



Best Practices in
Patient-centered
Musculoskeletal Care



2013 Musculoskeletal Summit

Best Practices in Patient-centered Musculoskeletal Care Summit

Themes and Recommendations

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Table of Contents

The Context for Identifying and Implementing Best Practices in Patient-centered Musculoskeletal Care	1
Cross-cutting Themes	2
Recommendations for Action from Summit Speakers and Participants	3
Research and Data to Build an Evidence Base for Best Practices and for Establishing, Disseminating, and Implementing Guidelines	3
Identifying and Delivering Patient-Centered Care.....	5
Current Best Practices and their Implementation	5
Next Steps.....	6

Presentations and discussions at the 2013 Musculoskeletal Summit, convened in November 2013 by the U.S. Bone and Joint Initiative (USBJI), were organized to explore several key themes:

*What does **patient-centered care** look like — and how can it be measured?*

*What is known about **current best practices** for musculoskeletal conditions?
How are these best practices **defined and implemented**?*

*How can best practices in patient-centered musculoskeletal care be **advanced** in the near future?*

In sessions related to each of these themes, Summit participants — representing patients, providers, industry, payers, and other stakeholders — heard from a distinguished roster of speakers on current ideas about best practices and patient-centered musculoskeletal care. Throughout the Summit discussions and in small group sessions, participants combined their own perspectives and expertise with information from speakers to develop recommendations and action steps.

This summary provides highlights of themes, observations, and recommended actions that emerged from the Summit presentations and discussions.

The Context for Identifying and Implementing Best Practices in Patient-centered Musculoskeletal Care

The Summit discussions happened to coincide with the release of new guidelines on the use of statins in the management of cholesterol by the American Heart Association and the American College of Cardiology. The new guidelines represented a significant change concerning the patients who should be prescribed cholesterol-lowering statins. The headlines, confusion and controversy surrounding the new guidelines were noted by several Summit speakers, reminding participants of the difficulties that underlie any efforts to develop clear, effective, patient-centered guidelines and practices (and the imperative to invest in getting them right, ideally the first time).

The Patient Protection and Affordable Care Act (ACA) was also the subject of headlines in the media at the time of the Summit, prompting frequent references. In particular, Summit participants noted the prospect for payment reforms, greater accountability (and the data to make this possible), and a focus on both comparative effectiveness research and patient-centered medical homes as trends supporting best practices in musculoskeletal care.

Several speakers noted the trend towards consolidation of health care systems and insurers, as well as the likelihood of health systems assuming some risk themselves (e.g., by simultaneously serving as providers, insurers, and employers for large populations). As the policy environment and payment models shift in directions more similar to other countries' health systems (prompted by the ACA and broader economic forces), it may be fruitful to consider how other countries and their systems have established, disseminated, and implemented patient-centered best practices in musculoskeletal care.

Inherently interdisciplinary and offered across multiple settings, musculoskeletal care has a long history of focusing on meaningful clinical outcomes, including measures of function and quality of life, that may be less commonly used in other arenas of health care.

Speakers noted that, in many ways, the field of musculoskeletal care is well positioned to lead the way in the new health care environment that is emerging from ACA reforms and other shifts in how health care is provided, measured, and reimbursed. Inherently interdisciplinary and offered across multiple settings, musculoskeletal care has a long history of focusing on meaningful clinical outcomes, including measures of function and quality of life, that may be less commonly used in other arenas of health care. In addition, there are opportunities in many musculoskeletal conditions to maximize current efforts and explore new venues for prevention and early intervention.

Cross-cutting Themes

Thriving in this new and still-evolving environment poses great challenges, some unique to musculoskeletal care. Although the field is inherently interdisciplinary, the high-functioning, interdisciplinary teams envisioned by Summit participants are currently far from a patient-centered standard of care. The configuration of actual teams across settings, how team members work together and share information, and — crucially — who is in charge of these teams remain unclear in many systems. This uncertainty can contribute to excessively fragmented care (especially for some conditions) that undermines the goals of providing patient-centered, cost-effective care and can make the outcomes sought by patients, care teams, and health systems elusive. In addition, the roles of primary care providers have not yet been defined or integrated within the musculoskeletal care team.

Defining a vision of coordinated musculoskeletal care and delineating the roles and functions of team members have many important implications. These include implications for the definition of patient-centered care, data and monitoring systems, research investments and priorities, professional education and training, assumption of financial risk, and advocacy — to name a few. Recommended actions for moving forward in these areas are considered below.

Recommendations for Action from Summit Speakers and Participants

The recommendations and next steps below were generated by Summit speakers and by participants, discussing the Summit’s key themes in both plenary and small group sessions. Although these suggestions were not formalized or prioritized during the Summit, they form a useful starting point for consideration by USBJI members and partners as they consider where to focus their efforts in the near future.

Many of the recommendations are cross-cutting, but they are grouped below in three areas corresponding to the main Summit themes: evaluating and measuring outcomes of patient-centered care, to build an evidence base for best practices (including establishing, dissemination, and implementing guidelines); defining and delivering patient-centered care; and future advancements in current best practices.

Recommendations for Action — Key Areas

- Research and data to build an evidence base for best practices and for establishing, disseminating, and implementing guidelines
- Identifying and delivering patient-centered care
- Current best practices and their implementation

Research and Data to Build an Evidence Base for Best Practices and for Establishing, Disseminating, and Implementing Guidelines

- **Make reviews of evidence more systematic.** One of the challenges in identifying best practices is that “systematic” reviews of evidence are not always as systematic as they could be. Better reporting of the common phenomenon of enrolled patients Lost to Follow-up (LTFU), clarifying Composite Endpoints (CEPs) to avoid being misleading, and a more skeptical stance toward subgroup analyses and reporting would be helpful in establishing evidence. In addition, evidence should be evaluated for possible differences according to sex/gender and/or race/ethnicity.
- **Guidelines and associated quality measures should move beyond their current focus on the process of care and test methods to better define patient outcomes and improve quality of care.** Measuring quality is the first step to improving care, but it is an imperfect science. To accelerate the adoption of clinical best practices, translating research into practice requires “globalizing the evidence, while localizing the decision,” and it is not easy.
- **Create an environment for best practices by developing and empowering good teams to identify, promote and create systems for patient-centered best practices.** Getting to best practices is labor-intensive and data-dependent, but yields to concerted effort — e.g., through consistent tackling of identified problems via Plan-Do-Study-Act (PDSA) cycles.

- **Explore evolving information technology systems and their uses to generate data that make a difference in the outcome for patients and quality improvement purposes (beyond billing).** Could Electronic Medical Record (EMR) vendors be approached about providing more useful data that can capture standardized data elements across multiple settings and EHR's in a seamless manner? The next level of outcomes data are needed to document what is being done right and where there are opportunities for improvement, with data coordinated across IT platforms.
- **Determine the best parameters for measuring and applying Patient Reported Outcomes (PROs).** How can PROs be applied to registries and quality data collection? What are the gains from assessing levels of health-related quality of life (HRQOL), fatigue, and participation, or patients attaining a Patient Acceptable State (PASS)?
- **Incorporate routine outcome measures in rehabilitation practice.** Evaluate promising interventions with carefully targeted endpoints.
- **Identify the most relevant cost metrics to document value — and use them.** The American Academy of Orthopaedic Surgeons (AAOS) “A Nation in Motion” advocacy campaign has used commissioned research from a team of health economists to document the net savings to society (not just payers) of keeping patients mobile and productive, with the analysis applied to a number of common, high-cost conditions and procedures.
 - Cost, benefit, and value data can be used to make a stronger case for investments in musculoskeletal care. For example, the value proposition is crucial to Accountable Care Organizations (ACOs), bundled payments, and other features of accountable care. Research funding devoted to musculoskeletal care is limited in comparison with the extent of the burden — and the imbalance will be exacerbated as the population ages. Payment/reimbursement systems do not yet reflect ideal standards of care; stronger evidence, guidelines, and outcomes are needed to educate insurers and payers. (Reimbursement codes tailored to encourage care coordination would be helpful as well.)
- **Assess and address the barriers to more comprehensive patient registries for musculoskeletal conditions.** Data from patient registries could inform and determine best practices, but are currently a very incomplete patchwork. USBJI could help in several ways: by developing policy language around Institutional Review Board (IRB) requirements for informed consent; by developing a thorough inventory of existing registries (documenting their purpose, conceptual taxonomy, quality of PROs) and then collating this information to identify gaps.

Developing common metrics — items all registries collect (possibly derived from an analysis of gaps) — would also be an important contribution.

- **Research efforts should prioritize patient engagement and implementable interventions.** Understanding levers for patient engagement and applying implementation science across settings will improve the quality of care and outcomes for all patients, but are particularly relevant for closing persistent health disparities gaps.

Identifying and Delivering Patient-centered Care

- **Patient-centered care should include families and/or caregivers as well.** Organizations can and should assess the degree to which they develop authentic partnerships with patients and families living with musculoskeletal concerns. To what degree are patients and families involved in developing care processes and systems of care across settings; quality improvement and patient safety initiatives; planning patient and family education and peer support programs; and educating staff, clinicians, trainees, students, and researchers?
- **Patient-centered care should achieve individual care and population health goals simultaneously.** For example, the practice of patient-centered care is integral to reducing disparities.
- **Patients and their families and/or caregivers can be educated to become better advocates for patients.** A patient outreach and advocacy training program under the auspices of USBJI would help empower and educate patients to be contributing members of their own care teams.
- **Patients and families/caregivers should be assisted in sifting through reams of Web-based information and advice — much of it inadequately vetted and evaluated, if at all.** USBJI could play a role by assessing existing information (e.g., Web sites and apps most frequently visited) and offering a USBJI “seal of approval.” Information on best practices geared to specific populations — such as children transitioning from pediatric to adult care or individuals with chronic illnesses — would be particularly useful.

Current Best Practices and their Future Advancement

- **Develop one or more models for team-based musculoskeletal care, based on settings where it is already occurring; evaluate the outcomes of these care teams; and develop clinical practice guidelines from the outcomes of this research.** At the Summit, several possible examples were described. Across these settings, common features associated with success include keeping programs simple, identifying and cultivating internal champions,

empowering and engaging primary care providers, robust data collection and monitoring, taking advantage of “teachable moments” with patients, communicating across teams and settings, and follow up care.

- A related tool to support interdisciplinary teams could be a template for how interdisciplinary workflow actually happens. What works in different environments? How do team members and groups integrate their work and collaborate?
- Challenges to convening effective interdisciplinary teams include identifying who is in charge of coordinating the multiple specialties that are involved and the lack of relevant training among all those who might interact with the patient. For example, although musculoskeletal care is typically interdisciplinary, long-term follow-up may be more successful if it is delegated to specific member(s) of the team. An example of this approach is the Fracture Liaison Service.¹
- **Professional education should incorporate team-based approaches:** Care coordination should become second nature as physicians, nurses, physical and occupational therapists, and others to develop their roles within the team.

Next Steps

The 2013 Summit provided a forum for speakers and participants to share and explore specific ideas about defining and implementing best practices in musculoskeletal care, understanding what patient-centered care looks like and how it could be measured, and identifying current best practices for musculoskeletal conditions.

Next steps for the USBJI include reviewing the above-mentioned best practices and then reaching out to the participating organizations to identify opportunities where the USBJI is best positioned to address these as an organization of organizations. These opportunities most likely will be in disseminating current guidelines, engaging the primary care community, encouraging the development of interdisciplinary professional education models, as well as addressing sex/gender and race/ethnicity disparities that may exist in musculoskeletal conditions. As with all USBJI efforts, engagement of the patient community and the public are crucial to success.

¹ For more information about Fracture Liaison Services, visit <http://www.capturethefracture.org/fracture-liaison-services>.