



The State of the Independent Practice in 2026

What Independent Practices Reveal About Financial Pressure, Administrative Burden, and the Path Forward

WHITEPAPER

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Independent physician practices remain firmly committed to independence. That commitment continues to shape how physicians and practice leaders define control over clinical decision-making, patient relationships, and long-term strategy.

What has changed is the level of effort required to sustain that independence.

New research from Veradigm, based on a national survey of 360 leaders from independent ambulatory practices, highlights a widening gap between confidence and operational reality. While 69% of respondents say they are extremely or very confident their practice will remain independent over the next three to five years, nearly all are operating under increased financial, administrative, and operational pressure.

Acquisition pressure is widespread. 94% of practices report being approached about acquisition or consolidation in the past two years, and more than one-third said those approaches occurred 4 or more times. Engagement with these opportunities is not uncommon. 62% of practices report participating in some level of discussion, and 26% advanced to serious negotiations before ultimately choosing to remain independent. Independence remains the goal, but it is increasingly being evaluated rather than assumed.

The most significant threats to independence are not clinical; they are operational and financial. Increased operating costs, administrative and regulatory burden, and reimbursement pressure rank as the most significant threats to long-term independence. These pressures are not evenly distributed across the market. Practices with more than 40 clinicians report the highest levels of financial strain, with 82% experiencing increased financial pressure and 60% describing that increase as significant. Smaller practices report lower levels of financial escalation but significantly higher administrative burden with fewer internal resources to absorb it.

Revenue cycle complexity is one of the clearest drivers of that instability. Nearly half of practices report rising claim denial volumes, and fewer than half describe their revenue or cash flow as highly predictable. More critically, only 24% of respondents report high or complete visibility into sources of revenue leakage. For many practices, issues are only detected after financial impact has already occurred. This creates a reactive operating model that reduces predictability and limits control.

Administrative burden has become systemic. More than half of respondents rated administrative workload as very or extremely challenging, and 65% of clinicians reported spending at least one hour per day completing documentation outside of patient visits. One quarter report two or more hours daily. Workforce strain compounds this challenge. Every staffing category in the survey was selected by at least 31% of respondents as difficult to recruit or retain, indicating a broad-based capacity constraint rather than isolated shortages.

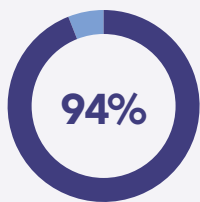
The data also highlights two important shifts in how practices are thinking about engagement and technology.

First, patient engagement is increasingly constrained by financial barriers. 57% of respondents identify cost of care as the primary barrier to patient engagement, significantly higher than time constraints, overwhelm, or difficulty understanding information. This reframes engagement as a financial strategy issue rather than a communication challenge.

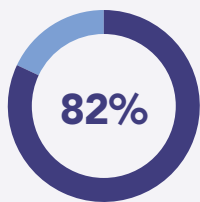
Second, technology is no longer viewed as optional. 79% of respondents say technology will be extremely or very important to long term financial and operational stability, and 57% believe automation and AI enabled workflows could significantly improve practice efficiency. Adoption is being driven less by innovation alone and more by the need to sustain operations under increasing pressure.

Independent practices are not struggling due to lack of demand or commitment. They are operating in a more complex environment with less margin for error.

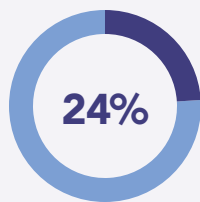
Practices that successfully maintain independence will not be those that attempt to preserve existing workflows. They will be those that improve financial visibility earlier, reduce manual processes, strengthen operational discipline, and adapt how they manage both clinical and administrative work.



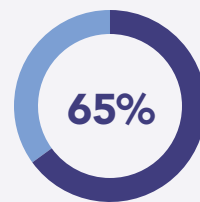
of practices report being approached about acquisition or consolidation in the past two years, and more than one-third said those approaches occurred 4 or more times



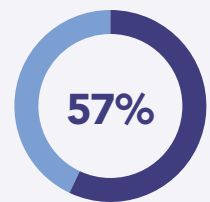
of practices with more than 40 clinicians report experiencing increased financial pressure



of respondents report high or complete visibility into sources of revenue leakage



of clinicians reported spending at least one hour per day completing documentation outside of patient visits



of respondents identify cost of care as the primary barrier to patient engagement, significantly higher than time constraints, overwhelm, or difficulty understanding information

STUDY OVERVIEW

This whitepaper is based on a double blinded online survey of 360 leaders from independent ambulatory practices across the United States. Respondents included 210 physicians or clinical leaders and 150 practice managers or administrative leaders.

All respondents were screened to confirm that their practices were independent and not part of a hospital system, health system, or integrated delivery network (IDN). The survey was fielded in March 2026 and focused on practice independence, financial performance, operational challenges, administrative burden, workforce constraints, data exchange, patient engagement, and technology adoption.

The respondent base was distributed across all major U.S. regions, with representation from the South, West, Midwest, and Northeast, with the South accounting for the largest share. The respondent base reflects a broad distribution of practice sizes, with solo practices representing 18% of respondents, practices with 2 to 10 clinicians making up 29%, practices with 11 to 40 clinicians making up 40%, and practices with more than 40 clinicians making up 13%.

This mix is important because independent practices are not a single, uniform market. A solo physician owner, a five-provider primary care group, and a 50-clinician independent specialty organization are all trying to preserve independence under different operating conditions. The analysis in this paper, therefore, goes beyond aggregate findings to highlight how challenges and priorities vary by practice size and role.

The goal is not only to describe what independent practices are experiencing, but to interpret what those findings mean in practice, and where leaders may need to adapt.

INTRODUCTION

Independent physician practices are operating in a healthcare environment defined by sustained, multidimensional pressure. Financial constraints, administrative complexity, regulatory expansion, workforce instability, payer friction, and competitive consolidation are converging, reshaping what it takes to remain independent.

None of these forces are new on their own. What has changed is their cumulative effect. Together, they are reducing the margin for errors and increasing the operational discipline required to remain independent.

Practices are managing rising labor and technology costs alongside expanding documentation, reporting, and compliance requirements. Payer expectations continue to evolve. Revenue cycle complexity remains high, and reimbursement continues to shift across fee-for-service and value-based models. Data exchange is still fragmented, requiring manual effort to reconcile information across systems. At the same time, patient expectations for access, responsiveness, and transparency continue to grow.

Overlaying all of this is a steady increase in acquisition pressure. Independent practices are being approached repeatedly by hospitals, health systems, and investor-backed organizations. Even practices that have no intention of selling are being forced to evaluate what independence will require going forward.

In this context, independence is no longer a passive state. It is an operating model that must be actively sustained.

The pressure does not present the same way for every practice. Solo and small practices often feel administrative burden and time constraints most acutely. Larger independent groups are more likely to report severe financial pressure, rising denials, and infrastructure complexity. Physicians experience documentation and workflow disruption directly, while administrative leaders see the broader operational impact across staffing, systems, and financial performance.

These differences matter. They help explain why “independent practice” remains a shared identity, even as the practical challenges of sustaining it vary widely.

This research examines how those pressures are showing up across the areas that increasingly define independent practice performance: independence and acquisition pressure; revenue cycle and financial performance; workforce and administrative burden; interoperability and regulatory readiness; patient engagement; and technology and AI readiness. Across each of these areas, one theme remains consistent. Sustaining independence increasingly depends on improving visibility, reducing manual work, strengthening operational execution, and adapting to a more complex operating environment.

SECTION 1: INDEPENDENCE AND ACQUISITION

Confidence in independence remains strong, but is increasingly tested

Independent physician practices continue to express strong confidence in their ability to remain independent. 69% of respondents report being extremely or very confident that their practice will remain independent over the next three to five years.

That level of confidence reflects more than optimism. It reflects how practices define the value of independence itself. For many respondents, independence extends beyond ownership. It includes the ability to control clinical workflows, staffing decisions, scheduling priorities, patient engagement strategies, and local operating strategy. It also reflects a belief that care quality and patient relationships are strengthened when decisions are made close to the community being served.

At the same time, that confidence exists alongside intense external pressure.

Only 6% of respondents said their practice had not been approached about acquisition or consolidation in the past two years. For the remaining majority, outreach has become routine.

Acquisition outreach is now widespread

94% of practices report being approached about acquisition or consolidation within the past two years, and more than a third report being approached four or more times.

This level of outreach is not incidental. It reflects a broader market shift in which independent practices are being actively targeted by larger organizations seeking growth, scale, and market access.

Importantly, practices are not simply dismissing these approaches. 62% report engaging in some level of discussion, and 26% advanced to serious negotiations before ultimately deciding to remain independent.

This pattern reflects a broader market shift. Independence is no longer assumed as a default outcome. It is being actively evaluated against the operational and financial realities of the current environment.

Repeated outreach also changes how leaders think about risk. Even practices that are firmly committed to independence are being exposed to alternative operating models and are being asked to assess their own vulnerabilities more directly.

The strongest threats to independence are financial and operational

When respondents were asked about the biggest threats to long-term independence, the top answers were not clinical. The top-ranked threats include increased operating costs at 46%, followed by administrative and regulatory burden at 39% and reimbursement pressure at 38%.

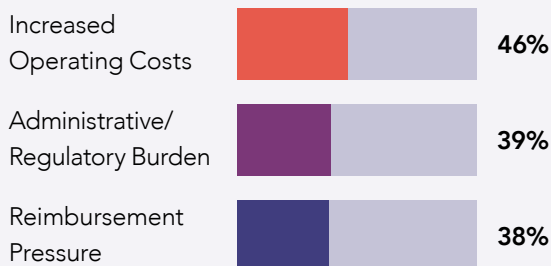
These findings are important because they clarify what is not driving concern. Practices are not citing declining patient demand or clinical limitations. They are pointing to the growing complexity of running the business side of the practice.

Role-based differences provide additional context. Physicians emphasize reimbursement pressure and operating costs, reflecting concern about sustaining clinical revenue.

Practice managers and administrative leaders point to rising technology and infrastructure costs, as well as the difficulty of sustaining operational support at current levels.

These perspectives are complementary. Together, they illustrate a system in which both clinical and operational leaders are experiencing strain from different angles.

TOP-RANKED THREATS TO LONG-TERM INDEPENDENCE



Variation by practice size

The survey findings suggest that acquisition is rarely viewed as a preferred outcome. Instead, it is often considered a response to increasing strain.

That question presents differently depending on practice size:

- Solo and small practices often experience sustainability challenges as a function of time and administrative burden. When documentation, compliance, and operational tasks consume a growing share of the day, independence can begin to feel unsustainable.
- Mid-sized practices face a different challenge. Growth introduces new complexity in staffing, coordination, and systems, but infrastructure does not always scale at the same pace.
- Large independent practices are more likely to experience sustainability challenges through financial volatility, denial pressure, and increasing infrastructure demands. Scale introduces additional complexity across payer relationships, staffing, and operational consistency.

In all cases, acquisition pressure interacts with existing operational strain. Practices are not being pulled toward consolidation solely by external interest. They are being pushed to evaluate it by the increasing difficulty of sustaining their current model.

Operational implications for independent practices

Independence remains a viable and widely preferred model. However, it is becoming more conditional.

Practices that intend to remain independent will need to operate with greater financial discipline, stronger operational control, and better visibility into performance than in the past. Confidence alone is no longer sufficient. Sustainability depends on execution.

SECTION 2: REVENUE CYCLE AND FINANCIAL OPTIMIZATION

Financial pressure is rising, and scale is increasing exposure, not reducing it

Revenue cycle performance has become one of the most important determinants of whether an independent practice can sustain itself over time. 54% of respondents report increased financial pressure over the past 12 months, and 48% report rising claim denial volumes.

At a high level, these figures indicate broad-based strain across the independent practice landscape. A closer examination, however, suggests that the intensity and nature of that strain vary meaningfully by practice size.

Practices with more than 40 clinicians report the highest levels of financial pressure. 82% reported increased financial pressure, and 60% said that the increase was significant. While larger organizations benefit from scale in areas such as contracting leverage and operational resources, the data suggests that scale may also introduce additional complexity. A broader mix of payer relationships, increased staffing requirements, and more complex workflows may increase the likelihood of variability in revenue cycle performance.

Smaller practices report a different pattern. Solo and small group practices are less likely to report sharp increases in financial pressure, but they often operate with more limited internal resources. As a result, even modest disruptions—such as delays in reimbursement or staffing gaps—may have a more immediate operational impact. Across practice types, one outcome remains consistent. Financial predictability appears to be limited. Fewer than half of practices describe their monthly revenue or cash flow as highly predictable. This lack of predictability may affect a range of decisions, including staffing, technology investment, and growth planning. Even when revenue stabilizes over time, variability may introduce additional management complexity.

HOW LIMITED REVENUE VISIBILITY LEADS TO DELAYED ISSUE DETECTION AND FINANCIAL INSTABILITY

54%

of respondents report increased financial pressure over the past 12 months

48% report rising claim denial volumes

24% of respondents report high or complete visibility into sources of revenue leakage, including denials, underpayments, and delayed collections

29% said their visibility was limited or nonexistent, while the remainder operate with partial visibility

Visibility into revenue cycle performance remains limited

Limited visibility into revenue cycle performance is a contributing factor to ongoing financial strain.

Only 24% of respondents report high or complete visibility into sources of revenue leakage, including denials, underpayments, and delayed collections. 29% said their visibility was limited or nonexistent, while the remainder operate with partial visibility.

The timing of issue detection reinforces this gap.

In many cases, this level of visibility may be sufficient to identify that issues exist, but not to understand their full scope or detect them early. Timing appears to be a key challenge. A relatively small proportion of respondents report identifying revenue cycle issues in real time. For most, without timely insight, practices identify issues only after financial impact has occurred. Resolution timelines further extend this process. Many practices report that resolving revenue cycle issues requires additional time after identification, often spanning several days to multiple weeks.

These patterns reveal a lagging operational model, in which issue detection and resolution occur after the financial impact has already occurred. This may limit practices' ability to intervene proactively and contribute to ongoing variability in financial performance.

This dynamic reflects not only performance challenges but also structural limitations in how revenue cycle operations are monitored and managed. Practices may not always have access to the level of real-time or near-real-time insight required to identify emerging issues, understand root causes, and respond in a timely manner.

Denials are broadly distributed across the revenue cycle

The survey also provides insight into the nature of claim denials and the extent to which they are concentrated within specific areas of the revenue cycle.

Additional contributors, including coordination of benefits, medical necessity denials, and timely filing issues, remain significant.

Seven of nine denial categories cluster within a narrow range of 25% to 39%. This distribution suggests that denial risk is not concentrated in a single workflow area. Instead, it appears to span multiple stages of the revenue cycle, including front-end intake, documentation, coding, and payer adjudication.

This pattern has implications for how denial reduction efforts are approached. Improvements in one area may not fully address denial volume if other parts of the workflow remain exposed. A more coordinated approach, spanning multiple stages of the revenue cycle, may be required to achieve sustained improvement.

ACROSS RESPONDENTS, DENIAL DRIVERS ARE RELATIVELY EVENLY DISTRIBUTED:

- 39%** Eligibility or coverage issues
- 38%** Coding errors or mismatches
- 34%** Missing or incomplete claim information
- 34%** Prior authorization issues
- 34%** Payer policy changes
- 33%** Documentation gaps

Perspectives on denial drivers vary by role and practice type

Perceptions of denial drivers differ based on role within the organization.

Physicians and clinical leaders are more likely to emphasize prior authorization requirements and documentation-related denials. These areas are closely tied to clinical workflows and the need to demonstrate medical necessity.

Practice managers and administrative leaders more frequently identify coding errors, eligibility issues, and payer policy changes as primary drivers. These areas are more closely aligned with operational processes and front- and back-end workflow execution.

Variation is also observed across practice sizes.

- Larger practices report greater exposure to payer policy changes, which may reflect the complexity of managing multiple payer contracts and reimbursement models
- Smaller practices more frequently encounter front-end challenges, such as eligibility verification and coordination of benefits, where manual processes and limited staffing may increase risk

These differences highlight the importance of aligning clinical and administrative perspectives when evaluating revenue cycle performance. Challenges that appear distinct from one vantage point may be interconnected across the full workflow.

Revenue cycle operating models reflect increasing complexity

The survey also highlights how practices are managing revenue cycle operations. 29% operate primarily in-house, 58% use a hybrid model, and 13% rely primarily on outsourced services.

The prevalence of hybrid models reflects the need to balance internal control with access to specialized expertise and additional capacity. Overall, revenue cycle performance is no longer purely a back office function. It is a primary driver of financial stability, staffing flexibility, investment capacity, and confidence in long term independence. With the hybrid approach, aligning processes, maintaining visibility across functions, and ensuring consistent performance may become more challenging when responsibilities are distributed across internal and external teams.

Confidence in revenue cycle performance remains moderate

Despite the central role of the revenue cycle in financial performance, confidence levels appear to be moderate rather than strong.

58% of respondents report high confidence in their ability to effectively manage and reduce claim denials. Confidence in financial stability over the next one to two years is similar.

A substantial portion of practices operate without a high degree of confidence in one of their most critical operational functions. This may influence decision-making related to staffing, investment, and long-term planning.

Implications by practice size

- **Solo and small practices:** Financial risk may be more immediate due to limited staffing and reliance on manual processes, particularly in front-end workflows
- **Mid-sized practices (2-40 clinicians):** Increasing scale introduces additional workflow complexity, which may outpace process standardization and infrastructure
- **Large practices (40+ clinicians):** Greater exposure to payer variability and operational complexity may contribute to higher levels of financial pressure and denial volume

Operational implications for independent practices

Revenue cycle performance is not only a financial function, but a core operational capability.

Limited visibility, distributed denial drivers, and variation in workflow execution may contribute to ongoing variability in financial outcomes. Practices that rely on delayed detection and reactive resolution may face increasing challenges as payer requirements evolve and operational complexity grows.

Strengthening revenue cycle performance may therefore require a combination of improved visibility, more consistent process execution, and closer alignment across clinical and administrative functions.

SECTION 3: INTEROPERABILITY, DATA EXCHANGE, AND REGULATORY READINESS

Fragmented data continues to affect both clinical and operational performance

As care delivery becomes increasingly distributed across settings, independent physician practices face growing challenges to coordinate with a broader range of external entities, including hospitals, specialists, laboratories, and payers. In this environment, timely access to complete and accurate data is essential.

This access remains inconsistent. Half of respondents say they often or always encounter fragmented or incomplete patient information when coordinating care.

This fragmentation creates real operational consequences. From a clinical perspective, incomplete information may affect decision-making, particularly when relevant history, test results, or prior treatments are not readily available. From an operational perspective, fragmentation increases the amount of manual work required to reconcile records, request missing information, and ensure continuity across encounters. The impact is not confined to clinical coordination. Fragmented data disrupts clinical workflows and complicates billing, reporting, and compliance activities. When fragmentation occurs frequently, it may affect the overall efficiency of care delivery and increase the likelihood of delays or rework.

44%

OF RESPONDENTS IDENTIFY MANUAL WORK AND MULTIPLE PROCESS STEPS AS THE TOP CHALLENGE AFFECTING INTEROPERABILITY

Manual processes remain the dominant method for bridging data gaps

Despite ongoing investment in health IT systems, many practices continue to rely on manual processes to manage data exchange. 44% of respondents identify manual work and multiple process steps as the top challenge affecting interoperability. This suggests that, in practice, system connectivity does not always translate into seamless data flow.

Practices often rely on a combination of methods to bridge these gaps, including manual data entry across systems, fax- or document-based information exchange, and direct outreach to external organizations to obtain missing records. While these approaches may support continuity in the short term, they introduce additional workload and increase the potential for inconsistency or error.

Manual processes may also affect the timeliness of information. Delays in obtaining or reconciling data can extend the time required for care coordination, billing, and reporting activities.

Interoperability challenges extend into administrative and financial workflows

Although interoperability is often discussed in the context of clinical data exchange, the survey findings suggest that its impact extends into administrative and financial workflows.

Incomplete or delayed data may affect claim submission accuracy, documentation completeness, and reporting requirements for quality and compliance programs. These effects reinforce the connection between data exchange and revenue cycle performance. When data is fragmented or delayed, downstream processes may be affected, increasing the likelihood of rework or denial.

This relationship highlights the extent to which interoperability challenges are embedded within broader operational systems rather than confined to clinical workflows alone.

Interoperability challenges are compounded by the growing weight of data exchange

Regulatory and reporting requirements are increasing the burden

Interoperability challenges are compounded by the growing weight of data exchange and reporting requirements.

More than half of respondents report moderate to extreme difficulty meeting data exchange and reporting obligations. These requirements often require additional documentation, audits, and performance reporting across multiple programs and payers, increasing compliance complexity. For independent practices with limited staffing and resources, compliance activities can consume a disproportionate share of time and resources. In some cases, the effort required to meet reporting requirements may compete directly with other operational priorities.

As regulatory expectations continue to evolve, the ability to access, integrate, and report on data efficiently may become an increasingly important determinant of operational performance.

VARIATION BY PRACTICE SIZE

The impact of interoperability challenges varies by practice size.

Solo practices often experience data fragmentation as a time constraint. Limited staff capacity means that manual reconciliation and follow-up activities fall directly on clinicians or a small number of administrative staff.

Mid-sized practices (2-40 clinicians) may experience increased complexity as patient volume and referral networks expand. Coordination across multiple external partners may increase the frequency and impact of data gaps.

Large practices (40+ clinicians) face additional challenges related to scale. Greater reliance on standardized workflows and consistent data availability may increase sensitivity to fragmentation, particularly when coordinating across multiple systems and partners.

These differences suggest that while interoperability challenges are common, their operational impact varies depending on organizational structure and scale.

Relationship between interoperability and administrative burden

The findings also suggest a strong relationship between interoperability challenges and administrative workload.

When data does not flow efficiently between systems, practices are required to compensate through manual effort. This may include reconciling duplicate or conflicting records, requesting and tracking missing information, or re-entering data across multiple systems. These activities contribute directly to administrative burden and may reduce the time available for higher-value tasks.

This relationship reinforces the broader theme of the research. Many operational challenges are interconnected. Interoperability gaps contribute to administrative workload, which in turn affects staffing capacity and overall efficiency.

Operational implications for independent practices

Interoperability is not solely a technical consideration. It is a core operational factor that influences efficiency, quality, and financial performance.

The findings suggest that practices that rely heavily on manual processes for data exchange face increasing strain as care coordination requirements expand and reporting obligations grow.

Improving interoperability may therefore require not only system connectivity, but also workflow alignment, data standardization, and process integration. Practices that are able to reduce manual effort and improve data flow may be better positioned to manage complexity and maintain operational consistency.

SECTION 4: PATIENT ENGAGEMENT

Engagement remains a strategic priority, but expectations are increasing

Independent physician practices continue to place high value on patient engagement as an important component of care delivery. Most respondents report moderate to high effectiveness connecting with patients between visits through messaging, follow ups, and access to information. Engagement is widely viewed as essential to continuity of care, adherence, and patient satisfaction.

At the same time, patient expectations are rising. Practices are increasingly expected to provide timely responses, convenient scheduling, and ongoing communication outside of the clinical encounter.

While these efforts support better outcomes, they also increase demand on staff and systems. Meeting these expectations requires sustained effort. Engagement is no longer limited to periodic interactions. It has become an ongoing process that spans multiple touchpoints across the patient experience.

Engagement activities are driving administrative burden

Patient engagement is a meaningful contributor to administrative burden. Responding to patient messages represents the largest engagement related administrative burden, cited by 51% of respondents, followed by post-visit follow-ups 40% and sharing results and instructions at 39%. Appointment scheduling and post visit follow ups add further pressure, particularly when managed through manual workflows.

These activities are essential to maintaining continuity of care and patient satisfaction. For many practices, engagement tasks are layered onto existing responsibilities rather than replacing other work. This creates cumulative strain across clinical and administrative teams, and limits scalability as patient communication volume grows.

In many cases, these responsibilities are layered onto existing workflows rather than replacing other tasks. This increases overall workload and contributes to operational strain, particularly in practices with limited staffing capacity.

The impact varies by role.

- Physicians may experience engagement-related tasks as interruptions to clinical workflows, particularly when managing messages or follow-ups outside of scheduled visit time
- Practice managers and administrative staff may experience increased workload related to scheduling coordination, communication management, and patient support

These differences highlight the need to consider both clinical and operational perspectives when evaluating engagement strategies.

Financial considerations are a primary barrier to engagement

One of the most significant findings in the survey relates to the role of financial considerations in patient engagement. 57% of respondents identify financial concerns as the primary factor preventing patients from actively participating in their care. This is notably higher than other commonly cited barriers, including time constraints, competing priorities, or difficulty understanding medical information. This finding suggests that engagement challenges may not be driven primarily by communication gaps. Instead, they may be influenced by the patient's broader financial experience.

When patients are uncertain about costs, concerned about affordability, or navigating complex billing processes, they may be less likely to engage fully with recommended care plans, follow-up visits, or ongoing treatment.

This dynamic reframes patient engagement as both a clinical and financial issue.

57%

OF RESPONDENTS IDENTIFY FINANCIAL CONCERNS AS THE PRIMARY FACTOR PREVENTING PATIENTS FROM ACTIVELY PARTICIPATING IN THEIR CARE

Engagement challenges extend across the patient journey

Independent practices remain committed to patient engagement, but current approaches may not be sustainable without greater efficiency. The influence of financial considerations suggests that engagement challenges may occur at multiple points in the patient journey, including:

- Scheduling decisions when patients consider cost before booking appointments
- Care adherence when treatment plans involve out-of-pocket expenses
- Follow-up engagement when billing or payment processes create friction

In this context, engagement is not limited to communication between visits. It is shaped by the overall experience of accessing and paying for care.

Practices that focus exclusively on communication strategies may not fully address these underlying drivers.

VARIATION BY PRACTICE SIZE

The nature of patient engagement challenges appears to vary across practice types.

Solo practices may offer more personalized engagement, but may be limited by time and capacity to manage ongoing communication and follow-up

Mid-sized practices (2-40 clinicians) may face increasing demand for structured engagement workflows as patient volume grows

Large practices (40+ clinicians) may require more standardized and scalable approaches to engagement, particularly when managing higher volumes of patient interactions

These differences suggest that engagement strategies may need to be tailored to the organization's scale and structure.

Relationship between engagement and operational efficiency

Patient engagement is closely linked to operational efficiency.

High volumes of patient communication, scheduling activity, and follow-up coordination may increase administrative workload and contribute to workflow fragmentation. At the same time, ineffective engagement may result in missed appointments, incomplete care plans, or reduced adherence, which can affect both clinical outcomes and financial performance.

This relationship highlights the need to balance engagement efforts with operational capacity. Practices may need to consider how engagement workflows are designed, how responsibilities are distributed, and how processes can be streamlined.

Operational implications for independent practices

Patient engagement is no longer solely a communication function. It is an operational and financial consideration that influences both care delivery and practice performance.

The findings suggest that improving engagement may require a broader approach that includes aligning communication strategies with patient expectations, reducing administrative burden associated with engagement activities, and addressing financial barriers that affect patient participation.

Practices that can integrate these elements may be better positioned to improve engagement while maintaining operational efficiency.

SECTION 5: PRACTICE EFFICACY, AUTOMATION, AND AMBIENT TECHNOLOGY

Administrative workload remains a dominant operational challenge

Administrative workload is one of the most consistent sources of strain in the survey. Nonclinical tasks related to documentation, reporting, and compliance consume considerable time for independent physician practices and often extend beyond patient visits. More than half of respondents rated administrative workload as very or extremely challenging. That burden is especially visible in clinician time spent outside patient visits. Overall, 65% of physicians report spending an hour or more per day completing documentation outside scheduled appointments, and 26% reporting spending two hours or more.

The administrative tasks contributing most to this burden are practical and recurring. Clinicians most often spend time outside visits on medical record updates and notes, prior authorizations, and reporting, compliance, or administrative paperwork. Among physician and clinical leader respondents, reporting and compliance, denials management and appeals, and prior authorizations all rank prominently among the greatest administrative burdens, suggesting that the challenge extends beyond charting alone.

Administrative pressure is not simply a matter of inefficiency at the margins. It reflects an operating model in which documentation, reporting, prior authorizations, denial activity, and follow-up work continue to accumulate without corresponding relief elsewhere in the workflow. Over time, this may reduce clinical capacity, constrain improvement efforts, and make it more difficult for practices to operate with consistency.

Variation by practice size also appears relevant. The internal analysis in the current draft indicates that solo practices experience administrative strain especially acutely, while larger organizations more often report stronger financial pressure and more pronounced expectations around automation. This distinction matters because the same broad symptom, operational strain, may have different underlying drivers depending on the structure of the practice.

Workforce strain remains broad-based and closely tied to practice efficacy

Workforce challenges are closely intertwined with administrative burden, and the breadth of those challenges is one of the more consequential findings in the research. Physicians were cited as the hardest role to recruit and retain, selected by 48% of respondents. Billing staff followed at 44%, then clinical support staff at 42%, nurses at 39%, coders at 38%, front desk personnel at 32%, and NPs/PAs at 31%. Every staffing category in the survey was selected by at least 31% of respondents.

Role-level findings further reinforce this breadth. Among physician and clinical leader respondents, physicians, clinical support, nurses, billing staff, and coders all appear prominently as difficult roles to recruit and retain. Among practice managers and administrators, billing staff rank highest, followed by coders, physicians, and clinical support staff. Taken together, these results suggest that workforce strain is affecting clinical care, front-office operations, and revenue cycle management simultaneously.

That breadth changes the nature of the challenge. When a single role is hard to fill, work may be redistributed temporarily. When multiple roles are difficult to recruit and retain at the same time, strain is more likely to spread across the organization. Existing team members may absorb additional responsibilities, documentation time may extend, billing and follow-up work may remain unresolved longer, and leaders may have less capacity to focus on redesign or process improvement.

For independent practices, this suggests workforce strategy increasingly extends beyond recruitment and retention alone. It also involves how work is structured, where burden can be reduced, and which functions may require better tools, streamlined workflows, or external support in order to remain sustainable.

Practices report strong belief in the potential of automation and AI-enabled workflows

Despite these challenges, respondents demonstrate strong confidence in automation's role in improving practice efficiency. 88% of respondents said AI and automation could deliver at least moderate improvements, and 57% of respondents said automation and AI enabled workflows could greatly improve practice efficiency, particularly for documentation, administrative tasks, and repetitive workflows. Among practice managers and administrators, the proportion reporting significant or major improvement is even higher, while physician and clinical leader respondents also express broad confidence in automation's potential.



65% of physicians report spending an hour or more per day completing documentation outside scheduled appointments, and 26% reporting spending two hours or more.



Physicians were cited as the hardest role to recruit and retain, selected by 48% of respondents. Billing staff followed at 44%, then clinical support staff at 42%, nurses at 39%, coders at 38%, front desk personnel at 32%, and NPs/PAs at 31%. Every staffing category in the survey was selected by at least 31% of respondents.



88% of respondents said AI and automation could deliver at least moderate improvements, and 57% of respondents said automation and AI enabled workflows could greatly improve practice efficiency, particularly for documentation, administrative tasks, and repetitive workflows.



79% of respondents say technology will be extremely or very important to long term financial and operational stability.

This confidence is grounded in practical rather than abstract expectations. Physicians and clinical leaders view automation as a way to reduce documentation burden and reclaim time for patient care. Practice managers and administrators are more focused on consistency, error reduction, and operational stability amid staffing constraints. The difference is meaningful, but not contradictory. Automation is being evaluated from different operational vantage points within the same practice environment.

The distinction between these perspectives may be especially important for adoption. Administrative leaders often have direct visibility into repetitive tasks, workflow bottlenecks, and staffing shortfalls. Clinicians may be more sensitive to whether implementation introduces additional friction into the day-to-day experience of care delivery. As a result, the potential value of automation may be broadly recognized, while confidence in specific solutions may still depend on fit, timing, and workflow alignment.

This pattern closely mirrors the role automation plays in the broader whitepaper narrative. Across revenue cycle performance, interoperability, and patient engagement, the survey repeatedly points to manual effort, fragmented processes, and delayed visibility as sources of strain. In that context, confidence in automation appears to reflect a desire for operational relief rather than enthusiasm for technology in the abstract.

Technology is now foundational to staying independent

Respondents express a relatively high degree of confidence that current technology tools help reduce documentation and administrative burden. Overall, 64% report being extremely or very confident in their current tools, with similar results across physician and administrative respondents. Looking ahead, however, expectations are higher still: 79% of respondents say technology will be extremely or very important to long term financial and operational stability.

This gap between confidence in current tools and the expected importance of technology going forward is notable. Practices increasingly view technology not simply as a support function, but as part of the infrastructure required to remain viable. Technology is no longer viewed as an enhancement, but as foundational infrastructure.

That shift also changes how technology investment is likely to be evaluated. The question is not only whether digital tools belong in the independent practice model. It is which tools, workflows, and support structures most effectively reduce friction, improve visibility, extend capacity, and create practical operating leverage.

The data shows that appetite for technology increases with complexity. Larger practices are especially likely to believe that automation could produce significant gains, consistent with the broader survey finding that larger organizations tend to experience more intense financial pressure, denial growth, and process complexity. As workflows scale, the cost of manual work tends to compound, making technology investments more directly tied to sustainability.

VARIATION BY PRACTICE SIZE

The relationship between administrative burden, workforce constraints, and automation varies meaningfully by practice size, particularly in how strain is experienced and how relief is evaluated.

Solo practices tend to experience administrative burden most directly. Documentation, prior authorizations, and follow-up tasks are often handled by a small number of individuals, frequently including the physician. In this context, administrative workload translates quickly into extended work hours and reduced clinical capacity. Automation may be evaluated primarily in terms of immediate time savings and ease of implementation.

Mid-sized practices (2-40 clinicians) appear to experience a combination of staffing gaps and increasing coordination requirements. As workflows expand across more providers and staff, administrative work may become more distributed but not necessarily more efficient. Automation may be viewed as a way to stabilize workflows and reduce variability without requiring proportional increases in staffing.

Large practices (40+ clinicians) are more likely to experience strain related to scale and coordination. Higher staffing requirements, more specialized roles, and greater workflow complexity may increase the operational cost of manual processes. These organizations also appear more likely to expect significant gains from automation, particularly where it can improve consistency, reduce error rates, and support standardized workflows across teams.

Across all practice types, the underlying challenge is similar, but the operational implications differ. Smaller practices may prioritize simplicity and immediate relief, while larger organizations may focus on scalability and consistency. These differences suggest that approaches to automation and workflow redesign may need to be tailored to organizational scale and structure.

Operational implications for independent practices

Practice efficacy is increasingly shaped by the relationship between workload, staffing capacity, and workflow design.

Administrative burden remains high. Workforce strain is broad-based. At the same time, respondents report a strong belief that automation and AI-enabled workflows could relieve some of that pressure, particularly in documentation, repetitive administrative tasks, and other high-friction processes. Current tools appear to be helping, but expectations for future technology are even higher.

For independent practices, the implication is not that technology alone will resolve these challenges. Rather, it is that technology, automation, and external support are increasingly being evaluated as part of the operating model required to preserve capacity and sustain independence. Practices that align these investments with specific workflow needs may be better positioned to improve efficiency, reduce burden, and strengthen resilience over time.

SECTION 6: VALUE BASED CARE AND PAYER PROVIDER ALIGNMENT

Readiness is growing, but ease of participation remains uneven

Independent practices are not approaching value-based care from a place of unfamiliarity. 62% of respondents report feeling prepared to succeed in value based or risk based reimbursement models. In addition, 56% rated payer collaboration as very or extremely effective, reflecting increased familiarity with quality measurement and performance based incentives. These findings suggest that many independent practices are increasingly familiar with the expectations associated with quality measurement, payer collaboration, and performance-based reimbursement.

At the same time, preparedness does not guarantee ease of participation. For many practices, the challenge is not whether value-based care matters. It is whether the infrastructure required to participate successfully is manageable within the realities of an already pressured operating environment. Value based programs introduce additional demands related to reporting, data management, and financial risk that can strain independent practices.

This distinction is important because it suggests that willingness to engage is not the same as readiness to sustain performance. Practices may understand the goals of value-based care and recognize its strategic importance, while still encountering material difficulty in the operational work required to participate effectively.

Administrative complexity is the primary barrier

Administrative requirements present the most consequential obstacle to value based participation, cited by 49% of respondents. Financial risk followed at 38%, with limited data sharing, difficulty tracking quality measures, limited staff resources, and limited technology / analytics also surfacing prominently.

This ranking is revealing because it shifts the conversation away from ideology and toward operations. The survey does not suggest that independent practices are rejecting value-based care in principle. Instead, it suggests that many are confronting the administrative cost of participation. Program requirements, reporting obligations, documentation demands, payer communication, and performance tracking all add workload in environments that are often already constrained by staffing pressure and manual processes.

Financial risk is closely related to that administrative burden. When reporting is difficult, payer requirements are complex, and data is not easily accessible, the financial implications of participation may become harder to evaluate. In that sense, administrative friction and financial hesitation are not separate barriers so much as mutually reinforcing ones.

Limited visibility undermines proactive performance management

The survey findings show that many practices still have only moderate or limited visibility into payer requirements, quality metrics, and care gap opportunities. That matters because success in value-based arrangements depends on being able to identify issues during the measurement period rather than after results have already been reported.

When visibility is weak, performance management becomes more reactive. Care gaps may be identified too late to close them effectively. Quality performance may depend on delayed or incomplete information. Payer expectations may be interpreted inconsistently across teams. These conditions reduce the degree to which practices can manage performance with confidence, even when they understand what success requires conceptually.

The revenue cycle section highlights delayed visibility into financial leakage and issue detection. The interoperability section highlights fragmented data and manual reconciliation. Those same dynamics may also affect value-based participation, where timely, usable information is necessary for care management, quality tracking, and payer alignment.

62%

OF RESPONDENTS REPORT FEELING PREPARED TO SUCCEED IN VALUE BASED OR RISK BASED REIMBURSEMENT MODELS

56%

RATED PAYER COLLABORATION AS VERY OR EXTREMELY EFFECTIVE

Payer-provider alignment appears meaningful, but not yet frictionless

Respondents report a moderate to high level of effectiveness in working with payers to close care gaps and improve quality performance. That finding is encouraging because it suggests that payer-provider alignment is not absent from the independent practice environment. Many practices appear to be building the collaborative relationships required to participate in more advanced reimbursement models.

Even so, the overall pattern in the survey suggests that alignment is still limited by operational realities. Effective collaboration may be difficult to sustain when performance tracking is manual, reporting requirements are complex, and internal teams do not have full visibility into care-gap opportunities or measure performance. As a result, payer-provider alignment may be strongest where workflows, data access, and accountability structures are already relatively mature.

Physicians tend to focus more on clinical quality and care coordination, while practice managers emphasize reporting complexity, data management, and payer communication. These perspectives describe different dimensions of the same challenge and suggest that successful participation may depend on shared visibility across clinical and operational teams.

VARIATION BY PRACTICE SIZE

The experience of participating in value-based care differs by practice size, particularly in how administrative complexity, financial risk, and data requirements are managed.

Solo practices may face the greatest challenge in absorbing the administrative requirements associated with value-based programs. Reporting obligations, care-gap tracking, and payer communication often fall on a limited number of staff, which may make participation more time-intensive relative to available capacity. Financial risk may also feel more immediate in smaller organizations where variability is less easily absorbed.

Mid-sized practices (2-40 clinicians) may encounter increasing complexity as they scale participation. As patient volume and payer relationships expand, tracking performance across multiple measures and programs may become more difficult to manage consistently. These practices may be balancing growing readiness with the need for stronger infrastructure to support measurement and reporting.

Large practices (40+ clinicians) may be better positioned in terms of available resources, but may face challenges related to coordination and consistency. Managing performance across multiple providers, locations, and payer arrangements may increase reliance on standardized workflows and timely access to data. In this context, visibility into performance and alignment across teams may become critical to sustaining results.

These patterns show that while preparedness for value-based care is increasing across the independent practice market, the operational demands of participation are not uniform. The ability to manage administrative complexity, track performance effectively, and absorb financial risk may depend significantly on the scale and structure of the organization.

Operational implications for independent practices

Overall, the findings suggest that value based participation is achievable for independent practices, but not yet frictionless.

Preparedness is growing. Payer collaboration appears moderately strong. Participation continues to be constrained by administrative complexity, financial risk, and limited visibility into the information needed to manage performance proactively.

For independent practices, this suggests that success in value-based care may depend less on conceptual readiness alone and more on whether participation can be made operationally manageable. Reducing administrative friction, improving data accessibility, and strengthening alignment between payer expectations and practice workflows are essential to making value based care manageable and sustainable. That, in turn, reinforces that long-term independence increasingly depends on the ability to operate with greater visibility, less friction, and stronger coordination across the functions that shape performance.

STRATEGIC IMPLICATIONS

The findings from this research suggest that independent physician practices are navigating a more complex and interdependent operating environment than in previous years. Financial pressure, administrative workload, fragmented data, workforce constraints, and increasing payer and regulatory complexity are converging in ways that make reactive management increasingly risky and demand more deliberate, coordinated action.

Independence still matters, but is no longer sustained by clinical excellence alone. Preserving it requires active support through operating discipline, visibility, efficiency, and alignment across the organization.

1 INDEPENDENCE NOW DEPENDS ON OPERATING DISCIPLINE, NOT JUST COMMITMENT

Confidence in independence remains strong, but confidence alone is not enough. The most significant threats to independence are operational and financial. That means the practices most likely to preserve independence will be the ones that strengthen visibility, reduce avoidable friction, and respond faster when performance starts to weaken. Independence is increasingly being won in the mechanics of operations, not just in the philosophy of ownership.

2 REVENUE CYCLE VISIBILITY MUST MOVE EARLIER IN THE WORKFLOW

The survey suggests many practices are still discovering revenue cycle issues too late. Limited insight into financial performance is a recurring constraint throughout the research. Practices that lack timely visibility into revenue trends, denials, cash flow, and leakage are often forced into reactive decision-making after financial impact has already occurred. Instead, practices need earlier signals and clearer line of sight into what is affecting revenue before financial consequences accumulate. Revenue cycle performance can no longer be managed effectively as a lagging indicator problem. It has to be treated as an early-visibility problem as well. Earlier signals and clearer insights allow practices to forecast more accurately, prioritize corrective action, and plan with greater confidence.

3 WORKFORCE STRATEGY MUST INCLUDE WORKFLOW REDESIGN AND SUPPORT MODELS

The breadth of the staffing challenge makes one thing clear: many practices cannot rely on hiring alone to restore stability. They will need to rethink where manual work exists, which tasks consume disproportionate time, what can be standardized or automated, and where support models may help extend capacity without compromising independence. Workforce resilience increasingly depends on how work is designed, not just on how many people are on payroll.

4 PATIENT ENGAGEMENT STRATEGIES MUST ACCOUNT FOR AFFORDABILITY

The strongest patient engagement finding in the survey is financial. Cost of care outranked all other barriers to engagement. That means practices may need to think beyond message volume or outreach cadence. If the underlying barrier is financial strain, then better engagement will require more than better communication. It will require more frictionless pathways to action and a clearer understanding of where affordability shapes patient follow-through.

5 VALUE-BASED READINESS REQUIRES SIMPLIFICATION, NOT JUST PARTICIPATION

Many practices are open to value-based care. The barrier is not willingness alone. It is operational complexity. The organizations best positioned for success will be those that can reduce administrative friction, improve access to actionable performance data, and create stronger alignment between payer requirements and internal workflows. In that sense, value-based care readiness is increasingly a systems and operations question—not just a reimbursement strategy question.

Sustaining independence is becoming less about individual decisions and more about the overall design of the operating model. Practices that can improve visibility, reduce manual effort, and align workflows across functions may be better positioned to manage complexity and maintain stability over time.

WHAT INDEPENDENT PRACTICES NEED TO DO NEXT

While the challenges identified in this research are interconnected, the findings also point to several areas of focus that may help independent practices strengthen performance and sustainability.



Improve visibility into performance earlier in the workflow

Many practices report delayed visibility into financial performance, care gaps, and operational issues. Improving access to timely, actionable information may help support earlier intervention and reduce variability in outcomes.



Reduce reliance on manual processes

Manual work remains a consistent source of administrative burden across documentation, data exchange, and revenue cycle activities. Identifying opportunities to streamline or automate repetitive tasks may help improve efficiency and support staff capacity.



Strengthen coordination across clinical and administrative functions

The survey findings highlight the extent to which challenges are shared across roles. Improving alignment between clinical workflows, administrative processes, and financial operations may help reduce fragmentation and improve consistency.



Align patient engagement with the financial experience

Cost of care emerges as a primary barrier to patient engagement. Addressing financial transparency, billing clarity, and payment workflows may be an important component of improving engagement and care continuity.



Evaluate technology as part of the operating model

Technology is increasingly viewed as foundational rather than optional. Practices should evaluate technology not only in terms of functionality, but also in terms of how it supports workflow integration, visibility, and operational efficiency.

These areas do not represent isolated initiatives. They reflect a broader shift toward more integrated, data-informed, and scalable operating models. Practices that are able to make progress across these areas may be better positioned to navigate ongoing complexity.

CONCLUSION: SUSTAINING INDEPENDENCE IN A MORE DEMANDING ENVIRONMENT

Independent physician practices continue to demonstrate strong commitment to independence. At the same time, the environment in which they operate shows that the path to sustaining independence is more demanding.

Financial pressure, administrative burden, workforce constraints, and increasing expectations for data and technology are reshaping how practices function. These changes do not necessarily reduce the viability of independent practice, but they do alter what is required to sustain it.

Success is increasingly tied to how effectively practices can manage complexity. Improving visibility, reducing manual work, and strengthening coordination across workflows may play a central role in maintaining both performance and independence over time.

As the healthcare landscape continues to evolve, independent practices are likely to remain an important part of care delivery. Their ability to adapt operationally may be a key factor in determining how that role develops in the years ahead.

ABOUT VERADIGM

Veradigm works with independent physician practices to support the operational and financial performance areas highlighted in this research.

This includes helping practices improve revenue cycle performance, reduce administrative burden, enhance data exchange, and implement workflows that support greater efficiency and visibility. Veradigm solutions are designed to integrate with existing systems and workflows, with a focus on reducing friction and supporting sustainable operations.

To learn more about how Veradigm supports independent practices, visit veradigm.com or connect with our team.



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