The Vermont Blueprint for Health —
Prevention, Chronic Illness Management and Cost Containment

VT has embarked on an ambitious program to reduce the incidence, severity and costs of chronic illness. This paper summarizes the Strategic Plan Report on the Vermont Blueprint for Health prepared by the VT Department of Public Health in January 2007. The full report is available at: http://healthvermont.gov/admin/legislature/documents/Blueprint_leg_report.pdf

Premise

- Preventing disease and improving the quality of care for people with chronic illness are effective ways to reduce the overall demand for the highest cost treatment and services. Over time prevention and disease management will moderate costs.

Long-Term Goals

- The prevalence of chronic conditions will be reduced.
- The health status and quality of life for those with chronic conditions will be improved.
- The cost of caring for those with chronic conditions will be moderated..

Background

- Chronic conditions — including diabetes, hypertension, cardiovascular disease, asthma, arthritis, cancer, respiratory diseases, mental health disorders, and substance dependence — are common in VT.
- Over 15% of children have a chronic condition.
- Nearly 90% of the 65+ population have at least one chronic condition; 20% have 4+ chronic conditions.
- While less than 1/3 of the population has a chronic condition, they account for over 80% of the total health care spending for the state.
- Nationally, the percentage of the population with a chronic condition is expected to increase by 1% per year for the next 22 years.
- This increase is driven by a combination of an aging population, increased prevalence of obesity, and unhealthy behavior such as poor nutrition, physical inactivity, and tobacco use.

Chronic Care Under the Current System

- The current health care system is focused on short-term, acute, and episodic health needs.
  - Various stakeholders focus on different health indicators, have divergent priorities, and have different reimbursement structures.
- Prevention and management of chronic disease requires
  - a proactive, coordinated, ongoing, planned care
  - a supportive environment with the active involvement of the individual, families, providers and the community.
- Individuals with chronic conditions currently receive only about half of the medical care they need

Potential of Prevention and Disease Management

- Reducing the gap between recommended and delivered care holds the promise of significantly improving health outcomes and moderating costs.

- Through prevention and better disease management, quality of life will be improved, mortality rates will decline and overall health costs decreased.
    - For example, implementation of the Blueprint is expected to lower annual *per capita* health care costs for diabetes by as much as 12 percent over the next 15 years.
        - Since the cost of caring for diabetics is expected to rise 35% if the current system is continued, the Blueprint initiatives will slow the rate of increase, not result in reduced costs.
- In most instances, the Blueprint relies on proven strategies, but they have never been brought together into a comprehensive system.
- Challenges and barriers to this comprehensive system change are significant.
    - The impact on providers and insurers are largely unknown
    - Consumer expectations for health services are "largely incompatible" with Blueprint system and its expectation that consumers will bear greater responsibility for prevention and self-management.
    - All stakeholders must accept a mutual obligation and shared responsibility for achieving the Blueprint goals.
    - Blueprint implementation requires that social equity issues be addressed to ensure access for the poor, disabled, poorly educated, minorities and other vulnerable groups.

The Chronic Care Model

- The Blueprint envisions changes in laws, taxes, education and services
- to improve prevention
    - to create incentives for healthy behavior and disease management
    - to foster environmental changes for healthy choices
    - to market effective self-management
- The Blueprint envisions an informed, activated patient who interacts with a prepared, proactive practice team resulting in improved functional and clinical health outcomes.
- Individuals will be provided with a clear understanding of their own medical condition and self-management skills and will share responsibility for their care plan.
- The support of family, friends and the community will be promoted.
- An infrastructure will provide health education, resources, tools and incentives to develop self-care skills and self-confidence through a working partnership with providers and practice teams.
- Health plans and providers will employ disease-specific education programs, foster the development of the self-empowerment and behavior change skills and structure the best program for the individual's immediate and long term needs taking into account different learning styles and support structures.
- Individual providers and practice teams will use evidence based standards, establish common clinical guidelines and evaluation measures, guide and coach patients regarding self management, and link them to community services.
- The Blueprint assumes that health information technology, training, and practice redesign assistance will be available for practitioners.
- Information technology is a key component and the Chronic Care Information System will make data available to practitioners and patients and allow monitoring of Blueprint progress.
- "Effective chronic illness care is virtually impossible without information systems that assure ready access to key data… providing timely reminders about needed services and

summarized data to track and plan care [and facilitating] monitoring and quality improvement."

Financing

- The Blueprint acknowledges that implementation of prevention and chronic disease management systems will require increased state funding.
- The return on this investment will be in future costs avoided, not money saved.
  - Some costs may decrease as consistent standards of care are adopted.
- More appropriate and consistent use of medications may result in higher prescription costs.
- Funding for FY 2007 is $5.3 million with 60% provided by federal Medicaid matching funds.
- Additionally, providers will contribute in-kind and out-of-pocket and through the loss of billable time.