

Smart choices. Powerful tools.

The Vermont Blueprint for Health is a new collaborative approach to improving health and health care for people living with life-long illnesses such as diabetes, asthma and cardiovascular disease.

This approach involves major changes in the health care system based around the needs of patients. Information systems, effective patient self-management tools and community supports are examples of changes being developed as part of this effort.

Background:

According to a 2004 RAND Report, more than 50 percent of individuals with diabetes, hypertension, tobacco addiction, congestive heart failure, asthma, depression or hyperlipidemia, do not receive all the care they need. Inadequate care has an adverse impact on the health care system, health care costs, and the quality of life for individuals with or at risk for chronic diseases.

Chronic conditions are the leading cause of illness, disability and death

- 51% of all Vermont adults have one or more lifelong health conditions that likely require ongoing medical care
- 88% of Vermonters over age 65 report one or more chronic conditions
- about 25% of people with chronic conditions have limitations which restrict normal activities

Chronic conditions are the primary reason people receive health care

- 83% of national health care spending is for people with chronic conditions
- 81% of hospital admissions are for people with chronic conditions
- 76% of physician visits are for people with chronic conditions
- 91% of pharmacy expenses are for individuals with chronic conditions

Overall Health Care Costs

- Total health care spending for Vermont residents totaled \$2.8 billion in 2002
- Vermont health care expenditures grew an average of 10.8% annually from 1998 to 2002 (a per capita expense of \$4,536)
- Vermont Medicaid program spending increased an average of 13.9% each year from 1998-2002

Blueprint Vision:

Vermont will have a comprehensive, proactive system of care that improves the quality of life for people with or at risk for chronic conditions.

- The Blueprint will utilize the Chronic Care Model as the framework for the required system changes.
- The Blueprint will utilize a public-private partnership to facilitate and assure sustainability of the new system of care.
- The Blueprint will coordinate with other statewide initiatives to assure alignment of health care reform efforts.

The Vermont Blueprint for Health partners represent health care providers, businesses, consumers, health plans, community and non-profit groups, and government including over 100 active members on various committees and workgroups.

The Chronic Care Model, a national model for collaborative care and quality improvement, includes an active role for individuals, communities, the health care and public health systems, and provider practices.

Blueprint Objectives:

Self Management: *Vermonters with chronic conditions will be effective managers of their own health.*

- Implement the Healthier Living Workshop, designed to help people learn to effectively manage and live with chronic disease.
- Increase attendance at current disease specific self-management programs.
- Explore web based applications for consumer support.

Provider Practice: *The proportion of individuals receiving care consistent with evidence-based standards will increase.*

- Educate and engage the provider community and office support staff on the Chronic Care Model, use of clinical guidelines and decision support tools, and integration of information technology into practice work flow.
- Identify barriers and incentives to provision of evidence-based standards of care and implementation of the Chronic Care Model.
- Implement a regional roll out of the Vermont Blueprint for Health by hospital service areas.

Community Activation and Support: *Vermonters will live in communities that have a stated collective vision for a healthy community, and that actively pursue changes in the physical environment, social norms and individual behaviors to support a culture of health.*

- Encourage broad based community participation in chronic disease prevention activities.
- Promote community-level activities and programs designed to prevent risk factors for chronic disease and improve the health of those with chronic conditions.
- Continue efforts to expand opportunities for physical activity, changes to the physical environment, and policy interventions.

Health Information System: *A chronic care information system (registry functionality) will be available to providers and will support chronic disease prevention, treatment and management for effective individual and population based care.*

- Develop a statewide chronic care information system (CCIS)/patient registry in partnership with Vermont Technology Leaders (VITL), including system design, technical assistance, governance and business rules for secure information sharing.
- Develop and pilot the CCIS/registry application as part of a regional implementation strategy.

Health Care System: *Vermonters will be served by a health care system that invests in and recognizes quality.*

- Engage stakeholders in development of policies and plans to assure sustainability of the Vermont Blueprint for Health.
- Promote agreement on clinical guidelines and performance measures.
- Facilitate alignment of financial and other incentives.