VERMONT Blueprint for Health

Smart choices. Powerful tools.

The Facts About Chronic Conditions

FACT:
Caring for Vermonters with chronic conditions consumes more than 83% of the $2.8 billion spent in Vermont each year on health care.

FACT:
Chronic conditions are the leading cause of illness, disability and death in the United States.

FACT:
Over 50% of all adult Vermonters suffer from one or more chronic conditions.

FACT:
Over 40% of the direct care cost for Americans with chronic conditions comes from public funds.

FACT:
The number of people with chronic conditions—and the cost of their care—is expected to double by the year 2050.

Sources:
Vermont Department of Health; Robert Wood Johnson Foundation; National Institute of Health.

Chronic conditions are the most serious (and most costly) health problem facing Vermont today—and unless we act now, the problem will only get worse.

The leading chronic conditions in Vermont include heart disease, diabetes, asthma, hypertension, depression, cancer, liver disease and emphysema. All are serious conditions that, left untreated, can lead to the need for acute and/or emergency care—typically the most expensive and complex care of all.

And yet, most chronic diseases can be prevented, and when they do occur, can be successfully controlled by better lifestyle choices, regular medical monitoring, early treatment and/or appropriate medications.

The Vermont Blueprint for Health is a statewide initiative that provides Vermonters with chronic conditions the information, tools and support they need to successfully manage their health.

Inaugurated in 2004, the Vermont Blueprint for Health is off to a positive start and is already making a difference in several Vermont communities. Continued support for the Blueprint will assure that more Vermonters will benefit, helping not only to improve their health but also controlling the escalation of health care costs in our state.

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Background

The increasing number of Vermonters who experience serious health complications from chronic conditions, and the escalating cost of their care, demands a response.

The Vermont Blueprint for Health is built on the premise that prevention and improved chronic illness care will benefit the state and its people in three important ways:

1) By promoting healthy lifestyle options and prevention efforts, including support for infrastructure changes to foster active communities.

2) By helping Vermonters to live longer, healthier lives through appropriate and timely medical treatment and sound lifestyle choices.

3) By reducing overall demand for medical treatment services, many of which are currently funded through state programs, can lead to significant savings to the state and its residents.

The Vermont Blueprint for Health is based on the Chronic Care Model developed by Dr. Edward Wagner as part of the Improving Chronic Illness Care (ICIC) program of the Robert Wood Johnson Foundation, and on the work of Dr. Donald Berwick of the Institute for Healthcare Improvement. The Chronic Care Model integrates public health expertise with clinical health care delivery systems in order to deliver "the right care at the right time."

Vision

The Vermont Blueprint for Health is a whole new way of looking at chronic care. It is **proactive**, not reactive; holistic, not fragmented. Through prevention and planning, the Blueprint aims to help people with or at risk for chronic conditions stay as healthy as possible and avoid the need for expensive care and services.

In order to implement the Blueprint successfully, some significant changes to the state's health care system are needed. These include:

• **Promoting public policies** that support healthy lifestyles and effective health care.

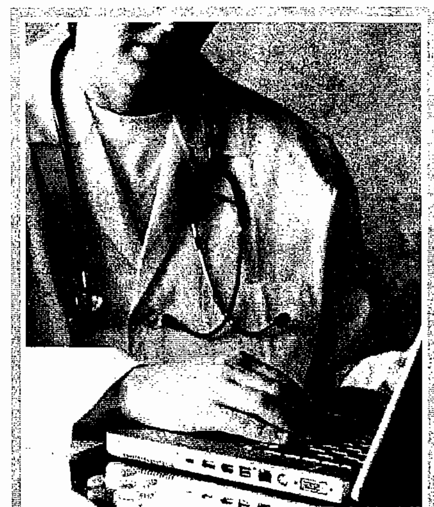
• **Effective and accessible community-centered programs and activities** to help people with chronic conditions successfully adopt and maintain healthier lifestyles. Because physical activity is a key component in the management of many chronic conditions, the first Blueprint focus area is on making daily physical exercise a community norm.

• **Self-management information and tools for individuals** through a wide range of information channels and innovative programs, workshops, etc. Patient participation is absolutely critical to the Blueprint, which ultimately is a patient-centered initiative.

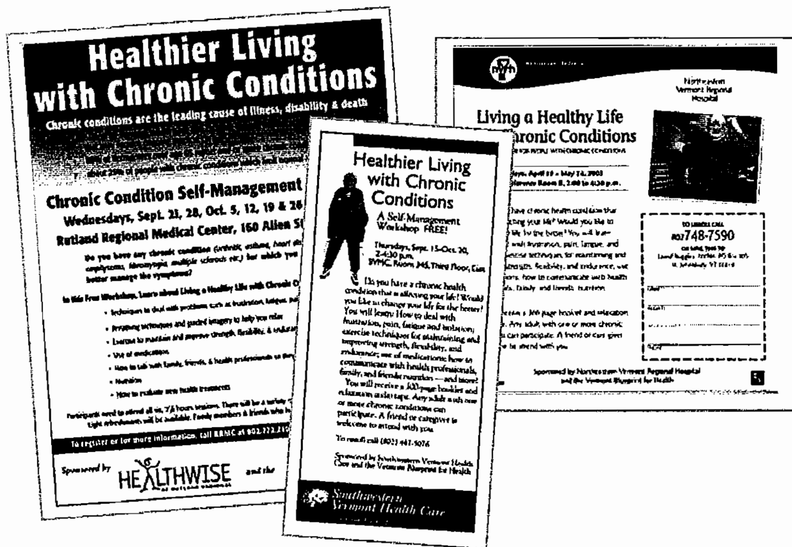
• **Improved health care information systems,** including patient registries, give physicians and other medical professionals the critical information and timely reminders they need to deliver the best care. Registries are also used to identify groups of patients that need additional attention and to facilitate quality improvement in health care.

• **Ideas and tools to help providers care for patients,** including centralized information systems, patient follow-up tools and evidence-based treatment guidelines.

• **Health system organizations (insurers, non-profits, etc.) will** support consumers and providers with coordinated approaches to quality standards, patient education and disease management; incentives to deliver better care, and alignment of their work with the Blueprint and other health reform initiatives.



Good data means good decisions. *Patient registries will give doctors and other health care professionals complete and accurate information about a patient's history and treatment, saving time and helping promote patient safety.*



Patient self-management: a key component of the Vermont Blueprint for Health. *In 2005, hospitals in two pilot communities sponsored "Healthier Living Workshops" for patients with chronic conditions. Over 150 people completed the workshops, which help patients take responsibility for managing their own health.*

2005: The Blueprint is launched

In 2005, the Vermont Blueprint for Health took the first steps towards a planned, statewide rollout by selecting two hospital service areas as **pilot communities:** Southwestern Medical Center in Bennington and Northeastern Regional Hospital in St. Johnsbury. Grants were awarded to fund local project managers to oversee implementation in both pilot communities.

Interest in the Blueprint is widespread and has won the support of national as well as state leaders. The Agency for Healthcare Research and Quality of the federal Department of Health and Human Services is providing invaluable assistance in helping to design an evaluation strategy for the Blueprint.

Public policy

Government support of the Blueprint comes not only from its financial contribution, but also alignment of policies and regulations. In 2005, the Health Resources Allocation Plan, prepared by BISHCA, incorporated implementation of the Blueprint; the Global Commitment includes steps to make the Medicaid program a full partner; and the Department of Health has adopted the Blueprint as an organizing framework and is realigning programs and operations to better improve health outcomes.

Community support

The Vermont Blueprint for Health encourages communities to become healthier places and to offer services that promote health. In 2005, the Vermont Department of Health awarded grants in both pilot communities to develop neighborhood walking programs. Pilot communities are encouraged to list health promotion services and provide an Internet link to Vermont 2-1-1 area resource listings. Grantees also receive technical assistance and guidance to help with start up of walking programs and aid local planners develop supporting policies and plans for environmental change (such as building sidewalks and recreational trails).

Self-management information and services

Patient participation is critical for the success of the Vermont Blueprint for Health. The good news is that most Vermonters seem eager to take the central role in the management of their health. In 2005, over 150 people completed the "Healthier Living Workshop" developed by Stanford University and adopted by the Blueprint. This highly-acclaimed, evidence-based course teaches successful self-management of chronic conditions through a variety of techniques. At least 30 people have been trained to be workshop leaders and workshops have been held in Bennington, St. Johnsbury, Bellows Falls, Burlington, Rutland, Springfield, Waterbury, White River Junction and Windsor.

Information systems development

The Blueprint has participated in development of an integrated health data system in several ways. The Vermont Health Record is a web-based patient registry that is being tested by physician offices in pilot communities and other locations throughout the state. The registry will allow providers to proactively manage their patients care, calling them in for needed care–not relying on patients' memories–and giving providers more complete information during visits. An assessment of information technology capacity in primary care practices has been completed. On-going collaboration with Vermont Information Technology Leaders (VITL) continue to assure alignment with other health information initiatives.

Provider participation

More than 75 percent of adult primary care providers in St. Johnsbury and Bennington have signed up to participate in the pilot program. The initial focus is on diabetes (a chronic condition that affects more than 29,000 Vermonters).

With the help of the Blueprint, providers are learning how to deliver effective proactive care to patients with chronic conditions.

Each participating practice has been given new, web-based information technology tools (the Vermont Health Record) to help them integrate the Chronic Care Model into their everyday routines.

Health systems

To be successful, the Blueprint for Health requires effective collaboration among insurance carriers (including Medicaid), business and other organizations to support consumers and providers make the changes that are needed. In 2005, standardized measures were developed to support payment reform. An inventory and assessment of disease management services offered by Vermont insurance carriers is currently underway.

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Goals for 2006

The Vermont Blueprint for Health is one of the best investments we can make in the future of our state. Not only can it dramatically improve the health of Vermonters, it can also strengthen our state's fiscal health by reducing the need for expensive acute and emergency care.

With the support of the legislature, we look forward to achieving several important goals in the coming year.

Major Blueprint Goals

- Expand the Blueprint for Health into one or more additional communities. An RFP to support this process will be issued early in 2006.
- Train additional leaders and offer the "Healthier Living Workshops" more frequently throughout the state.
- Help more physician practices use the Vermont Health Record to provide more complete patient information.
- Expand walking programs into more communities throughout the state.
- Add at least one new chronic condition to the Blueprint and the Vermont Health Record.
- Avoid the need for duplicate data entry by upgrading the Vermont Health Record to allow automatic input of data from laboratories, pharmacies, hospitals and other sources.
- Work with laboratories, pharmacies, hospitals and other sources of data to modify their data systems to feed into the Vermont Health Record.
- Develop recommendations for a new payment system that would reward providers for high quality care and patient wellness.

Sustainability

The Vermont Blueprint for Health is also a blueprint for fiscal responsibility. With improvements in both consumer self-care and proactive care management, we anticipate that the rapid increase in health care costs will be slowed, and in time, significant cost savings will result. Substantial investments to support development of this new infrastructure will be required.

These infrastructure costs include development and deployment of the integrated health information system; training and transition assistance for provider practices; expansion of self-management work to include more conditions and more methods; development of infrastructure for healthy communities; and a campaign to promote participation among all sectors in this exciting new endeavor.

Long-term sustainability is contingent on significant changes throughout the health system. These include a new financial model that creates incentives for healthy behaviors and for providing high quality care; increased emphasis on prevention; and, continued investment in self management and community development for health.

Public-private partnerships

A project of the magnitude and complexity of the Vermont Blueprint for Health requires the strong commitment of multiple interest groups and stakeholders if it is to succeed.

To lead this effort, we have forged a strong public-private partnership that includes state government, health insurance plans, business and community leaders, health care providers and consumers.

A supporting organizational structure has been developed that includes an Executive Committee working with the Commissioner of Health to set the vision and strategic direction; a Steering Committee that serves in an advisory capacity; and five statewide workgroups that assist with planning and evaluation of local implementation efforts.

A comprehensive five year strategic plan has been developed and approved by all partners and can be accessed at healthvermont.gov.

Blueprint for Health Partners

- AARP – Vermont Chapter
- Bi-State Primary Care Association
- Blue Cross-Blue Shield of Vermont
- CIGNA
- Consumer representatives
- Dartmouth College, School of Medicine
- Dartmouth Hitchcock Medical Center
- Fletcher Allen Health Care
- MVP Health Plan
- Northeast Healthcare Quality Foundation (QIO)
- Office of Senator Jeffords
- University of Vermont, College of Medicine:
  - Vermont Child Health Improvement Program
  - Area Health Education Centers
- University of Vermont, College of Nursing and Health Sciences
- Vermont Association of Hospitals and 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:
  - Department of Health
  - Department of Aging and Independent Living
  - Department of Banking, Insurance, Securities and Health Care Administration
  - Office of Vermont Health Access (Medicaid)
  - Department of Human Resources

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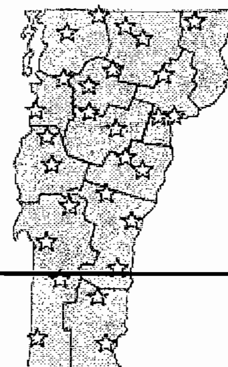
What is the Vermont Blueprint for Health?

The Vermont Blueprint for Health is a vision, a plan and a statewide partnership to improve health and the health care system for Vermonters. The Blueprint provides the information, tools and support that Vermonters with chronic conditions need to manage their own health – and that doctors need to keep their patients healthy.The Blueprint is working to change health care to a system focused on preventing illness and complications, rather than reacting to health emergencies.



Blueprint activities are statewide.

A new way to practice medicine.

The Blueprint is a new way of looking at the practice of medicine and chronic care. Hundreds of health care providers are signing on to the Blueprint to learn about innovations, tools, clinical guidelines and best practices to deliver effective, proactive care – and to involve patients in managing their own chronic conditions.

Vermonters learning to live healthier.

The Blueprint works to help Vermonters who have chronic conditions stay as healthy as possible – improving their quality and enjoyment of life and avoiding the need for complex care later when illness is harder to treat. Hundreds of Vermonters have attended **Healthier Living workshops** sponsored by the Blueprint. These self-help workshops teach individuals to manage their chronic conditions and improve their health.

Communities taking action for health.

Communities all over the state are joining the Blueprint to become healthier places to live, work, learn and play. The Blueprint guides and funds hospital service areas and communities to assess local infrastructure, start coalitions, recruit health care providers, host **Fit & Healthy Vermonters** events and Healthier Living workshops – encouraging everyone to take charge of their health.

A new medical information system.

Having the right information at the right time is essential for providing the best possible care for patients. The Blueprint is developing a web-based chronic care patient information system that is free to health care providers and requires only Internet access. Mt. Ascutney Hospital in Windsor will be the first to install and test this system in 2007.

Fact Sheets

- **Chronic Care Information System (CCIS)** (pdf)
- **Vermont Blueprint for Health Update 2007** (pdf)
- **The Chronic Care Initiative, Refocusing Health Care from Reactive to Proactive, 2005** (pdf)

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The Facts About Chronic Conditions

FACT:
Chronic conditions are the leading cause of illness, disability and death in the United States.

FACT:
Seven out of every 10 Americans who die each year, die of a chronic disease.

FACT:
Over 50% of all adult Vermonters have one or more chronic conditions.

FACT:
Caring for people with chronic conditions consumes 70% of the $3.3 billion spent in Vermont each year on health care.

FACT:
Over 40% of the direct care cost for Americans with chronic conditions comes from public funds.

FACT:
The number of people with chronic conditions—and the cost of their care—is expected to double by the year 2050.

Sources:
Vermont Department of Health; Robert Wood Johnson Foundation; National Institutes of Health; Center for Disease Control.

Chronic diseases are long-standing, persistent illnesses that are often not easily managed or quickly resolved. They are among the most prevalent and costly of all health problems. They are also the most preventable. These conditions present one of the most serious health challenges facing Vermont today, and, unless we act now, the problem will only get worse.

Common chronic diseases include arthritis, asthma, cancer, cardiovascular disease, lung disease, depression, diabetes, obesity, and osteoporosis. All are serious conditions which, if left untreated, can lead to the need for acute or emergency care — typically the most expensive and complex form of medical treatment.

And yet, most chronic diseases can be prevented. When they do occur, many such conditions can be successfully controlled by lifestyle changes, regular medical monitoring, early treatment, and medication.

The Vermont Blueprint for Health is a statewide initiative to provide Vermonters who have chronic conditions with the information, tools and support they need to successfully manage their health.

Launched by Governor Douglas in 2003 and endorsed in 2006 by the General Assembly under Act 191, the Vermont Blueprint for Health is already making significant progress in several communities. Continued legislative support for the Blueprint will ensure that more Vermonters will benefit, helping not only to improve their health but also to control the escalation of health care costs in our state.

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Vision

The increasing number of Vermonters who experience serious health complications from chronic conditions, and the escalating cost of their care, demands a response.

The Vermont Blueprint for Health is built on the premise that prevention and improved chronic illness care will result in:

• **A healthier population** through sound lifestyle choices, increased focus on prevention efforts, and support for community infrastructure that fosters physical activity.

• **Appropriate, timely, and effective medical treatment,** helping Vermonters to live longer, healthier lives.

• **Reduced demand for medical treatment services,** resulting in significant cost savings for government and individuals.

Approach

The Blueprint for Health is a new approach to giving Vermonters the tools they need to manage their chronic care. It is proactive and holistic, rather than reactive and fragmented.It is designed to help people who have chronic conditions, and those who may be at risk for developing them, through prevention and planning. The Blueprint seeks to achieve its goals by establishing and promoting the following:

• **Public policies that support healthy lifestyles** and effective health care.

• **Effective and accessible community-centered programs and activities** to encourage and maintain healthier lifestyles.

• **Self-management tools for individual participation and empowerment,** through innovative programs such as the Healthier Living Workshop.

• **Improved health care information systems**, including the Blueprint's Chronic Care Information System, to give physicians and other medical professionals the critical information needed to deliver evidence-based care. New information technology can help identify patients that need additional attention or specific interventions.

• **Coordinated approaches by health system organizations** including insurers, state government and non-profit health care organizations. This will result in better support for consumers and providers alike in the areas of patient education, quality standards, disease management, and incentives to deliver better care.

Strategic Plan

As part of Act 191, the Vermont Blueprint for Health delivered its revised Strategic Plan to the General Assembly. The plan is a guide for operational planning and implementation, as well as a reference for evaluation for the Blueprint over the next five years.

Critical to the development of the plan, its implementation targets, and its ongoing assessment has been the participation of the Blueprint executive committee, a variety of stakeholder work groups, and staff in participating communities and in the Department of Health.

Patient Self-Management
In "Healthier Living Workshops" patients with chronic conditions learn tools and techniques to better manage their health.

2006: Achievements

Increased Participation: Blueprint Expands to Six Communities

The Vermont Blueprint for Health first implemented its chronic care model in two hospital service areas: Northeastern Regional Medical Center in St. Johnsbury and Southwestern Medical Center in Bennington. In 2006, four additional hospital service areas were funded: Mt. Ascutney Hospital in Windsor, Springfield Hospital in Springfield, Central Vermont Hospital in Berlin, and Fletcher Allen Health Care in Burlington.

All six of these communities now have funding for local project managers, self-management regional coordinators, community physical activity initiatives, and additional provider education.

Communities Supporting Health

The Vermont Blueprint for Health encourages communities to become healthier places to live, work, learn and play. Collaboration has helped to better establish consistent program guidelines and coordinated efforts to support physical activity initiatives, and statewide grants have been awarded for this purpose.

In preparation for expanding the Blueprint beyond the six service areas, communities throughout the state have been funded to assess community infrastructure, develop coalitions and walking programs, and engage residents in these activities.

Provider Participation

Nearly 75 percent of all primary care providers in funded communities have signed on to the Blueprint. They have been active participants, learning about innovations and evidence-based standards for the delivery of effective, proactive care for patients with chronic conditions.

Implementation of this effort began with measures to prevent and manage diabetes. Steps to deal with the chronic conditions of hypertension and hyperlipidemia are now in the final stages of adoption. The Provider Practice Workgroup, a statewide coalition of health professionals, is advising the Blueprint on clinical issues such as adoption of best-practices guidelines, monitoring progress, and metrics of success.

Healthier Living Self-Management Programs

Because Vermonters must take a central role in the management of their health, consumer participation is critical for the success of the Blueprint for Health. In 2006, over 300 people completed the "Healthier Living Workshop," an evidence-based program originally developed by Stanford University. This course teaches self-management of chronic conditions through a variety of skill-building techniques. Under the Blueprint, workshop leaders have been trained and workshops conducted in 10 hospital service areas across the state.

Patient Information Systems

The Department of Health, in partnership with Vermont Information Technology Leaders, have contracted with GE Health Care and Orion Systems to develop a new web-based chronic care patient information system. This system will enhance the ability of health care providers to manage chronic illnesses for patients by giving providers the right information at the right time. Mt. Ascutney Hospital in Windsor will be the first participant to install and test this system in 2007.

Health Systems Collaboration

Effective collaboration with public and private insurance carriers, as well as support from private business and other organizations, is essential to the success of the Blueprint. We are working closely with the state Medicaid office to identify and adopt a common set of evidence-based standards in 2007 to support the Medicaid Disease Management program.

Coordinated Public Policy

With passage of Act 191, the Vermont Legislature's support for the Blueprint for Health strengthened existing links between government and private partners.

The State incorporated the priorities of the Blueprint into the selection process when, as an employer, it chose a health insurance benefits provider for state employees.

Under the Blueprint, physicians are collaborating with the Office of Vermont Health Access to adopt common clinical guidelines for both the Blueprint and OVHA's disease management program. With input from insurance partners, we anticipate that these guidelines will be used to establish common measures for standards of clinical practice.

Health Department staff worked with the Agency of Transportation advisory committee to develop a five-year Vermont Pedestrian and Bicycle Policy Plan, and VTrans staff serve on the Fit & Healthy Vermonters advisory committee as well as the Community Workgroup for the Blueprint.

National Recognition

Other states, as well as the federal government, are now looking at what Vermont is achieving in this area. We are sharing our experience and information on best practices with national health policy partners such as Academy Health. The U.S. Dept. of Health and Human Services' Agency for Healthcare Research & Quality has provided us with expertise on payment mechanisms and on our analysis of consumer and provider surveys. They also helped with sponsorship of a public event bringing national experts and local stakeholders together in Vermont.

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Major Goals for 2007

- Expand the Blueprint for Health into **additional communities** and health service areas throughout the state.
- Expand the Blueprint to include **additional chronic conditions**.
- Implement the **chronic care patient information system** in St. Johnsbury, Bennington, Windsor, Springfield, Central Vermont and Burlington areas.
- **Add chronic disease specialists** to local Health Department district offices to support community-level work with partners and integration with other activities.
- **Expand the availability** of the "Healthier Living Workshops."
- Continue to expand **physical activity initiatives statewide** in coordination with Fit & Healthy Vermonters.
- Increase work with community coalitions to **support disease prevention activities**.
- **Fund community level health and wellness** activities integrated with Coordinated Healthy Activity, Motivation and Prevention Programs (CHAMPPS).
- Develop **new payment recommendations** to reward providers for high quality care and patient wellness.

Sustainability

The Vermont Blueprint for Health is also a blueprint for fiscal responsibility. By improving both consumer self-care and proactive care management, the rapid increase in health care costs can be slowed, resulting in significant savings. Achieving this goal will require a long-term commitment by policymakers to sustain efforts as we move forward, making needed changes to our health systems infrastructure and programs.

Public Private Partnership

A project of the magnitude and complexity of the Vermont Blueprint for Health requires the strong commitment of multiple interest groups and stakeholders if it is to succeed. To lead this effort, we have forged a strong public-private partnership that includes state government, health insurance plans, business and community leaders, health care providers and consumers. The supporting organizational structure includes an Executive Committee working with the Commissioner of Health to advise on the vision and strategic direction, and five statewide workgroups that focus on the planning and evaluation of local implementation efforts.

Blueprint for Health Partners

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- State of Vermont:
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  - Office of Vermont Health Access (Medicaid)
  - Department of Human Resources

More information about the Vermont Blueprint for Health is available on the Vermont Department of Health website: **http://healthvermont.gov/blueprint.aspx**

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College of Medicine
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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: *Vermonter's 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 life-styles, 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 finacial and other incentives.
- Coordinate and collaborate with other health care reform efforts.

Vermont's Chronic Care Information System –

The right information. At the right time.

"Vermont's new Chronic Care Information System will make it easier for clinicians to offer the proactive care their patients with chronic illness need – to live healthier lives and to prevent the serious complications that chronic illnesses too often cause."

– Sharon Moffatt, RN, MSN, Commissioner of Health

- Chronic conditions such as diabetes, high blood pressure, high cholesterol or heart disease are the leading cause of illness, disability and death in Vermont.
- More than half of all adult Vermonters suffer from one or more of these complex chronic conditions.
- The Chronic Care Information System (CCIS) is designed to improve clinical outcomes by providing clinicians with the comprehensive patient information and clinical guidance they need to support diagnosis and treatment decisions.

CCIS is a new medical information system for a new way to practice medicine. Having the right information at the right time is essential for providing the best possible care for patients. As part of Vermont's Blueprint for Health, the Vermont Department of Health – in partnership with Vermont Information Technology Leaders (VITL) – has contracted with GE Health Care and Orion Systems to develop a comprehensive chronic care information system.

- **The heart of the system.** CCIS is a medical practice's portal to the Vermont Health Information Exchange – a statewide technology platform for exchanging health information in the state. Clinicians and medical practice staff can access comprehensive clinical data on patients with chronic diseases and make plans based on Vermont approved practice guidelines at the point of care.

- **Designed for providers. Patient-centered.** Designed specifically to support medical decision-making and improve clinical outcomes at the point of care, CCIS makes population health care management a reality. Clinicians and medical practice staff can keep track of their patients as never before.

- **Web-based. Free to use.** Because it is web-based, CCIS will be available to clinicians and medical practices statewide and at no cost. The new system will require only Internet access to use.

- **Secure and HIPAA-compliant access to data.** Access to data and use of data is tightly controlled. CCIS privacy policies have been developed by clinicians and are based on national guidelines that meet or exceed HIPAA and state privacy regulations.

CCIS is designed to meet the challenges of providing chronic disease care.

Caring for patients with chronic illness requires many clinical encounters over a long period of time – in doctors' offices, hospitals, labs and other facilities. Each encounter generates a great deal of data that must be collected and organized – and be readily available.

On top of the challenge of managing clinical data, clinicians are challenged to stay up-to-date on evidence-based standards of care, have adequate diagnostic support tools and office systems, and take extra, precious time to involve patients in effectively managing their own health.

CCIS is designed to meet the challenges that clinicians and medical practice staff face every day in caring for their patients with complex chronic illness.

CCIS offers clinical advantages right now.

- CCIS allows clinicians and medical practice staff to quickly and easily retrieve clinical information specific to the patient – as well as reminders such as:

  The last recorded A1C test on this patient was eight months ago. At least two A1C tests are recommended per year.

- Actionable care plans can be created and provided to the patient at the point of service.
- The system can generate reports on groups of patients, such as a practice's diabetic patients, and aggregate data from multiple practices and hospital service areas.
- CCIS integrates with a practice's Electronic Medical Records or Practice Management System, lessening the burden of data entry while sharing pertinent data across systems.
- Any size medical practice can incorporate the CCIS into its patient care process.
- Because of its connection with Vermont Information Technology Leaders (VITL), medical and demographic data can be made available to the provider from other sources such as pharmacy data.

CCIS will grow, based on physician experience and need.

- Clinician feedback and experience will drive future enhancements and modifications.
- Input from clinicians and the Blueprint Provider Work Group will continue to guide development and applications of CCIS. The Blueprint Provider Work Group is a volunteer, public-private consortium of clinicians and insurance carrier representatives with a two-year working history.
- Starting with diabetes and hypertension, CCIS will grow to add more chronic diseases.

For more information –

Visit the Vermont Department of Health Blueprint for Health at *healthvermont.gov*