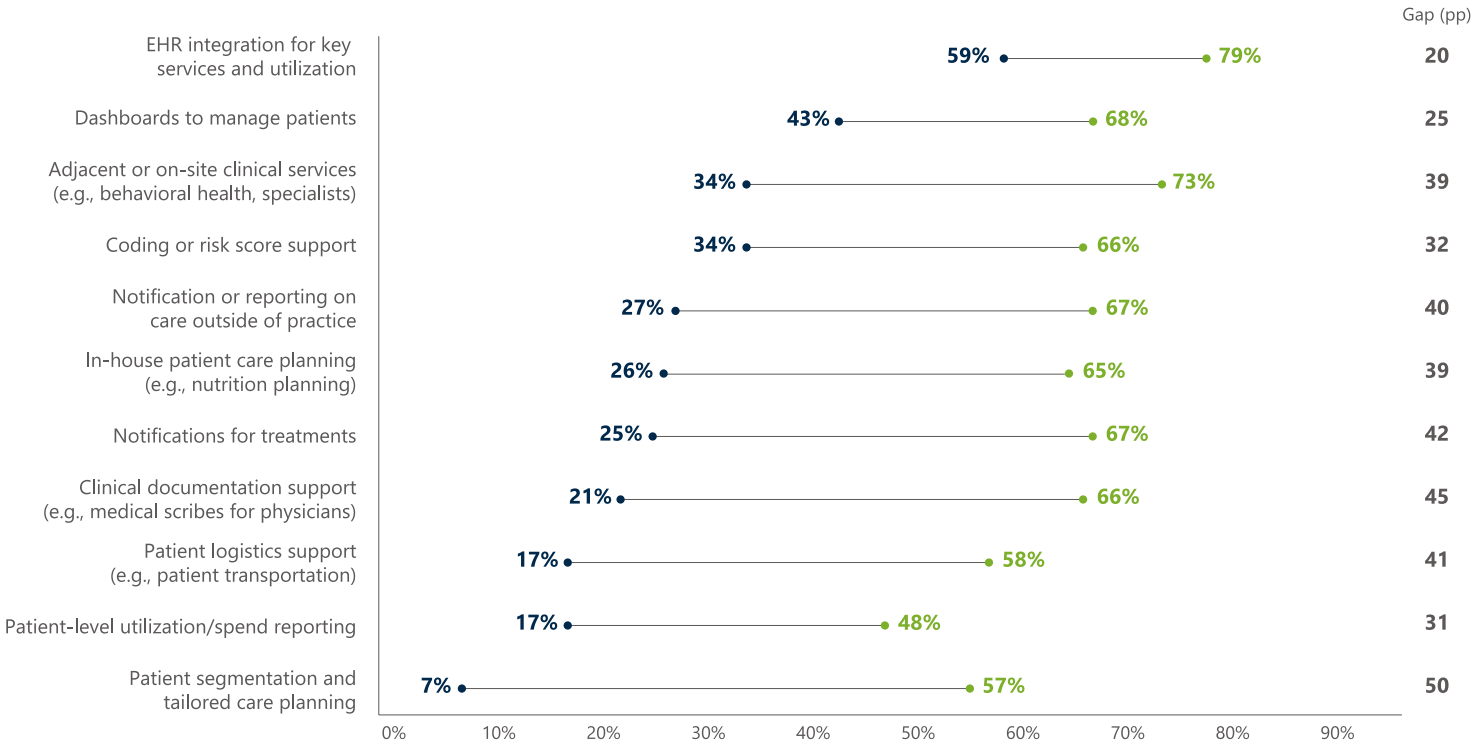
01 KEY TAKEAWAY

The Gap in Practice Capabilities to Deliver Against Value-Based Care Is Significant Overall and Wider Between Cohorts

We wanted to understand the prevalence of critical practice capabilities that enable value-based care performance. The chart below shows such prevalence of select capabilities among PCPs surveyed. This analysis compares the percent of PCPs who believed these capabilities were important to managing value-based care to those who were actually offered the capabilities within their practice.

Comparing Differences in Capabilities to Manage Spend

Offered Today vs. Perceived Importance

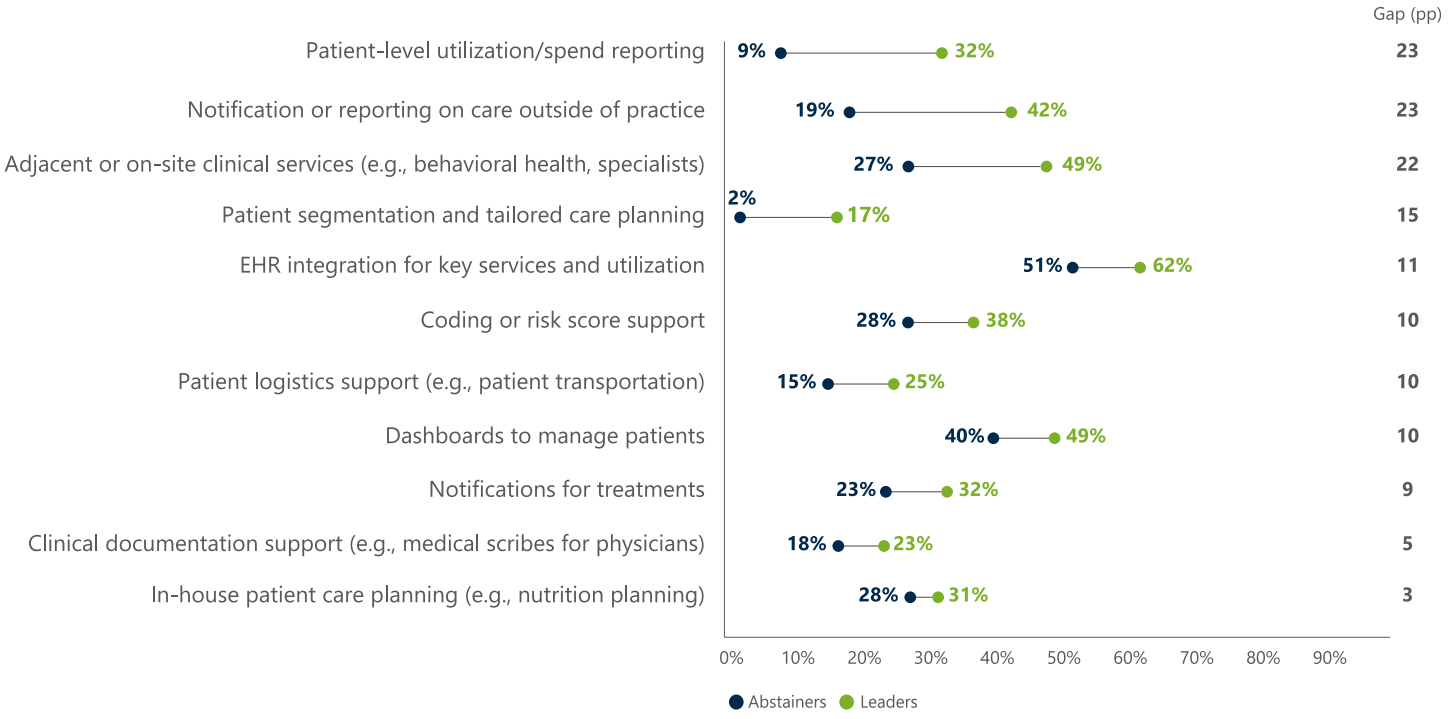


The most prevalent capability, understandably, is electronic health record (EHR) integration, which PCPs agree is also the most important in managing value-based care. The gap between currently offered and important for EHR integration is notably the smallest compared to other capabilities. Patient segmentation, clinical documentation support, and treatment notifications rank among the largest capability gaps in the market today. While the reasons for differences are likely to be multifactorial, the overall trend is clear: PCPs continue to perceive a significant lack of infrastructure across the board to manage against value-based care.

The analysis above may be the wish-list assessment of what a practice should have, but the analysis below compares differences in capabilities that exist in practice today between Leaders and Abstainers.

Comparing Differences in Capabilities to Manage Spend

Offered Today Comparing Abstainers vs. Leaders

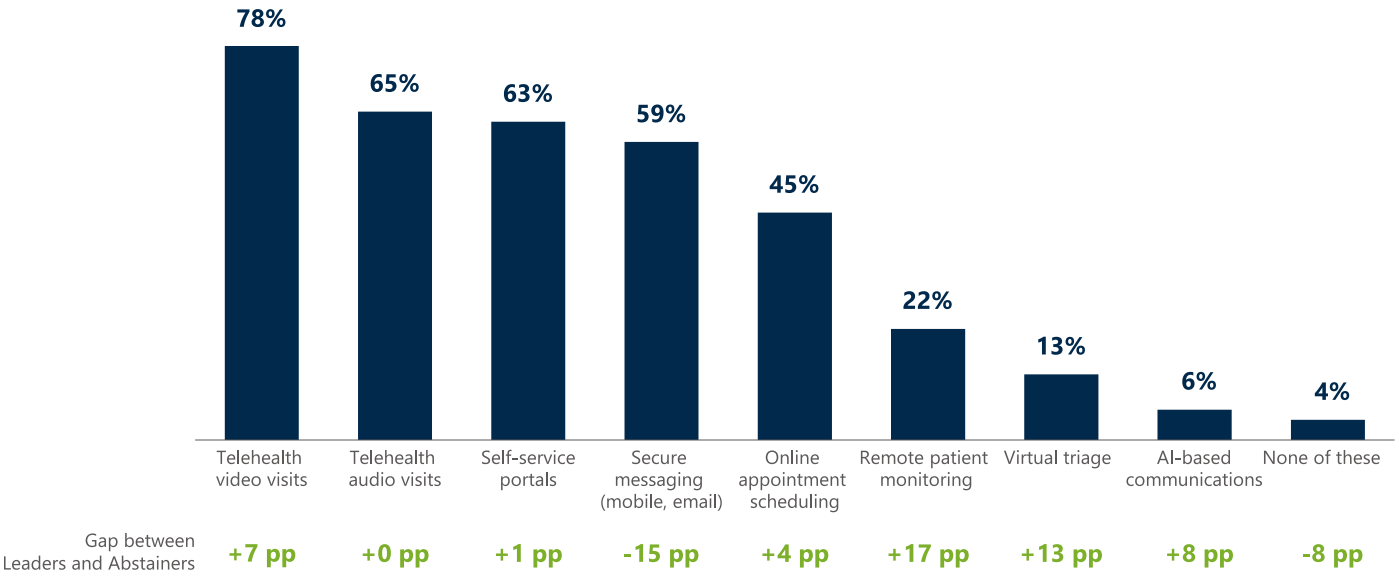


Across the board, Leaders have a higher prevalence of capabilities that support managing risk in value-based care arrangements. However, the size of the gap between Leaders and Abstainers differs significantly, with a greater gap for capabilities that drive financial performance. Utilization reporting (+23 percentage point gap), out-of-network care reporting (+23pp gap), and adjacent on-site clinical services (+22pp gap) have the greatest gaps. By comparison, activities such as clinical documentation support and patient care planning appear to be table stakes across the 2 cohorts.

These 2 analyses together can act as blueprints for practices seeking to build out the competencies required for managing to value.

In addition to the infrastructure noted above, we captured how technologies allow PCPs to stay connected to their patients when not in the office. Nearly all PCPs (96%) employed at least one of these patient-friendly technologies, a testament to how far the industry has come in serving patients as consumers. Among them, telehealth was highly prevalent, with nearly 4 in 5 PCPs offering video telehealth.

Percent of PCPs Using Each of the Following Patient Technologies



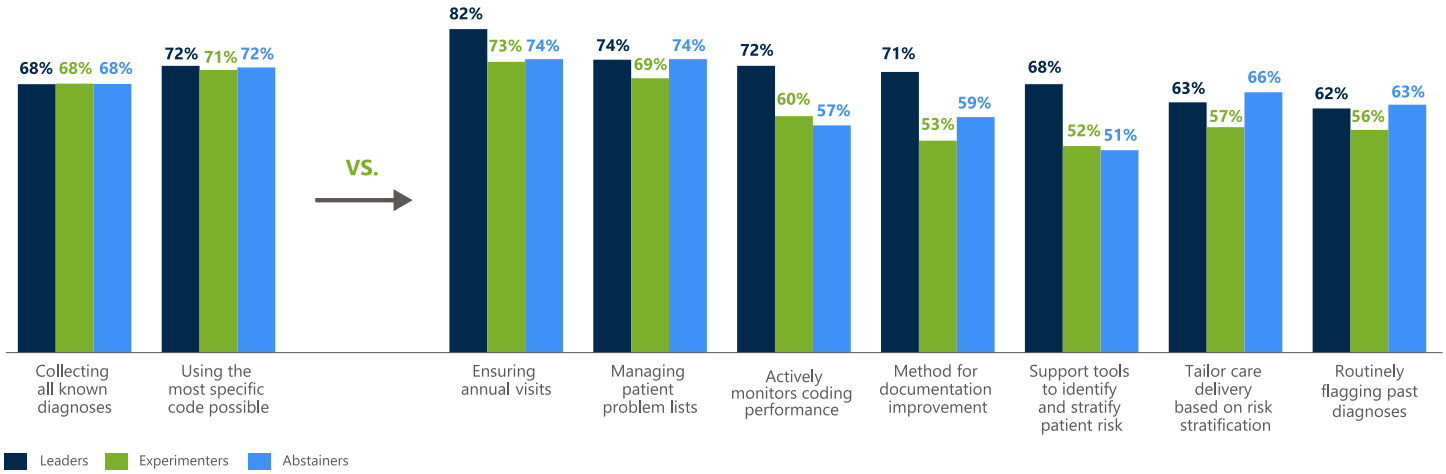
When compared by cohort, the practices generally employed these services at similar rates, with some minor variations. Leaders were 2.3 times and 3.5 times more likely to provide remote patient monitoring and virtual symptom triage services, respectively, as compared to their Abstainer peers. This may reflect a willingness of Leaders to push the boundaries of novel technologies that further enable them to stay ahead of patient clinical needs.

02 KEY TAKEAWAY

In General, PCPs Believe They Capture Codes Correctly, But Leading Risk Adjustment Practices Differ Between Cohorts

Risk adjustment, the practice of accurately capturing a patient's health conditions to ensure commensurate reimbursement, is a critical success driver for value-based PCPs. Ensuring coding accuracy requires a mosaic of active patient management activities. The graph below shows the prevalence of key risk-adjustment activities between PCP cohorts.

Comparing Risk Adjustment Activities (% Somewhat or Strongly Agree)



While PCPs in all 3 cohorts uniformly believe they collect all known diagnoses and use the most appropriate codes possible, the differences in their activities around risk adjustment reflect likely differences in their true performance against this important metric. Leaders are more likely to: see their patients annually (+8pp vs. Abstainers), have established methodologies for documentation (+12pp), actively monitor coding performance (+15pp), and leverage support tools for risk identification and stratification (+17pp).

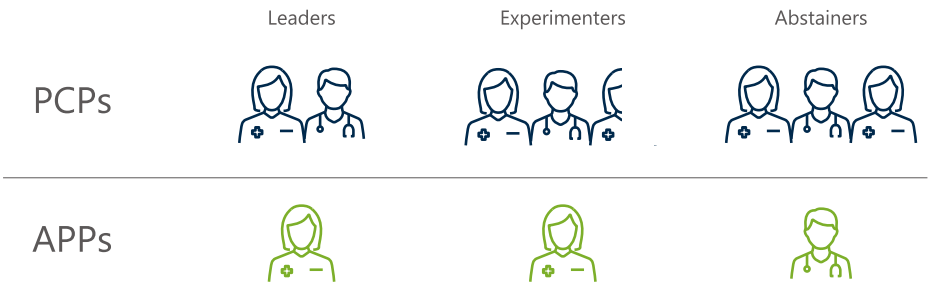
03 KEY TAKEAWAY

APP Utilization Improves with Greater Alignment to Value-Based Care

APPs, which include nurse practitioners (NPs) and physician assistants (PAs), enable PCPs to see a higher volume of patients and focus their time on patients who require a higher level of care. Accordingly, APPs are an important resource for practices seeking to manage to value-based contract models.

We find that the APP:PCP ratio improves noticeably as value alignment increases. Leader staffing ratios are 1:2 APPs-per-physician, as compared to 1:2.5 and 1:3 for Experimenters and Abstainers, respectively. This ratio allows the practice to treat more patients and its PCPs to practice at the top of their licenses.

Comparing APP:PCP Ratios



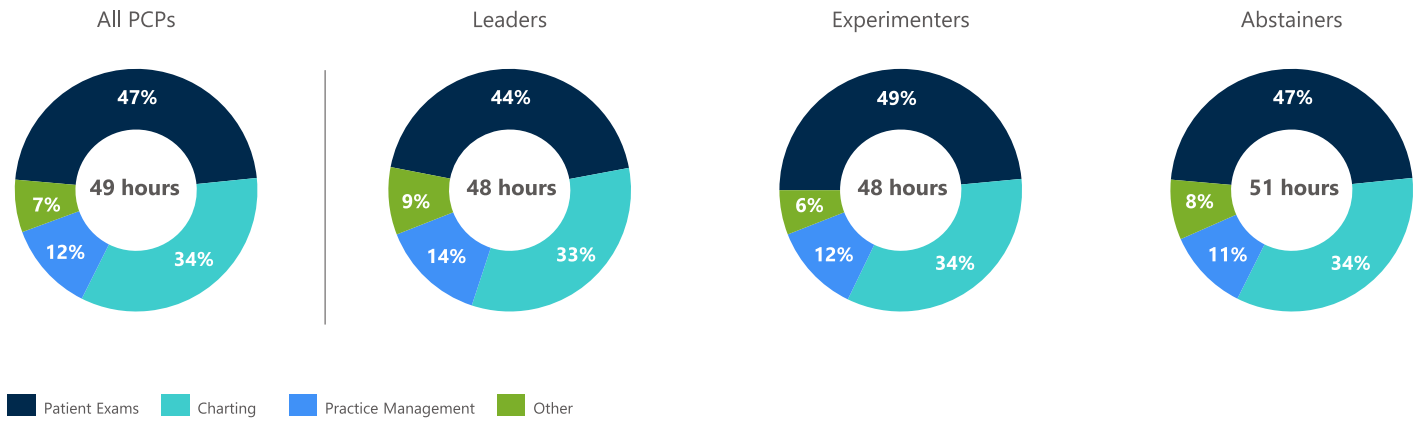
04 KEY TAKEAWAY

PCP Workload and Satisfaction Are Affected by Degree of Value-Based Care Alignment

We just explored the many resources practices employ to improve PCPs' ability to manage value-based care. We hypothesize that greater infrastructure present at value-aligned practices should translate to a reduced workload and improved job satisfaction.

Broadly, PCPs spend just shy of half of their 49-hour work week in direct patient care and approximately one-third of their time charting. The remaining time is related to practice management and other activities, such as rounding.

PCP Time Allocation

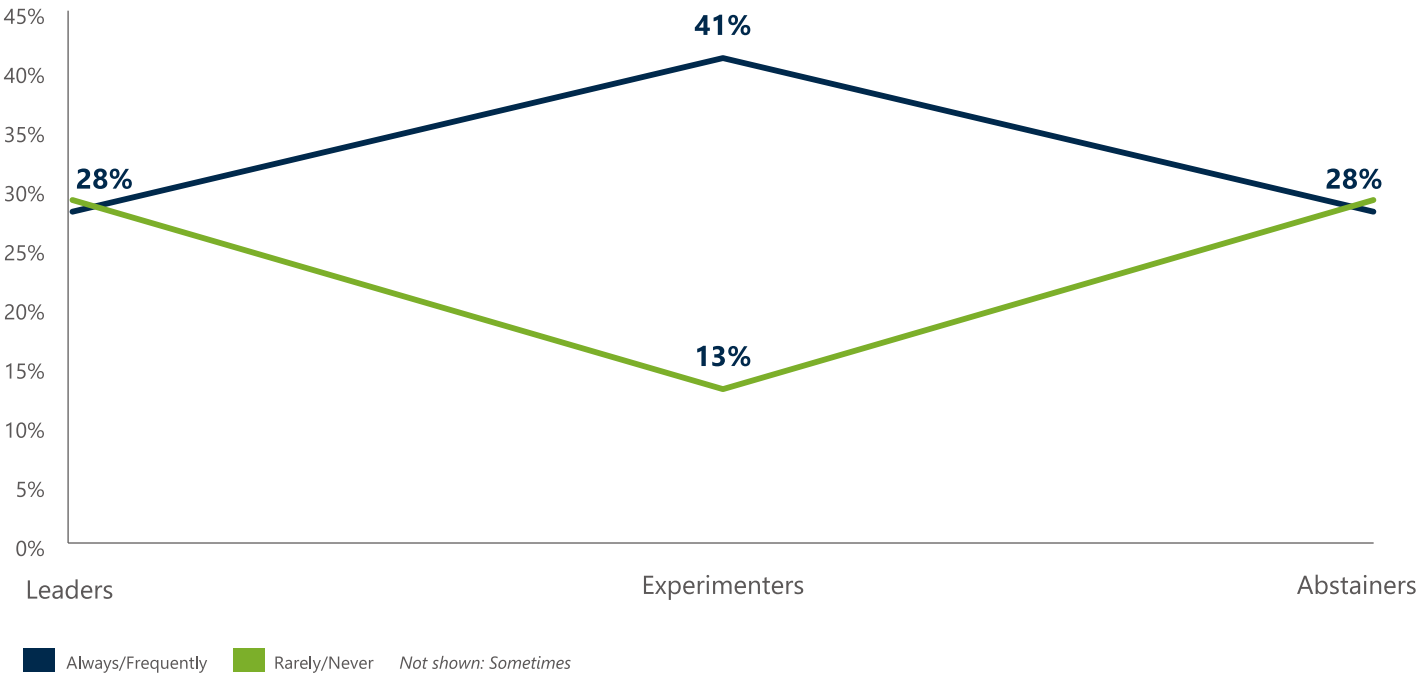


Leaders spend less time seeing patients and more time on practice management and other tasks than Experimenters and Abstainers. Said differently, as value-based care alignment rises, so does a PCP's focus on managing administrative tasks related to the practice. Also, notably, Leaders work on average 3 fewer hours per week than Abstainers. This is consistent with a common narrative around how value-aligned physicians are able to work fewer hours under their risk contracts as they are not incentivized to see patients and instead are incentivized to manage to outcomes. However, it is counterintuitive, given our earlier findings that these same PCPs have larger panels and see more patients per day.

In our first report, we shared that Leaders have the largest and oldest patient panels and see the most patients per day. By contrast, here we see that those same PCPs work the fewest hours among cohorts and allocate a lower share of their time to direct patient care as compared to their peers. These findings are seemingly contradictory as older and larger panels and seeing more patients each day may create a greater workload. However, the results speak to the nature of the practice's capabilities and support team model that enable physicians to both manage a larger and more complex patient load and work fewer hours simultaneously.

Finally, there is an interesting difference between these physician cohorts and their level of burnout. Leaders are similar to Abstainers (28%) in their level of burnout. By contrast, 41% (+13pp) of Experimenters always or frequently experience burnout.

How Often PCPs Experienced Burnout



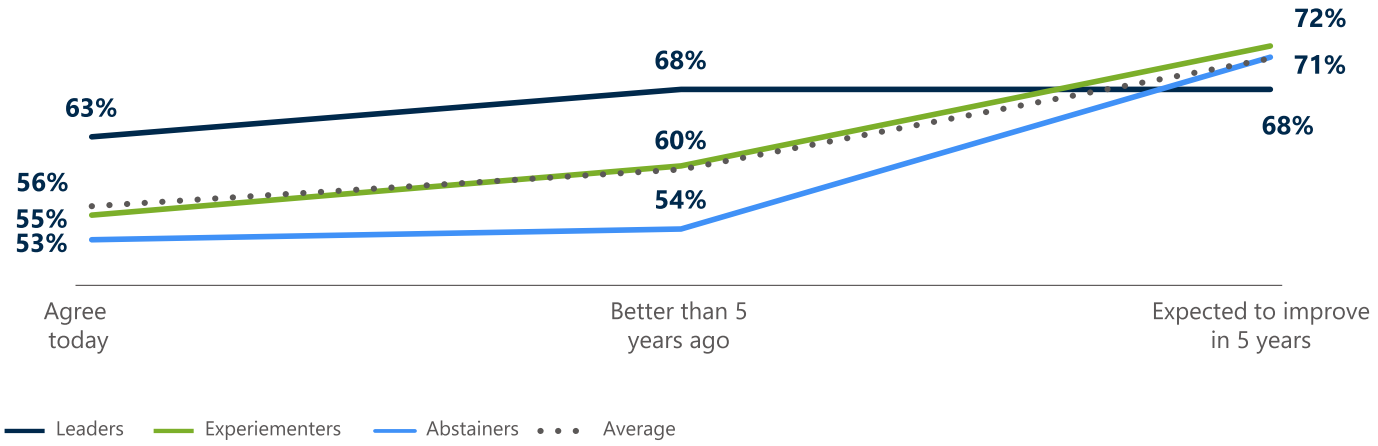
We hypothesize that this dichotomy could be explained by Experimenters being in an unfortunate middle ground, where they have made a commitment to managing value-based care contracts but have not invested in the required infrastructure that will improve their experience doing so. This commitment and lack of enabling infrastructure could create a compounding effect on their workload and reduce their job satisfaction.

05 KEY TAKEAWAY

PCPs Are Optimistic About the Future of Practice Capabilities to Manage Value-Based Care

More than half of PCPs believe they have the capabilities to deliver on value-based care today, and 71% anticipate these capabilities to further improve over the next 5 years. Of note, Abstainers are much more optimistic about the future. This cohort believes that capabilities improvement will accelerate, with 71% believing it will improve over the next 5 years, despite only 54% believing their capabilities today are better than they were 5 years ago.

Practice Has Capabilities to Deliver on Value-Based Care (% Somewhat or Strongly Agree)



Implications and Opportunities

This analysis points to a compelling theme: PCPs who are more aligned to value-based care have more sophisticated practice infrastructure to support them. There is a clear distinction between cohorts when it comes to practice capabilities, risk adjustment maturity, and APP utilization. These capabilities are table stakes when it comes time to participating in value-based care. Concurrently, PCP workload, time allocation, and satisfaction are affected by the level of alignment to value-based care, with Experimenters having higher levels of burnout than Leaders and Abstainers.

Practices looking to participate in value-based care must do so meaningfully and with intention, or they risk the professional satisfaction of their PCPs as a result. Commensurate with a commitment to value-based care is the mandate to invest in the capabilities required to deliver on it. Practices can make these investments to support their PCPs in managing their panels to perform successfully against value-based care contracts.

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SOURCES

1. Public filings as of 2022

About the Survey Data

SOURCE

We partnered with our survey administration firm ROI Rocket to field this survey in August 2022 with a target n=300 (n=307 achieved). We surveyed a representative sample of self-identified primary care physicians throughout the United States. Individuals captured in these data must have been a primary care physician who actively practices medicine and whose patient panel is at least 10% seniors. Those not meeting these criteria were not included in the results.

QUALIFICATIONS

Respondents to this survey must have met the following qualifications to be included in the n=307 sample used for our analysis:

QUESTIONS	ACCEPTABLE RESPONSES
What best describes your profession?	• Physician
What is your primary specialty as a physician?	• Primary Care • Family Medicine • Internal Medicine • Geriatric Care
Do you actively practice medicine today?	• Yes
In your estimation, what % of your patient panel is 65 years of age or older?	• 10-25% • 26%-50% • 51-75% • 76-90% • Over 90%

RESPONDENT PROFILE

	TOTAL	LEADERS	EXPERIMENTERS	ABSTAINERS
Total Responses	**307**	**65**	**146**	**96**
Reported Physician Specialty (Question: What is your primary specialty as a physician?)				
Family Medicine	59%	58%	60%	59%
Geriatric Care	2%	2%	2%	1%
Internal Medicine	18%	17%	15%	23%
Primary Care	21%	23%	23%	17%
Years Practicing (Question: How many years have you been practicing in your current specialty?)				
1-5	23%	12%	21%	33%
6-10	16%	17%	18%	11%
11-20	27%	26%	32%	20%
21-30	25%	34%	24%	20%
>30	10%	11%	5%	16%
Geographic Distribution (Question: In what state do you practice?)				
Midwest	26%	31%	25%	23%
Northeast	18%	15%	20%	18%
South	35%	28%	36%	38%
West	21%	26%	19%	22%
Employment Model (Question: What is the best way to describe your physician practice?)				
Employed by a single hospital or a multi-hospital health system	48%	32%	57%	46%
Independent physician practice not employed by a hospital or health system	50%	68%	42%	52%
I don't know	1%	0%	1%	2%
Payer Mix (Question: In your estimation, what is the health insurance mix of your practice?)				
Commercial	41%	39%	44%	36%
Medicaid (including Managed Medicaid)	16%	17%	15%	16%
Medicare (including Medicare Advantage)	33%	37%	32%	32%
Self-Pay, Uninsured, or Other	11%	6%	9%	16%

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