

**164: SHARED CARE FOR PATIENTS WITH A LUMBOSACRAL RADICULAR SYNDROME AT ST ANNA HOSPITAL**

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**Objectives:**

Redesign of the care process in primary and secondary care for patients with a lumbosacral radicular syndrome (LSRS), in order to avoid unnecessary referrals and magnetic resonance imaging.

**Methods:**

The project contains several phases. In the first part of the project a description of the care process in the hospital was made with ABC Flowcharter, followed by analysis and redesign of the care process. In the second phase the care processes in primary care were linked to the processes in hospital. A trade off was made between the medical specialists (neurologists, orthopaedic surgeons and radiologists) in the St Anna hospital and the general practitioners in the region. The hospital should redesign its care process and reduce the waiting time to three weeks only. General practitioners should adhere to the national guideline on LSRS, which advises to keep up with conservative treatment during the first six weeks. To obtain more insight in barriers that care providers might experience in practice following the guidelines, focus group interviews were held with GPs and physiotherapists. Additionally, an implementation strategy addressing the barriers was developed. At present the project is in this third phase: the actual implementation of the guidelines. Evaluation of the implementation process and hard endpoints (referrals and waiting time before operation) by a prospective recording study is carried out.

**Results:**

The careful analysis of the care process in the hospital revealed three important barriers for good continuity of care 1. The appointment gap for a consultation with the neurologist was too long (8 weeks) 2. The proportion of referred patients to the neurologist that cannot be treated in hospital is too high (25%) 3. The appointment gap to the MRI was too long (5 weeks). The result of these barriers was an average waiting time for an operation of three months and a tendency to refer more patients in an earlier stage.

During the second phase the focus group interviews revealed that physiotherapists play an important role in the chain of care. Physiotherapist are not used to keeping up with conservative treatment in these patients and thus overriding the GP's policy by e.g. advising the referral or magnetic resonance imaging. A third protocol describing in detail the care-flow in primary care and the distribution of tasks between GP and physiotherapists and the information that should be given to the patient was developed. The implementation strategy comprises a Kick off meeting with all physiotherapists in the region; implementation visits to all GP groups in the region, an information campaign to the public and feedback meetings with GPs.

**Conclusions:**

Careful analysis of the care process and an inventory of barriers to the implementation of practice guidelines are essential in redesigning care processes in care chains with many care disciplines. The patient factor should not be overlooked.