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CONFERENCE ABSTRACT

Scaling up case management strategies. The PAMI program

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Introduction: The PAMI program is a multipronged management strategy for the complex patients. During the last decade, it has been implemented from a pilot scale to more than 8000 people of the San Sebastian area. The program warrants intense follow up with clinical visits interspersed with telephone calls using specific questionnaires and activates prescription changes, early appointments or even direct hospital admissions when needed. It involves tight coordination of a case management nurse, GP and a referral internist. Since it was implemented significant reductions have been achieved in ED visits and days spent at the hospital, making the health system friendlier to patients of complex needs.

Description of practice change implemented: Scaling up of a multipronged management strategy for patients of complex needs

Aim: Improving quality of life and perceived quality of health assistance

Training patients and healthcare providers

Reducing length of stay and Emergency Department (ED) visits

Respecting patients' will on intensity of treatment and place of care provision

Target population:

- Multi-pathological patients with high readmission rates (mainly heart failure and COPD)

- Home-dependent patients

- Nursing home residents

- End of life patients

Timeline:

2005: Prediction rule development and validation for readmission risk

2006: Before and after study with a multipronged strategy (PAMI) targeting patients with high readmission rates.

2010: Comparative study of telemedicine vs PAMI

2010: Cluster randomized clinical trial of PAMI in nursing homes

2014: Implementation of the program in the primary care

2017: Complementary support of a call center

Highlights:

- Case management of complex patients with process-specific questionnaires

- Successful extension of the program to more than 8000 complex patients

- 30-50% of direct admissions (avoiding ED visit).

- Days spent at the hospital reduction by 25% for nursing home residents, 55% for home-dependents, 58% for heart failure patients, and 25% for patients with COPD

-ED visits made by each group was also reduced by 58%, 70%, 70% and 45% respectively.

-Complementary patient management trough call center further improving outcomes.

-80-100% found training satisfactory

-90-100% rated the hospital accessibility "excellent"

-90-100% perceived significant improvements in the global management of the process.

Sustainability: Huge reduction in EDs visits and days spent at the hospital likely to improve cost-effectiveness

Transferability: The technology and protocols are available to all in the Basque Country. Geographical differences exist in hospital accessibility.

Conclusions: This strategy improved perceived quality of life and length of stay while avoiding many ED visits. The main achievement is the scaling up of such a program from a pilot study to a population of 8000 complex patients.

Discussion: Case management strategies can be successfully scaled up if integration tools are available. The scaled up version of PAMI had a slight loss of effectiveness compared to the pilot, but this has been overcame adding call center support in the follow up.

Lessons learned: Anticipation of problems, new technologies and integrated assistance focused on the user will be the keys of the future care.

Keywords: scale up; case management; multi pathological