Musculoskeletal Care Coordination
A Primer for Orthopaedic Surgeons

Contributors
Alexandra E. Page, MD
Vice-chair Health Care Systems Committee. Editor
K. William Kumler III, MD, MBA
member Health Care Systems Committee. Co-Editor
Samuel G. Agnew, MD
member Health Care Systems Committee
Craig A. Butler, MD, MBA
Chair AAOS Health Care Systems Committee
Brian R. McCardel, MD
member Health Care Systems Committee
Peggy L. Naas, MD, MBA
member Health Care Systems Committee
Marc E. Rankin, MD
member Health Care Systems Committee

AAOS Staff
Matthew T wetten, MA
AAOS Senior Manager, Regulatory, Quality and Medical Affairs
Simit Pandya
AAOS Government Relations Specialist

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Daniel M Adair, MD (Member): There is no current disclosure data available for that person.
Samuel G Agnew, MD (Member): 3B (Zimmer Fracture Delphi HealthCare Partners Bacterin International);3C (Accelero Health Care Partners: Orthopaedic Service Line management Select International: Executive Search Firm);7 (eMedicine );8 (Journal of Trauma); Submitted on: 11/18/2011. *
Thomas G Friermood, MD (Member): 9 (Colorado Orthopedic Society); Submitted on: 10/11/2012. *
David A Halsey, MD (Member): 8 (SLACK Incorporated); 9 (AAOS; American Association of Hip and Knee Surgeons); Submitted on: 08/18/2012. *
K William Kumler, III MD (Member): 9 (AAOS Health Care Systems Committee; AAOS); Submitted on: 02/21/2013. *
Brian R McCardel, MD (Member): There is no current disclosure data available for that person.
Peggy L Naas, MD, MBA (Member): 9 (AAOS; AHA); Submitted on: 10/17/2012. *
Alexandra Elizabeth Page, MD (Member): 8 (Techniques in Foot & Ankle Surgery);9 (AAOS; San Diego County Medical Society, California Orthopaedic Association); Submitted on: 01/07/2013. *
Marc E Rankin, MD (LFP Member): 8 (Orthopedics );9 (Eastern Orthopedic Association); Submitted on: 10/25/2011. *
Matthew J Twetten (Staff Liaison): (n) Submitted on: 10/08/2012. *

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Dear Colleague,

The AAOS Health Care Systems Committee has worked over the past year to grow our collective knowledge in the area of delivery system reform. This primer is a product of that effort and represents the incipient push of the AAOS to lead the change required to improve the value of orthopaedic care and the services we provide to our patients. Whether formally through Accountable Care Organizations or Bundled Payments or informally to improve patient care, coordination care will likely be required in future care delivery models.

This primer responds to a request the AAOS Board of Specialty Societies and Board of Councilors, representing all AAOS fellows, made to our leadership to examine this area of health care reform. It should be understood that as a Primer, this document only covers basic elements and is not designed to be exhaustive. On behalf of fellow committee members, we hope that you appreciate our efforts to “get out in front” on health care system issues and ask that you stay connected as we work in the area of payment reform in the coming year.

Respectfully,

Alexandra E. Page, MD
Editor, Primer on Musculoskeletal Care Coordination

Vice Chair, Health Care Systems Committee

K. William Kumler III, MD, MBA
Chair, Musculoskeletal Care Coordination Symposium
Co-Editor, Primer on Musculoskeletal Care Coordination

Craig A. Butler, MD, MBA, CPE
Chair, Health Care Systems Committee
Council on Advocacy
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Chapter 1-The Orthopaedic Surgeon and Care Coordination

Why should Orthopaedists care about coordination of medical care? It is about teamwork which provides efficient and quality care for patients. It can keep referral sources happy and patients coming through the door. Care coordination can optimize patient outcomes with fewer return calls, office visits, or readmissions. For some specialized practices, the cost vs. benefit of care coordination may not be apparent, but patient and health care reform demands may give a competitive advantage to those practices which recognize this component of providing “patient-centered care.”

Increasing specialization of medicine has fragmented the physician-patient relationship. The evolution of integration in medical care moved through the Gatekeeper model, into the Medical Home Model (care coordinator) and now to the Patient Centered Medical Home (PCMH) model which is evolving into the Patient Centered Medical Home Neighborhood (PCMH-N) Model. For optimal musculoskeletal care, should there be a Patient Centered Musculoskeletal Home? Based on the current requirements for certification of a PCMH by National Committee for Quality Assurance (NCQA), most Orthopaedists would not be prepared or interested in the responsibilities of a PCMH. An alternative for specialists is to add value to the health care team by participating as a “Neighbor” in the PCMH (designated PCMH-N). “Musculoskeletal Care Coordination” (MSK-CC) provides an umbrella term for the myriad ways Orthopaedic Surgeons can offer value in these coordinated care models. Early involvement of orthopaedic surgeons in development of such a system presents an opportunity to improve the delivery system for the whole profession. Team work with PCP’s and other referring colleagues can provide clear definitions of provider roles and responsibilities and ultimately improve health care delivery. As masters of the musculoskeletal knowledge base, orthopaedic surgeons can guide decisions to optimize musculoskeletal care. This might include shared educational development between various specialties, including identification of possible trigger points for referral. This primer is intended to educate Orthopaedists about the PCMH concept, its place in delivery and payment reform, and provide suggestions for development and implementation of care coordination models for an effective PCMH-N.

Chapter 2- Evolution of the Patient Centered Medical Home and Care Coordination

Evolution of the PCMH

The PCMH evolved as a response to challenges observed in the US model of healthcare delivery. Failure of care coordination may account for $25-45 billion dollars annually, based on an estimated 20% waste in healthcare expenditures. Ideally, the PCMH offers solutions to the costs and poor outcomes that can result from poorly coordinated care. The original concept of a medical home started with the American Academy of Pediatrics (AAP) in 1967. Further refinements emerged from the AAP as well as the American College of Physicians (ACP) and the American Academy of Family Physicians (AAFP). These three groups working with the American Osteopathic Association formalized the concept as the “Joint Principles of the Patient-Centered Medical Home,” published in 2007. The critical components include:

- **Personal physician** with whom each patient can develop an ongoing relationship.
- **Physician directed medical practice** with a personal physician leading team of individuals who collectively take responsibility for the ongoing patient care.
- **Whole person orientation** by providing all the patient’s health care needs or appropriately arrange care with other qualified professionals.
- **Care is coordinated and/or integrated** across all elements of the health care system and the community.
- **Quality and safety** including continuous quality improvement with physician, patient, & family members; use of evidence-based medicine; decision-making support; use of information technology.
- **Enhanced access** to care through use of creative access modes.
- **Payment reform** to appropriately recognize the added value provided to patients in a patient-centered medical home.

Pilot projects for the PCMH emerged from CMS in 2006 and states further began incorporating the concept into SCHIP and Medicaid programs. Reviews noted various approaches but cautioned that development was more “laborious and complex than initially envisioned.” Incorporation of the PCMH faced challenges, including organizational changes and the need for payment reform to sustain success of the model. The Joint Principles (above) define the fundamental components of the PCMH. Evidence supports that the “four pillars of primary care” (access to first-contact, coordinated, comprehensive...
care and sustained personal relationships) can help achieve the goals of higher quality and lower cost health care. Data also demonstrate the current system inadequately facilitates coordination. To address this communication breakdown, the PCMH puts the PCP at the hub of a wheel with the spokes leading out to specialists (although some redraw this model with the patient at the hub or with a spider web network connecting specialists directly). To the PCP, receiving all relevant information from treatment teams minimizes confusion for the patient and allows coordination between specialists, avoiding duplication of studies.

**Specialty PCMH**

Noting early successes in the PCMH models and potential for payment reform, specialty medical groups have explored serving as a medical home for a subset of patients. The Accountable Care Act allows for this broader definition of a medical home. Specifics on this option are evolving within multiple specialty societies. However, a survey of 372 specialty practices revealed that the vast majority (85%) of specialty practices serve as PCP to 10% or less of their patients, suggesting limited value of the “Specialty PCMH”. As noted earlier, this model would appeal to very few orthopaedic surgeons, but other specialties (e.g. OB-Gyn, Renal) may pursue it.

**PCMH - Neighborhood**

Expanding the communication and coordination with specialists, the ACP refined the concept of the PCMH, introducing the “Neighborhood” idea in 2010 in a position paper outlining possible roles for specialists. As with the “Joint Principles,” these provide a vision for interaction of the multiple medical team members, but specifically facilitate allowing the PCP to take a central role in the patient care to:

- Provide effective bidirectional communication with a focus on care coordination and information sharing with the PCMH
- Engage in timely and appropriate referrals/consultations
- Support patient-centered care co-management
- Establish care coordination agreements that:
  - Define roles/responsibilities/expectations
  - Provide specific parameters for secondary referrals/admissions, emergencies
- Align incentives

For the PCP, communication with specialty physician members in the PCMH-N would reflect the same efficiencies of the medical home. The ACP position paper identifies specific forms of clinical interactions between the PCMH and the specialist:

- Preconsultation exchange – to prioritize care or clarify the need for a referral
- Formal consultation – to address a discrete question or procedure
- Co-management models:
  - Co-management with shared disease management (e.g. rheumatoid arthritis or degenerative joint disease)
  - Co-management with principal care by the specialist (e.g. Young adult with osteogenesis imperfecta)
  - Co-management with principal care for a limited period (e.g. fracture care, epidural injection)
- Transfer of patient to a specialty PCMH for all care (e.g. ACL injury in a healthy young adult)

**PCMH Model and Hospital Systems**

Hospital systems and physicians have experienced changes in practice patterns resulting in a disconnect between ambulatory and inpatient care. Hospitalists working in shifts increasingly provide inpatient primary care; community PCP’s no longer even come to the hospital. Re-admission rates may reflect this disconnect, with 21% of most common three hospital DRGs (congestive heart failure, community acquired pneumonia and acute myocardial infarction) readmitted to the hospital within 30 days of discharge. A study showed that more than half of these patients after discharge had not had a follow up visit with a primary care physician.

While the walls of the hospital were very porous to readmission, they posed a barrier to coordination of information and care between the silos of hospital inpatient care and community care. Potential costs in these avoidable readmissions were estimated in the range of $15 to 17 billion dollars per year. As models shift to payment for value, the new mantras include “high quality at low cost” and “the right care at the right time and at the right location.” Denied reimbursement for avoidable re-admissions provides economic motivation for hospitals to reach beyond their walls. Hospitals now have “care coordinators” rather than discharge planners. Shared information has become a strategic and operational necessity for success. Electronic health records are patient-centered and portable, and available at all sites of care. Other sites of care including freestanding emergency departments, urgent care, retail clinics, and ambulatory imaging and surgery centers are also included in the flow of patient-centered data and information, further enabling coordination of the care.
With changing payment models and penalties as well as increasing employers of physicians, hospitals have become health systems providing care beyond the acute inpatient episode. PCMHs provide care within a coordinated “medical neighborhood” linking the various sites of care with specialists and other community health resources. Health systems now have care navigators to support this coordinated care by focusing on prevention and active population management. It should be noted that payment for data documented outcomes may significantly affect hospitals. Successful “upstream” prevention and improved access to multiple venues of care may decrease the number of ill patients presenting to the doors of the emergency department. With financial incentives to coordinate care and reduce hospital acquired conditions, preventable re-admissions may actually be prevented. Shared financial responsibility can drive hospitals to coordinate more closely with the PCP/PCMH and the specialty “neighbors” to assure follow up and prevention of medical or surgical complications.

Chapter 3-Orthopaedics, MSK-CC, and Payment Reform

As noted in the introduction, any delivery system reform demands a concomitant payment reform model. With value-based payments, establishing (and ultimately tracking and reporting) the value of care coordination becomes critical.

Defining Orthopaedic Value in Care Coordination

To successfully meet a projected explosion in patient demand for MSK treatment, all stakeholders should participate in systems which provide care at a competitive cost in each community. The healthcare value equation (Value = Patient Outcome/Cost of Care) applies at both the individual and population levels. The orthopedist can improve outcomes by taking ownership of the complete cycle of musculoskeletal care [diagnosis treatment prevention of recurrence return to desired level of function]; particularly in the case of surgically appropriate disease or injury states. MSK-CC with PCP’s could ideally provide value through:

• minimizing duplication of services;
• helping PCP’s identify conditions which they can treat;
• improved access for patients requiring an orthopaedic surgeon for care;
• predictable time from diagnosis to treatment, minimizing disability time.

Orthopaedic surgeons can also play a substantive role developing and implementing processes which improve cost control. Optimization may require skilled practitioners at various levels including non-operative orthopaedists and physician extenders (nurse practitioners, physician assistants, advanced practice physical therapists). For example, proportionally higher costs occur in the post-acute setting so optimization of discharge and rehabilitation processes including utilization of non-physician providers could substantially reduce costs in this treatment stage. With MSK-CC, the Orthopaedic surgeon would assure that these resources function in a cohesive and patient-centered fashion. Further, coordinating medical and orthopaedic post-acute care including rehabilitation can offer:

• improved patient functionality and ultimate outcome
• decreased medical and surgical complications, lower readmission rates;
• decreased need for long-term, or skilled care.

Ascribing (and reimbursing) the enhanced value to surgeons offering patient-centered, coordinated care remains a challenge. The proposed NCQA criteria for recognizing a physician as a “good neighbor” includes an overwhelming 22 different categories by which a specialist might be graded, with up to 13 elements in each, with up to 3 different types of supporting documentation to be submitted, including logs and screenshots. Simplification of the NCQA criteria could encourage specialists to participate in the PCHM-N model. For an orthopaedic surgeon, the efficiencies of a coordinated care process could improve both office and operating room access for more patients. The health care system can benefit from improved patient access and outcomes as well as lower re-admission rates.

MSK-CC and Payment Reform

Lack of reimbursement represents a current barrier to the widespread implementation of the PCMH. Payment models in the demonstrations varied and an optimal payment structure has not been clearly defined. The PCMH offers value in multiple ways including non-physician care coordination, expanded access to the physician and team, accessible real-time data. Specific to coordination with hospital discharge, avoidance of readmission offers potentially large savings. The RAND Corporation, with support from the National Quality Foundation (NQF), has identified eleven models of payment reform (list in Table) from well over 100 implemented and proposed payment reform programs. Care coordination is integral to most of these payment reform models. Future payment models will and do include payment for care coordination.
Current FFS infrastructure for specialists does not include payment for care coordination in the role of orthopaedic surgeons facilitates designing coordination payment reform models. Proactively defining of future payment distribution algorithms within the care delivery reform models. The NCQA is also developing potential performance measures for interactions in these activities add value and, hence, should be included in any planned reimbursements for care coordination. The ACP, by defining the PCMH Neighbor, has sublety codified potential performance measures for interactions in these delivery reform models. The NCQA is also developing a Specialty Practice Recognition Program that parallels their PCMH certification process. These efforts should be recognized as the potential model for the infrastructure of future payment distribution algorithms within the care coordination payment reform models. Proactively defining the role of orthopaedic surgeons facilitates designing payment models for our contribution in this role.

The key points for payment reform in care coordination include:

- In the absence of active involvement, specialty roles will be determined by outside stakeholders
- Orthopaedic surgeons should actively lead efforts which improve coordination of musculoskeletal care delivery.

**Chapter 4-MSK-CC: Present And Future**

**Current MSK-CC Models**

Current models of coordinated musculoskeletal care are common in acute care hospital settings including orthopaedic service lines, orthopaedic centers of excellence, and co-management agreements. With the emergence of payment models such as episode-based bundled payments, new models of care have likewise emerged. One example of coordinated orthopaedic care is the Geisinger “guarantee” or “Proven Care”. For total joint replacement patients, care from preadmission to discharge and any complications are included in a single “guaranteed price.” The success of this model requires intense attention to efficient, predictable processes with reproducible outcomes and avoidance of complications. The Geisinger Orthopaedic Department Chair, Dr. Michael Suk, identifies the “physician clinical activist” role, which provides perspective on what resources are required to successfully and predictably deliver the desired outcomes. Process and outcome metrics have been identified and data are collected from the acute stay and thorough follow up. The Geisinger model has been supported through its provider-owned health plan data stream, physician employment model, and hospital-clinic common ownership and culture.

Other examples include orthopaedic institute models with planned care pathways, where coordination produces referrals from primary care to sequenced specialty clinic interventions such as seen at ThedaCare system in Appleton, Wisconsin. This results in patients sent to orthopaedic surgeons when surgical intervention is most likely. For example, interval care may be provided for “arthritis” by the appropriate mix of rheumatologists, sports medicine specialists, occupational medicine physicians and “midlevel” professionals such as physician assistants and nurse practitioners. Appropriate interventions, diagnostic studies, and referrals are identified and coordinated to avoid inappropriate imaging or other diagnostic studies, minimize duplicative interventions, and reduce non value added referrals. Each care professional is utilized at the appropriate level of their training and experience. This provides a musculoskeletal care pathway with more predictable patient experience and value outcome. These pathways can be across a continuum of care and specialists such as for “arthritis” or “back pain”.

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**Table –Summary Of Payment Reform Models**

<table>
<thead>
<tr>
<th>Global Payments</th>
<th>ACO-Shared Savings</th>
<th>Medical Homes</th>
<th>Bundled Payments</th>
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</thead>
<tbody>
<tr>
<td>Pay for Coordination</td>
<td>Hospital Pay for Performance</td>
<td>Pay Adjustment for Readmission</td>
<td>Hospital-Physician Gain sharing</td>
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<tr>
<td>Payment Adjustment for HACs</td>
<td>Physician Pay for Performance</td>
<td>Payment for Shared Decision Making</td>
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</table>

CMS recently included a provision in the proposed 2013 Medicare Physician Fee Schedule (MPFS) to pay for care coordination and care management services. Under the current fee-for-service (FFS) model these payments are principally directed toward primary care providers. Recently deployed models, including ACOs, PCMHs, and even bundled payments, will necessarily require distribution of payments for care coordination to all providers involved. Orthopaedic surgeons should define and perhaps standardize their role in coordinating care to participate in reimbursement for providing this service.

Care coordination includes activities such as reviewing diagnostic tests and treatments, establishing care plans, and communicating with other members of the health care team. Orthopaedic surgeons routinely manage transitions from acute to post-acute care, coordinate care delivered by other providers (e.g. therapists) and these care management activities add value and, hence, should be included in any planned reimbursements for care coordination. The ACP, by defining the PCMH Neighbor, has sublety codified potential performance measures for interactions in these delivery reform models. The NCQA is also developing a Specialty Practice Recognition Program that parallels their PCMH certification process. These efforts should be recognized as the potential model for the infrastructure of future payment distribution algorithms within the care coordination payment reform models. Proactively defining the role of orthopaedic surgeons facilitates designing payment models for our contribution in this role.

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MSK-CC: The Orthopaedic Surgeon as a Neighbor

Providing the most coherent and cost-effective care for patients requires cooperation of providers beyond the PCMH, including specialists, hospitals, pharmacies, home health care agencies, extended care facilities, and more. The vision of the medical neighborhood isn’t geographic, but rather a set of “good neighbor” relationships surrounding the patient, providing a community of care with the patient at the center. This can be as simple as a curbside consultation in the hallway or a “pre-referral” phone call to discuss appropriateness of referral, to a more in-depth recommendation for pre-visit testing, to development of a comprehensive care plan for a complicated patient. Historically, consultation occurred through existing primary and specialty care referral paths. The “neighborhood” can codify existing relationships or facilitate new relationships through the implementation of Care Coordination Agreements identify expectations for communication, coordination, timeliness, and patient-focus. The need for such agreements will often be defined by the specialty, the clinical setting, current relationships, and the needs of the patient. These agreements are perhaps best considered as legally akin to Memoranda of Understanding rather than contracts. Ideally, a Care Coordination Agreement defines the relationship between the PCMH and specialty physicians or other neighborhood team members and the expectations to facilitate timely and complete communication.

In the PCMH-N the responsibilities of the PCP when referring to a specialist could include:

- Prepare patient by providing appropriate and adequate information on the reason for referral
- Indicate specific clinical interaction requested (see Chap 2)
- Indicate urgency, provide contact info for patient
- Review secondary diagnoses or suggested referrals from other Specialty Neighbors
- If co-managing, advise Specialty Neighbor of relevant clinical status changes
- Contact patient if appropriate when notified by Specialty Neighbor of “no show”

In return, specialist responsibilities could include:

- Review request (potentially including imaging studies) and triage by urgency
- Accept the referral or suggest alternative option
- Provide timely, appropriate, and adequate response
- Notify PCMH of no shows
- Refer secondary diagnoses back to PCMH unless directly related to the referred problem
- Communication to PCMH about any secondary referrals
- Copy PCMH on referral response EVEN if patient seen by self-referral or was referred by another physician.

Finally, the PCPs identify critical elements expected in a response from Specialty Neighbor referrals:

- Answer the clinical question
- Recommend the optimal form of co-management if this type of clinical interaction is requested
- Confirm existing, add, or change diagnoses
- Medication and/or equipment changes
- Testing results, testing pending, scheduled or recommended
- Procedures completed, scheduled or recommended
- Education completed, scheduled, or recommended
- Any recommended services or actions to be done by the PCMH
- Scheduled or recommended follow-up

MSK-CC Tool Box for Implementation

Providing coordinated MSK care requires reaching out to primary care physicians to form pathways for orthopedic conditions. First steps can include:

- **Increasing the awareness of the “home/neighbor” relationship.** Understanding the origin and goals of the PCMH model can help clarify the needs of the PCP. If the PCMH and/or Neighborhood are not active in your community, engage referring doctors in discussion about establishing the model.

- **Identify and demonstrate the need to be a good neighbor.** Current workflow is often episode-based, with no feedback or coordination, except as a “courtesy”. The value of care coordination may not be recognized by providers who have successfully practiced for years in their own silo.

- **Work with other Orthopaedic Surgeon neighbors.** The PCP will need to coordinate with other orthopaedic surgeons in the community, likely in your subspecialty, as well as other specialties. Coordinating protocols (e.g. VTED prophylaxis, medical clearance expectations) with other surgeons could enhance value to the medical system.

- **Include the hospital.** Desire to avoid “preventable” readmissions should motivate hospitals to recognize the value of a coordinated PCMH-N to provide pre-op optimization and post-op complications.

- **Choose an electronic medical record system and/or explore integration with PCP’s and the hospital.** Many EMR’s are integrated with software (Health Care
Level 7) that permits communication between different systems. Many of the efficiencies of the PCMH-N rely on effective use of this tool, including tracking, measuring, and reporting outcome metrics critical to value-based reimbursement.

- **Develop Care Coordination Agreements.** Invite your most reliable primary care referring physicians to establish a memorandum of understanding, which focuses on the specifics of referral discussed above.

- **Tailor Care Coordination Agreements to your practice.** If you want more patients ready for surgery, then the primary care physician can address office-based procedures. For example, the PCP can confirm a TJR patient has failed conservative treatment and meets the CMS criteria. If you prefer to address non-operative treatment, clarify more appropriate referral stages.

- **Integrate physician extenders.** Physicians Assistants, Nurse Practitioners and other care providers can optimize value in care coordination. Defining their roles and provide adequate training for your practice preferences.

- **Start small and grow.** Consider focusing on one orthopedic condition (e.g., knee arthrosis) for care coordination. Arrange the office to maximize treating and tracking of these patients, with staff establishing pathways based on the stage of treatment (e.g., conservative treatment, surgery, pre-op and follow up visits). After success with several defined areas, work on the broader definition of all MSK care.

- **Consider the place for orthopaedic decision-support aids in coordinated care.** This can help patients determine their orthopedic goals, clarify preference for conservative vs. operative treatment, and thus which physician should lead care at a given point in time.

**Advanced steps** for practices already working on care coordination:

- **Improve Neighborhood relationships.** Work with members of the MSK-CC team (PCP, physician extenders) to optimize quality and measure, test, refine, and implement practice improvements. Review outcomes to confirm your care model specifically addresses the needs of your population and the other Neighborhood members.

- **Explore creative options for improved patient access.** Develop a practice website where patients can have access to the MSK-CC team and educational information. Telemedicine or virtual visits can provide access for non-urgent needs outside regular office time. Some commercial insurers are beginning reimbursement for these virtual visits.

- **Engage the hospital to provide resources at a higher level.** For example, a qualified orthopaedic home health nurse could clarify an expected post-op finding from a true complication. In a coordinated system, a same or next-day evaluation by the appropriate medical or orthopaedic team member can provide care. This can save the hospital system a costly ER visit or non-reimbursed admission.

**Future steps at the national level:**

- **Lead efforts which improve coordination of musculoskeletal care delivery, identifying roles for orthopaedic surgeons in care coordination.**

- **Support Payment Reform which facilitates these care models.** In the absence of active involvement, specialty roles will be determined by outside stakeholders

**Summary And Conclusions**

Care Coordination, as a concept, is simple and straightforward: provide the right care in the right place, at the right time to achieve the desired outcome. Care Coordination in action is potentially as complex and challenging as any other aspect of health care delivery, but boils down to the “team” concept. As long as the “team” performs well and achieves the desired results, all stakeholders will be satisfied. Even identifying team members presents a challenge. The PCMH-N recognizes the many players on the health care team and formalizes their organization. To optimize care coordination in a PCMH-N, orthopaedic surgeons should take ownership of MSK injuries and diseases. Work with PCPs and other providers to evolve coordination models which can add value to the care of MSK conditions. Identify the team members in your own community and begin the process of defining expectations and forming agreements on responsibilities to achieve care coordination.
Abbreviations
ACO – Accountable Care Organization
AAFP – American Academy of Family Physicians
AAP – American Academy of Pediatrics
ACP – American College of Physicians
CMS – Centers for Medicare and Medicaid Services
EMR – electronic medical record
FFS – fee for service
HCSC – Health Care Systems Committee – An AAOS committee
IT – information technology
MPFS – Medicare Physician Fee Schedule
MSK – Musculoskeletal
MSK-CC – Musculoskeletal Care Coordination
NCQA – National Committee for Quality Assurance – this is a private accreditation body
NQF – National Quality Forum – a non-profit entity
PCMH – Patient Centered Medical Home
PCMH- N - Patient Centered Medical Home Neighborhood
PCP – Primary Care Provider
SCHIP – State Children’s Health Insurance Program

References