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Editorial

Specialist-Led Care in Hand Surgery: Matching Clinical Complexity to the Future of Care Delivery

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Hand surgeons today face increasing pressures that shape both daily clinical practice and the broader delivery of musculoskeletal care. Declining reimbursement, expanding administrative burden, and restricted access to certain treatment options intersect with the inherent complexity of hand pathology and the high volume of patients requiring timely, accurate diagnosis. Fragmented care pathways—particularly when patients enter

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Ms. Jacoby works closely with sponsors and management teams on platform formation, buy-and-build execution, governance structure, leadership alignment, and exit preparation. She is often engaged in situations involving rapid growth, recapitalization, founder transition, or operational underperformance, where clear board-level decision making and disciplined execution are required.

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Ms. Jacoby currently serves on advisory boards and industry committees and is a frequent speaker on private equity, middle-market governance, and scaling founder-led and physician-led organizations. She brings to the boardroom a practical, performance-oriented perspective with deep experience aligning investors, management, and operators to drive enterprise value.

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through urgent care or emergency departments—can lead to mis-triage, unnecessary imaging, and delayed treatment.

As orthopedic care continues migrating toward ambulatory surgery centers (ASCs) and office-based settings, the specialty must adopt models that enhance efficiency without compromising outcomes.

Specialist-Led Care, defined as early evaluation and triage by a subspecialty-trained surgeon supported by standardized pathways and multidisciplinary teams, offers a framework to enhance the overall patient experience while reducing overall waste to the system. When operationalized through the Longitudinal Patient Experience (LPE) model, Specialist-Led Care can streamline triage, reduce unnecessary imaging and emergency department utilization, and support safe expansion into lower-cost settings. This paper explores how these models may help hand surgeons deliver higher-value care while mitigating burnout and preserving the long-term health of the specialty.

INTRODUCTION: THE EVOLVING LANDSCAPE OF HAND SURGERY

Hand surgeons manage a wide spectrum of pathology—from fractures and tendon injuries to nerve compression, infection, and chronic degenerative conditions—often under time-sensitive circumstances. Upper-extremity injuries represent nearly one-fifth of all emergency department musculoskeletal visits, yet they are frequently misdiagnosed, with tendon injuries and deep-space infections commonly missed on initial evaluation (Ootes et al. 2012; Kennedy et al. 2016; Sanderson et al. 2020).

These clinical demands are compounded by rising administrative burden and increasing productivity expectations. Recent studies highlight worsening burnout among orthopedic surgeons, driven by documentation load, workflow inefficiencies, and expanding non-clinical demands (Lu et al. 2025; Kamal et al. 2016).

Simultaneously, the broader orthopedic environment is shifting. Elective procedures continue migrating toward lower-cost, higher-efficiency sites of service, including office-based procedure suites and ASCs (S. Sraj 2024; Knopp and Esmaeili 2024). This shift reflects both economic necessity and patient preference and requires surgeons to design care pathways that expand office-based procedures, reduce waste, streamline care, and preserve quality. Achieving this transition also depends on access to innovative products and therapies—many of which are restricted or delayed by hospital or practice-level barriers.

Within this context, Specialist-Led Care offers a compelling framework for addressing these challenges.

THE SHIFT IN HEALTHCARE: ITS EFFECT ON PATIENT CARE

For many patients with hand injuries, the care journey begins with delays, detours, and uncertainty. Increased administrative demands—documentation, prior authorizations, compliance tasks—reduce surgeon availability for timely appointments and contribute to longer wait times and fragmented communication (S. A. Sraj et al. 2021).

Patients frequently enter the system through non-specialist settings where diagnostic accuracy for hand conditions remains low. Missed fractures, tendon injuries, and infections are consistently associated with worse functional outcomes, higher complication rates, and more invasive treatment (Mounts et al., n.d.).

Imaging practices add further friction. Emergency departments often order MRIs for conditions diagnosable by physical exam, despite evidence of MRI overuse in hand and wrist evaluations (Ring et al. 2009). This leads to additional appointments, prolonged uncertainty, higher out-of-pocket costs, and delays in definitive guidance.

These challenges reflect broader systemic misalignment.

SYSTEM-LEVEL MISALIGNMENT: WHY THE CURRENT CARE DELIVERY SYSTEM STRUGGLES

Value-based care is often described as a unifying framework, yet in practice it exposes a fundamental misalignment of incentives across payers, hospital systems, physicians, and patients. Payers focus on reducing total cost of care, while hospitals remain dependent on volume-driven revenue models. Physicians are measured on outcomes but lack control over upstream and downstream decisions that drive both cost and quality. Patients navigate a complex system with limited transparency, often defaulting to high-cost or fragmented pathways.

These competing priorities create friction across the care continuum, perpetuating unnecessary utilization and variable outcomes. In contrast, a specialist-led model—particularly in musculoskeletal care—is uniquely positioned to align decision-making with evidence-based pathways, appropriate site-of-service selection, and longitudinal accountability.

THE UNIQUE POSITION OF HAND SURGEONS: CLINICAL BREADTH, PROCEDURAL VERSATILITY, AND MIGRATION READINESS

Hand surgery is uniquely suited for ASC and office-based care, a trend accelerated by the removal of procedures from the Medicare inpatient-only list and by technologies that enable safe care in lower-acuity settings. WALANT (wide-awake local anesthesia no tourniquet) demonstrates excellent safety, high patient satisfaction, and meaningful cost

savings, reinforcing the feasibility of shifting appropriate procedures out of the hospital (S. Sraj 2024).

We posit that Specialist-Led Care, supported by LPE workflows, provides the operational structure needed to accelerate this migration. Efficient triage, standardized protocols, and surgeon-led decision-making ensure appropriate site-of-service selection, reduce unnecessary anesthesia use, improve throughput, and maintain quality as care shifts to more efficient settings.

SPECIALIST-LED CARE: A FRAMEWORK FOR HAND SURGERY

Hand surgery is particularly well-suited for a Specialist-Led Care model due to the wide spectrum of conditions—acute injuries, nerve compression, tendon pathology, infections—that are frequently misdiagnosed or delayed when patients first enter through primary care, urgent care, or emergency departments. Surgeon-led triage within hospital-based pathways can improve diagnostic accuracy, reduce unnecessary imaging, and expedite definitive treatment.

Advances such as WALANT, minimally invasive techniques, and streamlined perioperative protocols further strengthen alignment with Specialist-Led Care by enabling high-quality surgical care in lower-acuity settings. This migration reduces cost while reinforcing continuity and coordination.

Importantly, Specialist-Led Care does not isolate the surgeon; it amplifies their impact. Advanced practice providers, therapists, pain specialists, and behavioral health professionals work within subspecialty-optimized pathways that preserve autonomy while distributing workload. Evidence from orthopedic value-based programs shows that surgeon-directed pathways improve outcomes, reduce variability, and optimize resource utilization (Rana and Bozic 2015; *Penn LDI Research Update*, n.d.).

Appropriate site-of-service selection is central to this model. Many common hand conditions—including trigger finger, carpal tunnel syndrome, and selected Dupuytren's contractures—can be safely managed in office-based or ASC settings, reserving hospital resources for complex pathology.

THE LONGITUDINAL PATIENT EXPERIENCE (LPE): OPERATIONALIZING THE MODEL

The LPE model provides the operational backbone for Specialist-Led Care by structuring the entire episode of care around predictable, surgeon-designed pathways. LPE organizes care through standardized workflows, optimized triage algorithms, and disease-specific clinics—such as arthritis, Dupuytren's, and nerve clinics—that streamline patient flow and reduce variability (Vector Medical Group 2023).

Digital patient education reinforces surgeon guidance, preparing patients before visits and improving adherence. APP-driven evaluation and follow-up extend surgeon reach, preserving capacity for complex decision-making while maintaining protocol-aligned postoperative care. Together, these elements create a cohesive system that reduces inefficiencies, improves throughput, and supports safe expansion into ASC and office-based settings.

CONCLUSION

Rising clinical complexity, increasing administrative burden, and continued migration of care into ambulatory and office-based settings underscore the need for more coordinated, clinically driven models of care delivery in hand surgery.

Specialist-Led Care, supported by structured LPE workflows, offers a framework for improving diagnostic accuracy, reducing unnecessary utilization, and aligning site-of-service decisions with patient needs and resource efficiency. By centering subspecialty expertise at the point of triage and reinforcing predictable, team-based pathways, this model may strengthen practice sustainability while enhancing the value of care delivered.

Future research should evaluate real-world impact across diverse environments, including effects on diagnostic accuracy, imaging utilization, emergency department diversion, site-of-service migration, patient-reported outcomes, and surgeon workload.

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