

Vermont BLUEPRINT for Health

Blueprint Partners

AARP–Vermont Chapter
Blue Cross–Blue Shield of Vermont
Central Vermont Medical Center
CIGNA
Consumer representatives
Dartmouth College,
School of Medicine
Dartmouth Hitchcock Medical Center
Fletcher Allen Health Care
MVP Health Plan
Northeast Healthcare Quality Foundation
(QIO)
Northeastern Vermont Regional Hospital
Office of Senator Jeffords
Office of Senator Leahy
Rutland Regional Medical Center
Southwestern Vermont Health Care
University of Vermont,
College of Medicine
Vermont Child Health Improvement
Program
Area Health Education Ctrs
University of Vermont,
College of Nursing and Health
Sciences
Vermont Association of Hospitals &
Health Systems
Vermont Business Roundtable
Vermont Medical Society
Vermont Program for Quality in Health
Care (VPQHC)
Vermont Assembly of Home Health
Agencies

State of Vermont, Departments of:
Aging and Independent Living
Banking, Insurance, Securities & Health
Care Administration
Health
Human Resources
Office of Vermont Health Access
(Medicaid)

The Chronic Care Initiative

Refocusing Healthcare – from Reactive to Proactive

The Vermont Blueprint for Health involves 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 in the health care system being developed as part of this effort.

Background:

In a 2004 RAND Report more than 50 percent of individuals with diabetes, hypertension, tobacco addiction, congestive heart failure, asthma, depression or hyperlipidemia, are currently managed inadequately. The costs of inadequate care have an adverse impact on the health care system as well as quality of life of 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 Blueprint partners represent health care providers, businesses, consumers, health plans, community and non-profit groups, and government including over 80 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.

Workgroup Objectives:

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

- Implement the Stanford Chronic Disease Self-Management Program, designed to help people learn to effectively manage and live with chronic disease.
- Implement educational programs at retail establishments.
- Increase attendance at current disease specific self-management programs.

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 Blueprint Chronic Care Initiative in 2-3 communities.

Community Activation and Support: *Vermonters will live in communities that support healthy lifestyles, and have the ability to prevent and manage chronic conditions.*

- Inventory built environment—walking, bike paths, community resources.
- Implement new or expand existing physical activity programs in pilot communities.
- Develop criteria and award grants to communities for programs and services that support chronic disease prevention and management, and link communities to the health care system.
- Develop a toolkit for sharing successful evidence-based projects

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 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 Blueprint Chronic Care Initiative.
- Promote agreement on clinical guidelines and performance measures.
- Facilitate alignment of financial and other incentives.
- Coordinate and collaborate with other health care reform efforts.