CONFERENCE ABSTRACT

Integrated care pathways for low back pain (LBP) from primary to specialised care: a systematic review.
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Introduction: LBP is a leading cause of disability and exerts a considerable burden on healthcare systems. Management is frequently inconsistent with clinical guidelines, which advocate a demedicalised approach in primary care settings for most patients, with easy access to specialised care when necessary. Integrated care pathways have potential to enhance care quality and cost-effectiveness through bridging the evidence-practice gap and optimising resource use. Care integration across the primary-secondary care continuum aims to address care fragmentation, reduce duplication, improve clinical outcomes and enhance cost-effectiveness. This review aimed to synthesise the evidence for integrated care pathways for LBP from primary to specialised care.

Methods: This review was reported in accordance with Preferred Reporting Information for Systematic reviews and Meta-Analyses (PRISMA) guidelines. Electronic database searches (CINAHL, MEDLINE, Cochrane Library, EMBASE) were conducted (2006 onwards) with further manual and citation searching. Search results were exported to Covidence (systematic review software). Two independent reviewers conducted eligibility assessment and data extraction, as well as quality appraisal using the Effective Public Health Practice Project (EPHPP) Quality Assessment Tool for Quantitative Studies or the Critical Appraisal Skills Programme (CASP) qualitative studies checklist. A narrative synthesis of findings is presented.

Results: From 18,443 identified studies, 28 papers met inclusion criteria. LBP pathways were reported from high-income countries, primarily to address over-burdened secondary care services with long wait-times for consultant appointments. Pathways almost universally re-organised care using non-consultant interface services to manage the primary-secondary care boundary by triaging patients for surgical opinion or conservative management. Interface services aim to optimise use of the multidisciplinary workforce to ensure judicious use of surgical clinics. Accordingly, evaluation of healthcare resource use and patient flow predominated, with reports of enhanced service efficiency through decreased wait-times and appropriate use of consultant appointments. Interface services were evenly represented across community and hospital settings. Using a model that conceptualises care integration on a five-level continuum, the included pathways demonstrated the two most basic levels of integration, ‘full segregation’ or ‘linkage’. Low quality study designs, heterogenous outcomes and insufficient comparative data precluded definitive conclusions regarding clinical and cost-effectiveness of pathways.

Conclusions: Interface services, delivered by non-consultant multidisciplinary team members, to ensure appropriate referrals to specialised care dominated the LBP integrated care pathway
literature with enhanced efficiency of care delivery reported. Pathways demonstrated the most basic levels of care integration, ‘full segregation’ and ‘linkage’, across traditional healthcare boundaries.

Implications: Further exploration of the potential of care pathways as a model for the delivery of integrated, cost-effective, person-centred, guideline-concordant care which improves clinical outcomes for patients with LBP is required, with patient involvement in integrated care pathway development.