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CONFERENCE ABSTRACT

The CreG (Chronic Related Group) model to prompt integrated chronic care management: the experience of Lombardy Region

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Nearly one-third of the population live with some chronic conditions in Lombardy (3.5 millions out of more than 10 million residents), while expenditure on chronic diseases in the region accounts for about 75% of the of the Region's overall health care spending. In order to improve chronic care management through a population-based approach, in 2011 the Region launched a new model for chronic care, named CReG (Chronic Related Groups), starting with five Local Health Authorities (LHAs) as piloting settings, built on a health-based risk-adjusted capitated payment system, and on the provision of integrated and personalised care pathways (PCP).

The paper presents the most significant achievements of the CReG model, and highlights the main methodological and organisational challenges, in comparison with similar experience at international level.

The CReG clinical-risk adjustment model is built on three fundamental steps: classification of diseases, a grouping system, and a tariff rate estimation and validation model. Chronic patients to be enrolled in the pilot study were identified through disease-specific algorithms combining data on inpatient diagnosis/procedures (ICD-9-CM), outpatient drug delivery and services, systematically collected by the regional administrative databases (the BDA or 'Banca Dati Assistito'). All diagnoses were ranked based on the overall associated costs to the Regional Healthcare Service (RHS). The hierarchical grouping system (CReG grouper) relied on this ranking, providing a classification of the regional population into clinically-homogeneous categories (approximately 200), each corresponding to mono- or polypathologic conditions, according to a decreasing order of disease severity and costs. A prospective payment system was set up for each CReG Category, to provide an overall bundle tariff accounting for a one-year period of care (including pharmacy and outpatient services). The pilot programme has been managed in the Primary Care setting, through GP-cooperatives (CReG Manager) with several tools supporting care planning activities and the actual implementation of integrated clinical pathways (ICPs), based on prospective and flexible Personalized Care Plans (PCP), in particular:

- Evidence-Based Clinical Pathways (EBCPs),

- the so-called 'Expected Healthcare Service List' (EHSL), statistically estimated on the basis of 1-year historical consumptions,

- an IT system developed ad-hoc,

- a Care Management Service (CMS), set up by the GP-Cooperatives to support the implementation of PCPs, and ensure patients' compliance and adherence to care plans.

The paper discusses the results of a prospective matched-cohort study, based on patients registered with 484 participating GPs, used as the base-line 'CReG cohort', and a control sample of patients registered with GPs from the same 5 LHAs, but not managed according to the CReG protocol. More than 60.000 patients were enrolled and followed up for three years (2010-2013). Preliminary study results suggest the effectiveness of the CReG model on reducing hospitalization rates and risk of admissions to emergency departments, even though a longer observational period is needed to draw conclusions about the impact of CReG on quality and overall costs of care.

The paper provides insights on the regional strategy to set up the CReG model and to handle the change management process, with the adoption of a new payment system. The CReG model has been fully developed internally, relying on a consolidated regional information system, which allows record linkage at individual level of administrative data on healthcare services and users' consumptions data, taking into account both mono- and polypathological conditions. The historical amount of available data sustained the set-up of a robust and promising model for clinical risk adjustment at the individual level.

The CReG Prospective Payment System indeed was introduced as a mean to overcome service delivery fragmentation and to promote better care coordination across the whole care pathway. While the proposed care delivery innovations were properly accomplished by GPs Cooperatives, with the assistance of Care Management Services, some conflicts arose during the contract management process between the GPs Cooperatives and the LHAs.

Finally, the paper discusses the current challenges for future developments of the CReG-model in Primary Care, and also for exporting the CReG experience on prospective payment systems to other chronic care settings, in the context of current trends due to a Regional healthcare reform Act, issued in August 2015.

Keywords: creg; chronic related group; bundle payments; personalised care pathway; chronic care management; population health management