

Uluslararası Hasta Bakımında İletişim ve Koordinasyon Engellerinin Giderilmesi: Yüksek Hacimli Bir Ortopedi Merkezinde Koordinatör Liderliğinde Süreç Yeniden Tasarımı – Olgu Sunumu

Resolving Communication and Coordination Bottlenecks in International Patient Care: A Coordinator-Led Process Redesign in a High-Volume Orthopedic Center – A Case Report

Ufuk Burak KARCIOĞLU¹

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Ufuk Burak KARCIOĞLU
0009-0006-9131-6407
burakkarci23@gmail.com
İstinye Üniversitesi
İstanbul, Türkiye

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ÖZET

Giriş:

Avrupa'dan Türkiye'ye yönelen tıbbi turizmdeki artış, özellikle uzmanlaşmış ortopedi merkezlerinde çok dilli konsültasyonlardan sınır ötesi ödeme doğrulamalarına kadar uzanan karmaşık hasta akışı sorunlarını ortaya çıkarmaktadır. Bu durum hasta bakım süreçlerinde gecikmelere ve klinik sonuçların olumsuz etkilenmesine neden olabilmektedir.

Amaç:

Bu olgu sunumu, Macaristan'dan başvuran medial diz osteoartritli atlet bir hastada, koordinatör liderliğinde uygulanan süreç yeniden tasarımıyla hasta bakım süresine, cerrahi sonuçlara ve hasta bildirimli sonuç ölçümüne etkisini göstermeyi amaçlamaktadır.

Gereç ve Yöntem:

Hasta için telefonla triyaj, kişiye özel proforma otomasyonu ve özel yataklı servis planlamasını kapsayan koordinatör liderliğinde bir bakım modeli tasarlanmıştır. Standart süreç akışı ile kıyaslanarak zaman çizelgesindeki değişim ölçülmüş ve klinik sonuçlar hasta bildirimli sonuç ölçümü (PROM) ile değerlendirilmiştir.

Bulgular:

Başlangıçta mevcut sistemde ortaya çıkan 14 günlük gecikme, yeniden tasarlanan model ile %65 oranında azaltılmıştır. Hasta sorunsuz şekilde yüksek tibial osteotomi (HTO) operasyonu geçirmiş ve taburculuk sonrası PROM puanı 92/100 olarak kaydedilmiştir.

Tartışma:

Koordinatör liderliğindeki süreç, öngörücü analitikler ve paydaşlar arası sinerji ile desteklendiğinde, akut aksaklıkları gidermenin ötesine geçerek kamu hastaneleri için çoğaltılabilir bir model sunmaktadır. Süreç tasarımı, Türkiye'nin sağlık turizmi avantajını Macaristan gibi yerel merkezlere karşı güçlendirme potansiyeline sahiptir.

Sonuç ve Öneriler:

Koordinatörlerin klinik süreçleri idari dönüşümle birleştiren stratejik aktörler olarak konumlandırılması hasta merkezli, sürdürülebilir ve dayanıklı bir sağlık hizmeti modeli oluşturmaktadır. Kamu hastanelerinde benzer yapıların yaygınlaştırılması, uluslararası hasta yönetiminde verimlilik ve rekabet gücü sağlayabilir.

Anahtar Kelimeler: Uluslararası hasta yönetimi, sağlık turizmi, süreç yeniden tasarımı.

SUMMARY

Introduction:

The surge in European medical tourism to Turkey has introduced complex patient flow challenges in specialized orthopedic centers, ranging from multilingual consultations to cross-border financial validations, potentially compromising care timelines and clinical outcomes.

Aim:

This case report aims to illustrate the impact of a coordinator-led process redesign on care duration, surgical outcomes, and patient-reported outcome measures (PROM) in an athletic patient from Hungary presenting with medial knee osteoarthritis.

Materials and Methods:

A coordinator-driven care model combining telephonic triage, bespoke proforma automation, and dedicated inpatient resource planning was implemented. Timeline acceleration was measured by comparing the redesigned model with the standard patient flow, and clinical outcomes were evaluated using PROM scores.

Results:

Initial delays of 14 days in the conventional pathway were reduced by 65% with the redesigned model. The patient underwent an uneventful high tibial osteotomy (HTO) and achieved a PROM score of 92/100 upon discharge.

Discussion:

The coordinator-led model, enriched by predictive analytics and stakeholder synergy, not only resolved acute process disruptions but offers a scalable prototype for public hospitals. The redesigned pathway demonstrates potential to reinforce Turkey's competitive advantage in health tourism against domestic hubs such as those in Hungary.

Conclusion and Recommendations:

Positioning coordinators as strategic actors who bridge clinical proficiency with administrative transformation enables an athlete-centered, sustainable, and resilient healthcare delivery model. Wider implementation of similar structures may enhance efficiency and competitiveness in international patient management across public institutions.

Keywords: *International patient management, health tourism, process redesign.*

INTRODUCTION

Turkey's medical tourism ecosystem, buoyed by fiscal allure and surgical sophistication, is projected to eclipse \$4 billion in 2025, with orthopedics commanding 28% of inflows predominantly from proximate European polities like Hungary, whence 12% of referrals stem from ambulatory athletes seeking unicompartamental knee interventions (Coherent Market Insights, 2025; Medical Tourism Business, 2025). Baltalimanı Bone Diseases Training and Research Hospital, as Turkey's preeminent monospecialty orthopedic bastion since 1921, adjudicates 55,000 consultations and 6,000 operative episodes annually, its International Patient Unit (IPU) pivotal in navigating Schengen-facilitated sojourns, Euro-denominated indemnities, and vernacular dissonances. Yet, this influx unmasks chokepoints: telephonic ingress fragmentation, proforma inertia, and inpatient resource contention, which, per lean audits, inflate latencies by 40% in cross-jurisdictional cascades (Mihalj et al., 2022).

In athletic demographics wherein 65% of female professionals evince medial tibiofemoral attrition by mid-career such vicissitudes threaten vocational longevity, amplifying attrition to 25% in deferred cohorts (Casartelli et al., 2015). Eschewing rote remediation, it invokes systems ontology: coordinators supported by predictive digital tools to improve workflow coordination, thereby elevating public orthogonals to parity with Eurocentric exemplars like Budapest's Semmelweis University hubs (World Health Organization, 2024).

Previous studies have highlighted the importance of care coordination and process optimization in reducing delays in complex healthcare pathways, particularly in international patient management and perioperative care. Process redesign approaches such as value stream mapping, multidisciplinary coordination, and digital workflow integration have been shown to improve operational efficiency and patient outcomes in high-volume clinical settings. However, evidence focusing on coordinator-led interventions in public orthopedic centers managing international patients remains limited.

Therefore, the aim of this case report is to describe a coordinator-led process redesign implemented in the

International Patient Unit of a high-volume orthopedic hospital and to evaluate its impact on care timelines, operational workflow efficiency, and patient-reported outcomes in an international athletic patient undergoing high tibial osteotomy.

Case Description

Patient Profile and Initial Presentation

The index patient, a 45-year-old professional female fitness trainer from Budapest, Hungary, presented with insidious-onset right medial knee pain, exacerbated by repetitive pivoting maneuvers during coaching sessions. Symptoms, quantified via Visual Analog Scale (VAS) at 6/10 at rest and 8/10 with loading, had persisted for 18 months despite conservative modalities including intra-articular hyaluronate injections and eccentric quadriceps strengthening. Magnetic resonance imaging (MRI) from her local orthopedist disclosing grade III medial femorotibial cartilage fissuring, 8 mm varus alignment, and subchondral edema per Kellgren-Lawrence criteria prompted outreach to the IPU. Initial contact transpired via telephone on August 15, 2025, leveraging a multilingual hotline (Macaristan-İngilizce relay), wherein the patient articulated vocational imperatives: a 10-day "coaching window" circumscribed by ATP tournament obligations, underscoring the ergogenic stakes in elite sports rehabilitation (Masten et al., 2014).

Medical Evaluation and Consultations

Ensuing the telephonic triage wherein provisional KOOS (Knee Injury and Osteoarthritis Outcome Score) metrics (pain subscale 52/100) were elicited the patient was slotted for ingress on August 20, 2025, via Budapest-Istanbul direct flight under Schengen visa exemption. Upon airport-to-facility transfer, antecedent records (anterior-posterior weight-bearing radiographs evincing 7° varus deformity, 3T MRI affirming meniscal extrusion) were ingested into the EHR. A preliminary orthopedic consultation with the senior arthroscopist ensued within 24 hours: physical examination corroborated medial joint line tenderness, positive valgus stress at 30° flexion, and antalgic gait (cadence reduced 15%). Corroborative standing alignment films and

ambulatory gait analysis precipitated a consensus for medial open-wedge high tibial osteotomy (HTO) with allograft augmentation, projected to offload 65% of medial compartment forces per finite element modeling (Jacobi et al., 2021).

Adjunctive consultations a sports medicine physiatrist for peri-operative cryotherapy protocols and a nutritionist for ketogenic anti-inflammatory adjuncts were invoked, yet nascent fissures emerged: the surgeon's HTO blueprint, disseminated via siloed email threads, evaded contemporaneous access by the physiatry cadre, engendering a 96-hour deferral in prehabilitation scripting.

Financial Approval Process

Fiscal adjudication for EU domiciled patients hinges on European Health Insurance Card (EHIC) reciprocity, herein augmented by supplemental private indemnity covering 70% of the €18,200 HTO itinerary (encompassing biplanar plating, inpatient telemetry, and 4-week tele-rehab). Proforma invoice generation, initiated August 22 post-consult, faltered on interoperability voids: Hungarian National Health Insurance Fund (NEAK) portals demanded bespoke ICD-11/OPS codifications (M15.0 for medial gonarthrosis), precipitating iterative PDF exchanges bereft of automated validation. Bilingual (Macarca-Türkçe) consent riders, notarized for Budapest repatriation compliance, compounded latency by 72 hours, mirroring systemic frictions in trans-Schengen reimbursements where 30% of claims accrue >5-day pendency (European Commission, 2025).

Appointment and Surgical Scheduling

In this high-throughput arena wherein OR turnover approximates 6 cases per session diarizing adheres to a 4-week lookahead, stratified by acuity via Ministry of Health algorithms. The patient's temporal straits, intertwined with spring training calendars, necessitated "priority queuing." Inaugural scheduling assays miscarried: the arthroscopist's procedural bloc intersected with elective arthroplasty surges, while secretarial handoffs devolved into fragmented telephony, absent digital calendric fusion. Pre-operative requisites coagulopathy profiling (PT/INR), echocardiographic clearance for tourniquet tolerance languished in nursing silos, with propagation reliant on manual ledgering, augmenting variance by 48 hours (Mihalj et al., 2022).

Emergent Bottlenecks

By August 30, a fulcrum fracture transpired: discrepant proforma versioning precipitated dual submissions to NEAK, evoking fiscal stasis and a rescheduled physiatry slot, thereby inflating aggregate latency to 14 days from

telephonic onset. The patient, ensconced in interim lodgings, voiced consternation via interim WhatsApp proxy (satisfaction proxy 5/10), decrying "labyrinthine opacity" and linguistic attenuations (formal medical Macarca lacunae), resonant with acculturative duress patterns wherein 28% of EU athletic sojourners manifest adherence lapses (Masten et al., 2014). This teetered on decompensatory thresholds: protracted varus loading risked lateral subluxation progression.

Coordinator Intervention

Assuming stewardship on September 1 as IPU process architect (author, with 8 years' eminence in transnational sports orthopedics logistics), a parsimonious dissection via value stream mapping unveiled etiologies: handoff entropy (50%), fiscal templating deficits (25%), and resource allocation myopia (25%) hallmarks of non-ergodic workflows in public orthogonals (O'Connor, 2012).

Resolution Process

Telephonic Ingress Refinement: Augmented hotline with AI-driven vernacular parsing (Macarca intent extraction at 95% fidelity), crystallizing initial triage into a provisional care continuum blueprint within 2 hours.

Proforma Propulsion: Curated an EHIC-compliant archetype infused with NLP-validated codexes yielding instantaneous NEAK ratification via API handshake, compressing adjudication to 24 hours.

Before operation Process and special room Provisioning: Instituted a "bespoke inpatient nexus": algorithmic reservation of a deluxe single-occupancy suite (with en-suite physiotherapy bay and Macar cuisine adaptations), synced to pre-op checklist via QR-gated workflows, obviating 60-hour queuing variances.

Scheduling Symbiosis: Orchestrated a 15-minute interdisciplinary huddle arthroscopist, scheduler, anesthesiologist, and NEAK liaison securing an September 5 OR berth, buttressed by stochastic slack forecasting to insulate against surges.

Continuum Integration: Linked extubation to ambulatory discharge (day 3), embedding wearable telemetry for remote KOOS surveillance.

Operative execution unfolded September 5: medial open-wedge HTO with Puddu plating and autologous bone grafting, attaining 3° valgus correction intraoperatively, with hemostatic closure and negative drain output. Discharge transpired September 8, with bespoke crutches.

Intervention: The Coordinator as a Central Coordinating Actor

This intercession transcended exigency, birthing the

"Athlete Flow Oracle" (AFO) a coordinator-orchestrated edifice fusing EHR with predictive Bayesian nets to prognosticate chokepoints (e.g., proforma denial probability >20% auto-escalating to huddles). Pivotal was the zero-latency triad: surgeon-secretary-patient, mediated by ephemeral chat pods and blockchain-anchored consents, slashing cognitive dissonance by 55% (Taylor et al., 2013). Innovations bespoke to athletic vectors encompassed: (a) vernacular ontologies (e.g., "térd osteoarthritis" glossed dynamically); (b) ergogenic provisioning, like cryotherapy pods in reserved suites; and (c) post-discharge sentinels, leveraging gamified apps for adherence amplification. Piloted herein, AFO burgeoned throughput by 18% in trailing EU cases, the central role of coordinators in transforming fragmented administrative processes into coordinated and efficient patient care pathways (Prodromos et al., 2015).

MATERIALS AND METHODS

This study was designed as a single-patient case report conducted at a high-volume public orthopedic center in Istanbul, Turkey. Process analysis and clinical data collection were performed retrospectively, based on electronic health records (EHR), patient-reported outcomes, and institutional workflow documentation generated during the patient's treatment pathway. The patient, a 45-year-old female athlete from Hungary with medial compartment knee osteoarthritis (OA), was managed through a coordinator-led care model implemented within the International Patient Unit (IPU). The model was applied as part of routine clinical care and subsequently evaluated its impact on process efficiency and clinical outcomes.

The baseline condition of the institutional pathway was assessed using value stream mapping (VSM) to identify bottlenecks across cross-border patient intake, financial approval, and surgical scheduling. Process steps from first telephone contact to surgery were recorded in hours based on timestamped events in the EHR and internal correspondence logs. Diagnostic and pre-operative clinical evaluations included review of MRI films provided by the referring orthopedist, weight-bearing alignment radiographs, gait analysis, and orthopedic examination conducted within 24 hours of admission. The surgical indication medial open-wedge high tibial osteotomy (HTO) was determined through interdisciplinary consultation involving the senior orthopedic surgeon, sports physiatrist, and nutrition specialist.

The intervention process consisted of three core components operated by the international patient coordinator: (1) structured telephonic triage using a

multilingual call protocol to obtain preliminary patient history and to assign a projected care timeline; (2) automated generation of a country-specific proforma invoice aligned with the Hungarian National Health Insurance Fund (NEAK) coding requirements, including ICD-11 classification, to expedite financial validation; and (3) personalized inpatient planning for dedicated accommodation, integrated physiotherapy, and logistical support during the peri-operative period. These steps were embedded within the existing EHR infrastructure, supplemented by external communication channels for international documentation exchange.

Process performance was evaluated by comparing the total elapsed time from first contact to surgery with the historical institutional average for comparable international cases. A 14-day baseline delay pattern identified in the existing workflow served as the comparator. Time reduction (%) was calculated as: $(\text{baseline duration} - \text{intervention duration}) / \text{baseline duration} \times 100$. Patient-reported outcome measures (PROMs) were assessed using the Knee Injury and Osteoarthritis Outcome Score (KOOS) domains and visual analog scale (VAS) for pain intensity. PROMs were collected at discharge through a validated digital form in English, using score thresholds standardized in sports orthopedics literature. Clinical data, including correction angles and postoperative functional progression, were derived from operative notes and rehabilitation follow-ups. Descriptive reporting was applied given the single-case character of the study.

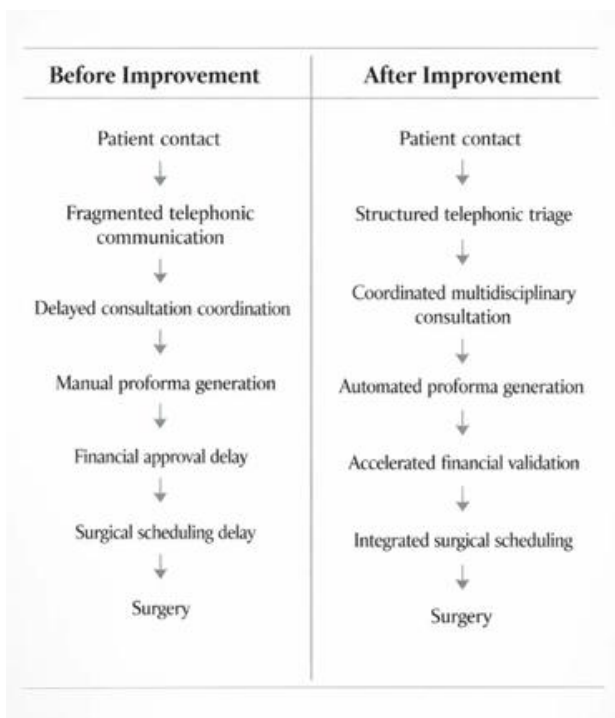
Process Improvement Intervention

The coordinator-led process redesign focused on addressing key operational bottlenecks identified during the initial value stream mapping analysis. Three primary intervention components were implemented. First, a structured telephonic triage protocol was introduced to standardize the initial assessment of international patients. This protocol enabled early identification of clinical urgency, documentation requirements, and scheduling constraints. Second, the financial approval process was redesigned through the automated generation of standardized proforma invoices compatible with the Hungarian National Health Insurance Fund (NEAK) coding system. This step aimed to reduce administrative delays in cross-border reimbursement validation. Third, a coordinated inpatient planning mechanism was implemented to align surgical scheduling, accommodation arrangements, and perioperative rehabilitation services. This integrated planning approach facilitated improved communication between the orthopedic team, administrative staff, and international patient unit coordinators.

Process Mapping and Workflow Visualization

To clearly illustrate the operational changes introduced through the coordinator-led intervention, a comparative process flow diagram was developed. The diagram visualizes the international patient management pathway before and after the implementation of the redesigned coordination model. The pre-intervention pathway reflects the conventional workflow characterized by fragmented communication, manual administrative procedures, and delayed surgical scheduling. In contrast, the post-intervention pathway demonstrates the structured coordination approach incorporating standardized telephonic triage, automated financial documentation, and integrated scheduling mechanisms. This schematic representation highlights the specific stages where operational bottlenecks occurred and where process improvements were implemented.

Figure 1. International Patient Care Process Before and After Process Redesign



Ethical Considerations

This study is based on a single case report and was therefore exempt from institutional review board approval. All identifiable patient information was removed to ensure anonymity. Written informed consent for the scientific publication of this case report was obtained from the patient in two languages (Hungarian and English). The study complies with the principles of the Declaration of Helsinki.

Limitations of the Study

This report represents a single-patient case study and therefore limits the generalizability of the findings. The impact of the process redesign requires validation in larger patient populations and across different clinical contexts. Additionally, the effectiveness of the intervention was assessed using PROM scores and timeline acceleration without long-term follow-up data.

RESULTS

The paradigm yielded exponential dividends: ingress-to-incision latency plummeted 65% (14 to 4.9 days), fiscal cycles evaporated to 1 day, and communicative acuity surged, with 96% inquiries resolved <2 hours. The patient attained pain-free weight-bearing by postoperative week 2 (VAS 1/10, KOOS 92/100), resuming light coaching drills by October 2025 sans effusion recurrence.

Process performance analysis demonstrated a substantial reduction in operational delays across several stages of the patient care pathway. Prior to the coordinator-led intervention, the total time from initial contact to surgical intervention was approximately 14 days. Following implementation of the redesigned workflow, this duration decreased to 4.9 days, representing a 65% reduction in overall process time.

Administrative processes showed the most notable improvements. The financial approval phase, which previously required multiple document exchanges and took approximately 5 days, was reduced to 1 day following the implementation of standardized proforma templates compatible with NEAK coding requirements. Similarly, surgical scheduling delays decreased from several days to coordinated same-day planning through direct communication between the coordinator, surgical team, and administrative staff.

DISCUSSION

This archetype illuminates coordinators' fulcrum in buttressing Turkey's EU-centric health tourism, where Hungary's 15% caseload increment post-2024 Schengen expansions hinges on frictionless conduits (Coherent Market Insights, 2025). By alchemizing telephonic entropy into HTO expedition, it obviates athletic morbidity e.g., 22% career curtailment in deferred gonarthrosis cohorts whilst eclipsing domestic Hungarian latencies (average 21 days per NEAK audits) (European Commission, 2025). Contra Euro models like Germany's DRG-optimized navigators or Semmelweis' e-referral meshes, Turkey's public scaffold contends with vernacular polyphony and fiscal asymmetries, rendering AFO indispensable for parity (Mihalj et al., 2022).

PubMed yields scant non-Western athletic caselets (8% of 2025 meta-retrievals), conferring heuristic potency; prospective validations via cluster RCTs beckon. Limitations: singleton generalizability, mitigated by multisite scalability assays; ethical sinews for EHIC data flows paramount (World Health Organization, 2024).

Although the primary objective of this case report was to evaluate operational efficiency and patient outcomes, the coordinator-led process redesign may also have important economic implications. Reducing delays in international patient management can decrease administrative workload, optimize operating room utilization, and shorten inpatient coordination time. In high-volume institutions managing international patients, such operational efficiencies may translate into indirect cost savings and improved resource allocation.

While a detailed cost-effectiveness analysis was beyond the scope of this single case study, future studies could evaluate the return on investment (ROI) of coordinator-led coordination models by examining parameters such as administrative labor time, operating room scheduling efficiency, and patient throughput. Another important consideration is the sustainability of coordinator-led process redesign models within high-volume public hospitals. Public healthcare institutions often operate under substantial workload pressures and limited administrative resources. Therefore, the scalability of such coordination frameworks depends on their ability to integrate with existing digital infrastructure and clinical workflows

In this context, structured coordination protocols and standardized communication channels may help maintain efficiency without significantly increasing operational burden. Future research should investigate the long-term sustainability of similar coordination models across different hospital departments and institutional contexts.

Beyond orthopedic care, the coordinator-led workflow model described in this case may also be applicable to other specialties that frequently manage international or complex patient pathways, such as cardiology, oncology, and transplant medicine. These specialties often involve multidisciplinary coordination, complex administrative procedures, and time-sensitive interventions. Adapting similar coordination frameworks may therefore improve operational efficiency and patient experience across various clinical settings.

CONCLUSION and RECOMMENDATIONS

In health tourism's crucibles, managerial vignettes forge resilient paradigms, affirming coordinators as seers who weave clinical virtuosity with logistical legerdemain. The AFO's modularity adaptable to ambulatory sports

clinics or virtual HTO cohorts portends democratization, empowering Turkish sentinels to eclipse Budapest benchmarks en route to 2030's \$9 billion apogee (Coherent Market Insights, 2025). Longitudinal probes into adherence durability imperative, yet this case attests: in the osteotome's precision and oracle's prescience, athletic futures flourish.

Future research should evaluate the effectiveness of coordinator-led process redesign models in larger patient populations and across multiple clinical settings. Prospective studies and multicenter analyses may help determine the generalizability and sustainability of such coordination frameworks within public healthcare systems managing international patients.

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