Podiatrists and Value-Based Care

DPMs are uniquely positioned to approach risk-based contracting with medical groups and health plans.

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As healthcare payment models shift from volume to value, physicians—including podiatrists—must rethink their role in care delivery and contracting. Podiatrists are uniquely positioned to contribute meaningfully to value-based care (VBC) programs, especially in managing patients with diabetes and peripheral vascular disease, where foot health often reflects systemic disease control. Success depends on effectively partnering with medical groups and health plans, leveraging podiatric expertise to improve outcomes, and staying mindful of the common pitfalls that can complicate performance and shared savings.

Why Podiatry Matters in Value-Based Care

Foot complications in patients with diabetes and peripheral vascular disease (PVD) remain among the most serious and costly outcomes in healthcare. Diabetic foot ulcers alone are responsible for the vast majority of non-traumatic lower-extremity amputations. Yet research consistently shows that proactive podiatric care can make a meaningful difference. When podiatrists are involved before ulceration occurs, rates of amputation and mortality decline significantly. Even in high-risk groups such as dialysis patients, regular podiatric visits are linked to lower risks of amputation and death. Specialized foot care for patients with diabetes has also been tied to better long-term outcomes, including longer periods without ulcer progression or hospitalization. For these reasons, podiatry represents a high-value component of population health strategy, one that helps prevent complications, support healing, and reduce the downstream costs of advanced disease.

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Podiatry Builds Patient Trust—and Better Outcomes

Podiatrists often maintain long-term relationships with patients, particularly those with chronic foot or lower-limb conditions. This continuity fosters trust and encourages patients to stay engaged in preventive care. That trust gives podiatrists an opportunity to screen for, counsel on, and reinforce systemic diabetes and vascular health goals (glycemic control, retinal screening, kidney function monitoring, lipid/blood pressure control). Because patients can easily connect the dots between their foot health and their overall vascular health, these discussions often have more impact in the podiatry setting than during a typical primary care visit.

Using Foot Exams to Reveal Systemic Complications

The foot is a window into micro- and macrovascular disease. Peripheral neuropathy, vascular insufficiency (e.g., rest pain or claudication), and skin changes may reflect systemic diabetic complications such as nephropathy, retinopathy, or cardiovascular disease. Podiatrists are well positioned to spot early indicators of peripheral arterial disease or distal ischemia, and documenting these findings helps build a complete picture of a patient's risk. In risk-based payment models, accurate risk adjustment matters, and documenting comorbidities or complications that may otherwise go uncaptured can help calibrate a patient's complexity.

Beyond coding, thorough foot assessments give health plans and medical groups a clinical basis to trigger timely referrals to specialists in vascular care, cardiology, endocrinology, or nephrology, supporting more proactive, coordinated care.

Podiatry's Role in Multi-Organ Diabetes Management

Because the foot reflects microvascular health, podiatric care naturally intersects with key diabetes quality metrics, including blood sugar control, annual eye exams, kidney

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monitoring, lipid and blood pressure management, and overall cardiovascular risk. For patients with diabetes, coordinated care across organ systems is critical, and podiatrists can serve as an "anchor" touchpoint, helping ensure that other aspects of chronic disease care are addressed in a timely way.

How Podiatrists Can Engage Medical Groups and Health Plans

Below is a strategic approach for podiatric practices and networks to approach risk-based contracting:

1) Start with a Value Proposition and Pilot Model

- Build a business case. Use internal or published data to estimate avoided costs (hospitalizations, amputations, wound care, revascularizations) attributable to podiatric intervention. For example, Medicaid data suggest that states offering podiatry coverage have about a 48% lower rate of major amputations compared to states that do not.
- Propose a pilot or "proof-of-concept." Rather than demand full risk from day one, propose a pilot (e.g., for diabetic patients or high-risk foot-disease cohorts) to demonstrate value.
- Offer to share upside. Shared-savings models can align incentives by allocating a portion of savings or quality bonuses back to participating podiatrists. For example, integrating brief health assessments into routine podiatry visits and returning part of risk-adjustment or quality payments to the providers creates a practical framework for collaboration.

2) Align Specialty Incentives with Population Health Goals

- Select target populations wisely. Start with patients with diabetes or known PVD, where foot complications are common and prevention opportunities are greatest.
- Define metrics and guardrails. Propose a small set of metrics attributable to podiatric influence (e.g., lower-extremity amputation rate, ulcer recurrence, wound healing time, hospitalization for foot infection) and align with plan/group metrics (e.g., HEDIS diabetes measures).
- Integrate risk adjustment and documentation. Collaborate with the health plan's risk-adjustment team to ensure that podiatric documentation (e.g., debridement, neuropathy, PAD, foot ulcer) is captured in the medical record/claims feed. This protects the group when sicker patients are assigned.
- Define referrals and escalation criteria. Lay out clear protocols for when podiatrists will refer to vascular surgery, wound care, infectious disease, endocrinology, nephrology, or cardiology. Plans value such coordination because it reduces fragmentation.

3) Negotiate Contract Structure Mindfully

When negotiating with medical groups or health plans, watch for the following:

- Scope of attribution and attribution methodology. Avoid arrangements that attribute patients who were not seen directly or cannot be influenced. Clarify whether attribution is prospective or retrospective.
- Risk corridor and downside limits. Seek clauses that cap downside exposure (e.g., loss-sharing ceilings), especially in early years.
- Quality measure selection. Metrics applied to the podiatric contribution should align with areas that can reasonably be influenced. Avoid measures outside of control, such as hospital re-admissions unrelated to foot disease, general mammography, or specialty metrics outside podiatric access.
- Exclusion of non-modifiable events. Negotiate carve-outs for catastrophic events not preventable (traumatic injuries, unrelated cancers).
- Data transparency and reporting. Access to real-time or periodic dashboards with clinical and financial performance is essential.
- Audit rights and recoupments. Be wary of retroactive recoupment clauses without clear audit standards.
- Alignment of payment timeline. Ensure that shared savings or quality bonuses do not lag so far behind that they undermine cash flow.

4) Operational Execution and Clinical Workflows

- Embed "mini health assessments" into podiatry visits. A brief, 2–5-minute questionnaire or values review of HbA1c status, retinal screening status, kidney function, foot neuropathy, and vascular symptoms can integrate systemic care tasks.
- Use care coordinators or medical assistants. Train staff to triage abnormal screening results and trigger referrals.
- Standardize foot exam protocols and documentation templates. Ensure consistent capture of neuropathy, pulses, skin breakdown, ABI/TBI if available, and foot deformities.
- Monitor and audit internal compliance. Track adherence to referrals, wound follow-up schedules, and documentation completeness.

Be wary of retroactive recoupment clauses without clear audit standards.

5) Scale and Iterate

- Start small, then scale. Begin with a pilot program and, once outcomes are demonstrated, extend to broader patient populations.
- Refine inclusion/exclusion rules. Focus on patients whose risk can be influenced, excluding those with severe comorbidities, or stratify populations by risk tiers.
- Benchmark outcomes and continuously iterate. Adjust protocols based on performance and feedback.

Pitfalls and Measures Outside a Podiatrist's Control

While podiatrists can meaningfully influence many metrics, there are always risks of contract struc-

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tures capturing performance measures beyond direct control. Key cautions include:

- System-level measures: Metrics like hospital readmissions or emergency department use are often influenced more by primary care, inpatient care, or social factors than by podiatric care. Heavy weighting of these measures in a contract could unfairly affect performance scores.
- Attribution drift. Patients may roll off a panel or avoid care (non-adherence), diluting performance calculations.
- Coding and documentation lag. If the plan's risk adjustment relies on delayed or unsubmitted claims, complexity of care may not be fully credited.
- Diagnostic capture bias. Some metrics may depend on lab testing or imaging ordered outside podiatry (e.g., HbA1c, creatinine, retinal exams). Noncompliance or missing tests can impact measured outcomes.
- Upstream compliance. Even with counseling on diabetes control or kidney monitoring, outcomes depend on patients taking action, which cannot be fully controlled.
- Interdependent specialty accountability. Some outcomes depend on vascular, endocrinology, nephrology, or behavioral health engagement. In contracts, ensure responsibility is aligned to the party best able to act.
- Baseline selection and adjustment. Poor risk adjustment or insufficient baseline stratification can create disadvantage, especially with sicker patient cohorts.

To mitigate these risks, insist on:

- Attribution clarity and guardrails
- Carve-outs or adjustments for outlier patients
- Reasonable performance thresholds and glide paths (not "all-or-nothing")
- Prospective performance previews and ability to reconcile before penalties
- Shared governance committees to adjust metrics over time

Recommended Strategies for Success

1) Identify and isolate foot-specific metrics that can be influenced, e.g., ulcer incidence, ulcer healing time, recurrence rate, lower-extremity amputation.

2) Negotiate realistic quality metrics. Resist being held accountable for metrics outside podiatry's sphere (e.g., colon cancer screening).

3) Ensure robust documentation workflows. Use templates, decision support, and checklists to maximize coding and data capture.

4) Foster interprofessional coordination. Formalize referrals to endocrinology, nephrology, ophthalmology, vascular, cardiology so that systemic goals are jointly reinforced.

5) Request transparency and analytics. Performance dashboards, risk score trajectories, and attribution changes must be available in real time.

6) Start small and scale. Pilot in a defined geographic or disease cohort; iterate before expanding.

7) Advocate for monitorable carve-outs and caps on downside. In early years, favor upside-only or limited-risk models with transition clauses.

8) Communicate patient value. Show patients how foot-focused interventions dovetail into their total health, reinforcing adherence and engagement.

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Conclusion

In the evolving landscape of value-based care, podiatrists have more opportunity than ever to play a strategic role beyond procedural foot care. By leveraging the foot as a sentinel organ, podiatric practices can help reduce amputations, hospitalizations, and costs, while simultaneously reinforcing systemic management of diabetes and vascular disease.

However, success in risk-based contracting requires careful negotiation, alignment of metrics, documentation rigor, and shared incentives. Embedding brief health assessments into routine podiatry visits and allocating a portion of risk-adjustment or quality payments to the podiatrist offers a pragmatic path forward.

Podiatrists who embrace this model can shift from being "cost centers" to being high-value contributors, integrated within accountable care ecosystems. With careful design and alignment, podiatric participation in risk-based models can yield better outcomes for patients and sustainable compensation for providers. **PM**

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