RWJF Culture of Health
Sentinel Community Snapshot:

Vermont
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ABOUT THIS REPORT

The Sentinel Communities project, conducted by RTI International in collaboration with the RAND Corporation, is sponsored by the Robert Wood Johnson Foundation. The project will monitor activities in each of 30 diverse communities around the country for at least 5 years. This Snapshot is the first in a series of planned reports about this Sentinel Community. Using data compiled in early 2016, it provides an initial overview of the community’s history, challenges, and approaches to building a Culture of Health. Visit cultureofhealth.org to see the full list of communities and links to other reports and information about the project.
Introduction

A small, sparsely populated state largely covered by forests and farmland, Vermont conjures up images of hardiness and a connection with nature. The state has long been at or near the top of most lists of the healthiest states in the nation. Low rates of obesity and tobacco use and a high level of insurance coverage contribute to health and well-being and influence the state’s top ranking.

Vermonters have a long history of embracing progressive causes and candidates. In 1777, Vermont was the first state to abolish slavery and establish public schools and, in 2000, became the first state to introduce civil unions. Later, Vermont became the first state to enact a same-sex marriage statute without being required to do so by a court decision. Its junior U.S. Senator, Bernie Sanders, is the longest-serving Independent in U.S. congressional history.

Despite its small and racially homogeneous population (94% white), Vermont has long served as a testing ground for various models of health system reform that have been tried by other states and the federal government. As of 2014, about 94% of residents have health insurance, due to the state’s sweeping 2006 law that increased access to affordable care and introduced a chronic care management approach known as Blueprint for Health. Novel experiments in health care payment continue: developmental work by Vermont’s Green Mountain Care Board, which oversees health spending in the state, to design and implement payment reform strategies that reflect local needs led to Vermont receiving a State Innovation Model grant from the Centers for Medicare & Medicaid Services.

Advocacy for universal health care access reflects a conviction held by many residents that health care is a right, not a privilege. In 1998,
a group of low-income workers formed the Vermont Workers’ Center, originally organized to help workers address workplace concerns and to raise the state’s minimum wage. Based on input about workers’ struggles with the market-based health system, the Center launched a grassroots campaign in 2008 to persuade lawmakers that Vermonters regarded health care as a human right. Today, the economic aspects of health care reform remain important in policy discussions among Vermont leaders, while human rights principles serve as guiding social norms.

With an activist history and long-standing commitment to health, it is not surprising that Vermont has led the nation in promoting efforts to improve health care access, equity, and affordability. Vermont is a long-established leader in forging consensus for a universal health care system, developing a promising health services model to manage chronic diseases, and promoting physical fitness as a shared value and a way of life for its residents. These efforts have produced success stories and cautionary tales. In addition to continued efforts to transform health care services, Vermont recently enacted a health in all policies approach, which incorporates health considerations into decisions involving cross-sector partners and state and local agencies.

A TOURIST AND FARMING HAVEN

With a population of 626,358, Vermont is situated in the northeastern United States and shares its northern border with Canada. Vermont has 14 counties and 9 incorporated cities; Burlington, with 42,283 residents, is its most populated city. More than one-quarter of all Vermonters live in Burlington’s Chittenden County. The state’s “Northeast Kingdom” comprises Caledonia, Essex, and Orleans counties and represents Vermont’s least-populated area. Tourism and farming, especially organic farming, are important facets of Vermont’s character and economy and promote the well-being and overall health of its residents. The Green Mountains traverse the length of the state and offer skiing, hiking, and tourism opportunities that support the state’s economy and overall quality of life. A number of ski resorts are among the state’s largest employers, albeit seasonally. In addition, 150 miles of the treasured Appalachian Trail wind through the Green Mountains.

Farming is an essential part of the state’s gross domestic product, with an estimated $4 billion impact, representing roughly 13% of Vermont’s economy. Leading agricultural products include dairy, beef cattle and calves, pigs and hogs, turkeys, eggs, apples, honey, and maple syrup. Food processing is the second largest manufacturing industry, with production, processing, and distribution responsible for more than 56,000 jobs in Vermont.

ECONOMIC, EDUCATION, AND HEALTH ASSETS

In addition to being more racially homogenous, Vermont is slightly wealthier, better educated, and significantly healthier compared with the nation as a whole. Vermonters’ median household income is $54,447 per year, slightly higher than the $53,482 national median household income. The higher household income is balanced by a higher-than-average cost of living ranking compared with the national average, according to the Cost of Living Index. Larger proportions of adults in Vermont, compared with the nation, have a bachelor’s degree or higher (35% vs 29%) or a graduate or professional degree (14% vs 11%). Vermont residents also fare better on many health measures than U.S. residents as a whole. For example, 16% of all Vermont residents report that they smoke compared with 18% of U.S. residents, 23% meet recommendations for physical activity compared with 20% of U.S. residents, and 29% of adults consume five or more servings of fruits and/or vegetables each day compared with 23% of U.S. adults. About one-fourth (25%) of all state residents are considered obese compared with 30% of U.S. residents. Nearly all (94%) Vermont residents have health insurance coverage, compared with the national average of 86%.

A COMMITMENT TO HEALTH AND HEALTH INSURANCE COVERAGE

Vermont’s long commitment to expanding access to health insurance sets it apart from much of the United States. The state’s efforts to expand insurance, first to pregnant women and children who did not qualify for Medicaid and, more recently, to all residents through a single-payer system, have generated national interest for nearly three decades. In 1995, the General Assembly created a health security trust fund to provide expanded access to health care benefits for uninsured low-income residents under the Vermont Health Access Plan. The plan expanded Medicaid for uninsured adults and for low-income childless adults; coverage was also extended to children in families with incomes up to three times the federal poverty level (FPL). By 2005, these efforts helped decrease Vermont’s uninsured rate to 9%, compared with the national rate of nearly 16%.

Yet challenges remained, especially for residents who could not afford private insurance but did not qualify for the newly expanded public programs. The contribution of unmanaged chronic disease—especially asthma, chronic obstructive pulmonary disease, congestive heart failure, diabetes, and coronary artery disease—to escalating health costs also began to emerge as an important health policy priority.

To address these concerns, the Vermont legislature passed the sweeping Vermont Health Care Reform Plan in 2006 to increase access to affordable care, improve cost control measures, and introduce chronic care management as a key aspect of the state’s health reform efforts. It created Catamount Health, a health insurance plan available to any uninsured Vermonter with incomes up to three times the FPL through the small group insurance market. Employers were required to either provide health insurance or help finance coverage for their workers.

THE SINGLE-PAYER IMPERATIVE

Within 5 years, an even more ambitious plan to address economic and health inequities was set in motion with the 2011 passage of Act 48, a blueprint for Vermont’s single-payer health system (“Brief Summary of Act 48”). The law came on the heels of the 2010 Affordable Care Act (ACA), which extended coverage to uninsured Americans and expanded insurance options through state-based insurance marketplaces. Worried about the overall impact of rising health costs, Vermont opted for an approach that would rein in costs for the state and make coverage more...
affordable for the 90% of residents in households with incomes under $150,000. The 2011 law put the state on a path toward a single-payer system that was scheduled to start in 2017 by

- establishing a board to recommend policies to improve the consumer experience and quality of care for patients and depart from the traditional methods of paying physicians and hospitals; and
- creating a health insurance exchange (Vermont Health Connect), the state marketplace for health insurance under the ACA for families, individuals, and small businesses to purchase health coverage beginning in 2014.

As part of the law, the state’s previously enacted Catamount Health and Vermont Health Access Plans were scheduled to expire at the end of 2013.

**ONLINE EXCHANGE THWARTS PROGRESS**

However, problems with the insurance exchange emerged at the outset and continued to worsen. Some enrollees found that their policies were canceled for non-payment even though they had paid their premiums, while others experienced security breaches. Despite efforts to address these problems, a feasible alternative to Vermont Health Connect could not be identified by the state’s office of health reform.

In December 2014, significantly higher-than-expected tax revenue requirements put an end to the state’s efforts to implement a single-payer system. However, the state remains committed to making health care accessible and affordable. Vermont officials and the federal government are negotiating details of an “all-payer” health system in which Medicaid, Medicare, and private insurers contract with hospitals and doctors to provide services at a predetermined amount.

In a separate but related effort that began in 2013, the Vermont Health Care Innovation Project has leveraged a $45 million State Innovation Model grant to fund proposals to improve health care delivery, build health information technology and databases, and test new models for paying health providers. The 4-year grant project serves as a conduit between public and private entities, encouraging collaboration among the Green Mountain Health Board, the Vermont Agency of Human Services, Medicaid, private health insurers, and health providers.

**GEOGRAPHIC DISPARITIES, LIMITED REACH**

Despite the prominence that Vermont gives to health and well-being in myriad ways, geographic disparities limit some residents’ ability to reap the benefits. Some Vermonters, especially those living in rural communities, face barriers to health care, healthy food, and access to physical activity. For example, in the Northeast Kingdom’s Essex County, one primary care provider is available for 3,113 residents (Figure 1). By contrast, in Chittenden County, home to Burlington, that ratio drops to 1 primary care provider for 603 residents. Access to mental health care and dental care is challenging in Essex County, with 1 mental health care provider available for 2,070 residents and 1 dental care provider available for 3,106 residents. Chittenden County’s ratio, by contrast, is 1 mental health provider per 273 residents and 1 dental care provider per 1,148 residents.

Residents living in Vermont’s rural counties also have lower levels of health insurance compared with residents in the rest of the state. In 2014, 88% of Essex County residents had insurance coverage, compared with 91% insurance coverage in Orleans and Caledonia counties.

In addition to gaps in insurance coverage and physician access, rural residents also face disparities in access to healthy foods and physical activity. For example, residents in Essex County have less access to locations for physical activity and to healthy foods compared with
residents in Chittenden County and Vermont as a whole\textsuperscript{27,28} (Figure 2). Residents in the Northeast Kingdom’s Orleans and Caledonia counties, along with Orange and Franklin counties, also have limited access to physical activity opportunities (less than 65%).\textsuperscript{29,30,31,32} Despite the state’s plentiful sources of healthy foods, 12% of residents in Essex County do not live near a grocery store, more than twice the level reported by residents in other Vermont counties.

**EDUCATION AND HEALTH INEQUITIES**
Health outcomes in Vermont vary by educational attainment. Individuals without a college degree report facing greater health challenges with obtaining medical care due to cost, being in poorer health, and getting insufficient physical activity\textsuperscript{33} (Figure 3).

**SUBSTANCE ABUSE ON THE RISE**
Substance abuse, especially opioid and heroin use, is a relatively new problem in Vermont, and one the state has begun to address. Vermonters of all ages, including adolescents, young adults, and adults, reported higher levels of illicit drug use compared with U.S. levels (Figures 4\textsuperscript{34} and 5\textsuperscript{16,35}).

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**Health Care Transformation and Cross-Sector Collaboration**

Vermont’s efforts to transform health care and establish a mandate to incorporate health in all policies exemplify its commitment to health and well-being. Building on nearly 30 years of experience, Vermont has expanded access to health coverage and reduced chronic disease in the state. Recognizing the need to move beyond health care access to address social determinants of health, in early 2016, the state established a health in all policies mandate and Blueprint for Health, both of which lay the groundwork for future cross-sectoral partnerships.

**INTEGRATED, PATIENT-CENTERED CARE**
The ACA put the national spotlight on the patient-centered medical home as a model to improve access; promote ongoing communication between patients, families, and their medical team; and boost overall quality. Thanks to its 2006 health reform plan, Vermont had already laid the groundwork to test innovative models and services that integrate services and systems.

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**Blueprint for Health**
In addition to Vermont’s long-standing efforts to enact bold health care legislation, the state has continued to leverage federal programs...
and create public-private models to expand coverage and access to care. Under its Blueprint for Health initiative, Vermont has assembled a statewide network of evidence-based practice facilitators, heads of community health teams, and project leaders who work with patient-centered medical homes, community health teams, and local health and human services experts. Services to improve disease prevention include individual care coordination, counseling, and integration with economic and social service support. Programs are informed by evaluations of health care quality and outcomes at the practice, community, and state levels.

Participating in the Blueprint is optional for health providers. However, Medicaid and major private insurers are required to support physician practices that participate as certified patient-centered medical homes with monthly payments. In 2015, the Vermont legislature approved the first increase in payments to providers since the program’s inception in 2003.

Recent analysis suggests that Vermont’s Blueprint for Health is having a positive effect on medical expenditures and utilization for patients enrolled in a patient-centered medical home. An evaluation of health delivery reforms from 2008 to 2013 found that these patients had lower hospital and outpatient expenditures and lower rates of surgical specialty visits, standard and advance imaging, and echography. Participants also maintained higher rates on the majority of the effective and preventive care measures examined in the study, such as adolescent well-care visits, breast cancer screening, and cervical cancer screening.

HEALTH IN ALL POLICIES EXECUTIVE ORDER

As part of an ongoing effort to improve awareness and disease prevention, the Vermont Public Health Association requested development of a statewide inter-agency governmental task force to examine social determinants of health. In January 2016, former Governor Peter Shumlin established a Health in All Policies Task Force, comprising nine state agencies. The Task Force aims to unify cross-sectoral agencies in their mission to improve health and well-being across and beyond governmental programs. With support from the Vermont Public Health Institute, the Task Force is working to prioritize health issues and identifying promising practices and evidence-based initiatives and activities across sectors.

TARGETING CHRONIC DISEASE AND SUBSTANCE ABUSE

The state’s public health, education, and agriculture departments as well as non-government stakeholders have invested in health promotion programs and policies that target chronic disease. For example, in 2009, the state mandated the Farm to Plate Initiative and Vermont Sustainable Jobs Fund to develop a 10-year plan to strengthen Vermont’s food system, increase economic development, create jobs, and improve access to healthy local food. The initiative uses a network of 11 task force groups that address a range of cross-cutting topics, including finance, energy, health, labor, and food access. Although the effectiveness of the effort is not yet established, the Farm to Plate Initiative will track 25 goals and measures over time, from food access and food-related health problems to farm production, jobs, and livable wages.

Expanding community and cross-sectoral participation in other areas of health, Vermont’s Department of Health in 2014 awarded 2-year grants as part of its “Healthy People in Healthy Communities” initiative. The grants support community-based chronic disease prevention strategies targeting alcohol and drug abuse, nutrition and physical activity, and tobacco control. Grantees include community-based boys
and girls clubs, youth coalitions, family centers, hospitals, and health and rehabilitation providers.

As opioid use increased across the nation, Vermont officials initiated efforts to reduce access and improve education. Former Governor Peter Shumlin devoted his 2014 State of the State address to the strategies to combat the state’s opioid epidemic. In 2016, the Vermont legislature enacted a measure that would create a controlled substances and pain management advisory council, fund a community grant program to support local opioid prevention strategies, create a program for disposal of unused prescription drugs, and establish a regional system of opioid addiction treatment.

CROSS-SECTOR INITIATIVES TO IMPROVE RURAL HEALTH
To better address the health care needs of rural residents, the Vermont Rural Health Primary Care Collaborative works with the Vermont Department of Health to target resources for the primary care workforce and health center sites that experience the greatest gaps to access. They are working to integrate behavioral, dental, and primary care and to bridge public health and primary care practice.

Healthy food initiatives have taken shape in areas lacking nearby grocery stores, such as Essex County, the state’s least populated county located in northeastern Vermont. Evolving from existing nutrition and physical activity programs, the Vermont Health Department developed the Northeast Kingdom Farm-to-School Program to promote a sense of community and collaborations between farms and communities to help rural schools build gardens, access food from local sources, and provide education on nutrition and agriculture.

Can Innovations Be Sustained?
Additional surveillance, data, and information gathering, analysis, and reporting will examine the extent to which Vermont’s policy environment is influencing its long-standing efforts to expand coverage, reduce costs, and improve access to initiatives that aim to prevent and manage chronic disease. Future reports will examine the impact of new initiatives to replace the state’s signature single-payer health plan and whether new leadership in the Governor’s office will significantly alter the priority the state has traditionally placed on health care access and equity. Specific questions include the following:

- To what extent has the state’s commitment to health care access and equity changed because of the highly publicized problems with the online health insurance exchange?
- How effective has the Blueprint for Health been in preventing and managing chronic disease, beyond lower expenditures for medical care?
- How does Vermont intend to address disparities in health and health care among many rural residents who have less access to physicians, physical activity, and healthy foods?
- Does the priority that Vermonters place on being environmentally friendly position them well for collective action on health?
- How can successful health care systems and financing reforms help Vermont to address significant, emerging public health problems, such as the striking increase in incidence of illicit drug use among adult and youth in the state?
- How will public health priorities change as a result of climate change, which will affect seasonal tourism, employment, revenue, and the economy in the near future?
- What can we learn about health care reform from Vermont that can be generalized to other states that have large rural areas?
- Beyond the state government, what organizations are engaged in activities that contribute to the state’s culture of health?
References