LYME DISEASE CASES INCREASING IN VERMONT
Contributor: Patsy Tassler Kelso, Ph.D, Epidemiologist

Lyme disease cases are on the rise in Vermont and throughout New England. Both the Health Department and the Agency of Agriculture have reported a surge in calls from people asking about ticks. The number of reported Lyme disease cases from tick bites in Vermont has nearly tripled in the past two years (29 cases in 2005, 83 cases in 2007). This is likely due to heightened awareness among Montytons and the numbers of infected ticks. A greater tick population does not necessarily mean that there is an increased risk of becoming infected with Lyme Disease, according to Patsy Kelso, an epidemiologist for the Vermont Department of Health. Lyme disease is only transmitted by the bite of black-legged ticks known as a deer ticks. While increased awareness is playing a role in the number of reported cases, there appears to also be an increase in the numbers of infected ticks.

Eleven of Vermont’s fourteen counties meet the Centers for Disease Control and Prevention’s definition of endemic for Lyme disease – a county in which at least two confirmed cases have been acquired, or in which tick vectors are infected with Borrelia burgdorferi. Ten counties meet the criteria because of human cases, while Grand Isle County has Ixodes scapularis ticks that are known to be infected with B. burgdorferi. Limited data suggest that Franklin and Lamoille counties have Lyme disease activity, although there is insufficient data from these counties to label them as endemic. The Lyme disease status of Essex County is largely unknown.

While the risk of contracting Lyme disease in Vermont is lower than in other northeast states, Lyme disease should be considered in the differential diagnosis for patients with signs and symptoms consistent with B. burgdorferi infection. These include fatigue, headache, fever, lymphadenopathy, myalgia, arthralgia, and an erythema migrans (EM) rash. EM usually develops 7-10 days (range, 3-30 days) after a tick bite. An EM rash ≥ 5 cm in diameter is diagnostic for Lyme disease. Tick bite hypersensitivity reactions, which appear as erythematous lesions within 48 hours of a tick bite, are usually < 5 cm in diameter and typically begin to disappear within 24-48 hours.

Laboratory testing should provide support for a clinical diagnosis of Lyme disease and should never be used as the sole basis for a Lyme disease diagnosis. Screening tests must be followed by the more specific Western immunoblot test. Testing can be arranged through a reference laboratory.

Persons who have been bitten by a tick should be monitored for signs and symptoms of Lyme disease for 30 days. Patients should be instructed to seek medical attention if an expanding erythematous rash or other symptoms of Lyme disease develop within one month of a tick bite.

Lyme disease is reportable to the Vermont Department of Health by calling 1-800-640-8774. Accurate diagnosis and reporting of Lyme disease will help the department better understand the morbidity associated with this disease in Vermont.

More information about Lyme Disease on Page 7
VERMONT RANKED SECOND IN NATION ON STATE-BY-STATE SCORECARD ON CHILDREN’S HEALTH

Vermont garnered another top health care ranking in a report on children’s health released May 28, 2008 by the Commonwealth Fund on a High Performance Health Systems. Vermont was ranked second overall, behind Iowa, in the quality of health care provided to children.

According to the report, “Iowa and Vermont have created children’s health care systems that are accessible, equitable, and deliver high-quality care, all while controlling levels of spending and family health insurance premiums.” The report goes on to note that both states have adopted policies over the last decade to expand children’s access to care. Specifically, they have expanded SCHIP and mandated public reporting of data by all child health plans and local and regional children’s health systems. The report concludes that this analysis demonstrates that such policies make a difference.

Commissioner of Health Sharon Moffatt credited Vermont’s focus on insuring children and the strong network of doctors, physicians and other health professionals across the state as key in developing and maintaining a system that ensures children grow up healthy. “Our health care community really stood up to meet the needs of the state’s children,” she said.

The Fund’s State Scorecard on Health Systems Performance focused on 13 indicators of child health system performance along the dimensions of access, quality, costs, and equity. Overall rankings for the New England states were as follows: Vermont (2), Maine (3), Massachusetts (4), New Hampshire (5), Rhode Island (8) and Connecticut (14).

Western and southern states tend to have lower health care costs. Vermont ranked 44th in cost with a personal health care spending rate per capita of $6069 as compared to $3,972 in Utah. The other New England states all ranked in the 40's on cost.

To view the full report, go to: http://www.commonwealthfund.org/publications/publications_show.htm?doc_id=687113

AMA PASSES VMS RESOLUTION AIMED AT REDUCING RISK OF IDENTITY THEFT IN CREDENTIALING PROCESS

This spring, Dr. David Butsch, Vermont’s delegate to the American Medical Association, secured the support of all six New England states for a VMS resolution to the AMA’s annual meeting to have the AMA advocate for the Council for Affordable Quality Healthcare (CAQH) to make social security numbers an optional field in their on-line provider credentialing application. At the June meeting in Chicago, the AMA passed the resolution without amendment.

The resolution was developed in response to the concerns raised by a number of Vermont physicians about identity theft during the credentialing process due to the CAQH’s requirement for physicians to include social security numbers, dates of birth and city of birth when completing the credentialing application.

The VMS resolution points out the National Provider Identifier (NPI) is a federally mandated initiative applicable to both Medicare and Medicaid that physicians’ claims must have included by May 23, 2008 to be processed for reimbursement. CAQH has indicated it is prepared to modify the system to accept the NPI as user-defined data for the NPI.

DEPARTMENT OF HEALTH ADVISORY FOR DIAGNOSIS OF LYMDE DISEASE

Only about 80% of Lyme disease patients have an erythema migrans rash. The rash may take a bull’s-eye appearance (http://www.cdc.gov/ncidod/dvbid/lyme/ld_LymeDiseaseRashPhotos.htm).

Lyme disease is reportable by laboratories. Health care providers are also required to report cases to the Vermont Department of Health, even without laboratory confirmation (i.e., a patient with an erythema migrans rash).

The Clinical Assessment, Treatment and Prevention of Lyme Disease, Human Granulocytic Anaplasmosis, and Babesiosis Clinical Practice Guidelines by the Infectious Diseases Society of America (http://www.journals.uchicago.edu/doi/full/10.1086/508667?prevSearch=Lyme+Diseas) identifies four criteria for Lyme prophylaxis. They are:

(a) the attached tick can be reliably identified as an adult or nymphal I. scapularis tick that is estimated to have been attached for ≥36 hours on the basis of the degree of engorgement of the tick with blood or of certainty about the time of exposure to the tick;
(b) prophyllaxis can be started within 72 hours of the time that the tick was removed;
(c) ecologic information indicates that the local rate of infection of these ticks with B. burgdorferi is ≥20%; and
(d) doxycycline treatment is not contraindicated.

In all 11 Vermont counties where Lyme is endemic, healthcare providers should assume that at least 20% of I. scapularis are infected. With this assumption, and if the other three criteria have been met, it would be reasonable to provide Lyme prophylaxis, this decision is left to the healthcare provider’s discretion.

LYME DISEASE

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The Vermont Department of Health recently updated the school entry immunization requirements to become effective in August 2008. The new requirements apply to all students entering kindergarten and 7th grade and to any student newly enrolling into a school, regardless of grade. For the full text of the VMS resolution on “Optional Use of Social Security Numbers During the CAQH Credentialing Process,” please go to: http://www.vtmd.org/AMA PASSESVMS RESOLUTION

Continued from Page 2

The National Diabetes Education Program’s (NDEP) latest resource for health care professionals is the 2008 Diabetes Numbers At-a-Glance, a handy pocket guide that provides a list of current recommendations to diagnose and manage pre-diabetes and diabetes, treatment goals based on American Diabetes Association clinical recommendations, and a diabetes management schedule. The guide is one of several clinical practice tools for health care professionals that are distilled from evidence-based national guidelines for diagnosis and care. All are available for free to order or download.

Additional helpful resources from NDEP include Guiding Principles for Diabetes Care, which outlines the important patient-centered principles of diabetes care and helps health care professionals meet key practice challenges. The BetterDiabetesCare website (www.BetterDiabetesCare.nih.gov) provides information, models, links, resources, and tools to help health care professionals assess needs for systems change, develop strategic plans, implement tools for action, and evaluate the systems change process. Health care professionals can receive CE/CME credit from Indiana University’s School of Medicine by using the website.

NDEP also has free patient education materials on both diabetes control and diabetes prevention. To learn more about diabetes patient materials and resources for health care professionals, visit www.ViaoDiabetesInfor.org or call 1-888-923-NDEP (6337). NDEP is a partnership of the National Institutes of Health, the Centers for Disease Control and Prevention, and more than 200 public and private partners.

New School Entry Immunization Requirements Effective August 2008

Students entering kindergarten will be required to have received the following:

- 5 DTaP – 4 if the 4th dose was given on/after the 4th birthday
- 4 Polio – 3 if the 3rd dose was given on/after the 4th birthday
- 2 Measles
- 2 Mumps
- 2 Rubella
- 3 Hepatitis B
- 2 Varicella – waived if the parent of guardian presents a Department-supplied form indicating the student has a history of disease

Students entering 7th grade will be required to have received the following:

- 1 Meningococcal conjugate vaccine (only for students attending residential-based schools such as boarding schools who live at these facilities)
- 1 Tdap booster
- 2 Measles
- 2 Mumps
- 2 Rubella
- 3 Hepatitis B
- 2 Varicella – waived if the parent of guardian presents a Department-supplied form indicating the student has a history of disease

Students entering a post-secondary school will be required to have received all of the above and the following:

- 1 Meningococcal conjugate vaccine (only for students attending residential-based schools such as boarding schools who live at these facilities)
- 1 Tdap booster

To view the new immunization regulations, go to: http://healthvermont.gov/hc/imm/index.aspx

New Immunization Requirements - In accordance with ACIP recommendations on the scheduling of vaccinations and on minimal intervals between doses, allowing for the ACIP-approved four-day grace period:

- In accordance with ACIP recommendations on the scheduling of vaccinations and on minimal intervals between doses, allowing for the ACIP-approved four-day grace period.
**Report Ranks Vermont Second Highest in Nation in PQRI Reporting**

The Centers for Medicare & Medicaid Services (CMS) have provided medical societies with preliminary physician participation data for the 2007 Physician Quality Reporting Initiative (PQRI) program. The data, based on claims submitted from July through November 2007, shows that Vermont physicians have the second highest rate of participation, with 30.96 percent attempted submissions. North Dakota had the highest rate at 39.72 percent. The national average was 15.74 percent.

In a phone interview, Dr. William Kassler, Chief Medical Officer for CMS Region 1, attributed the high rate of Vermont participation in part to the work of the Vermont Medical Society (VMS). The VMS conducted educational sessions via interactive television prior to implementation of the PQRI reporting period. Dr. Kassler explained that interactive broadcast sessions, such as those conducted by the VMS, are much more helpful than print information. “The VMS was significantly more involved in bringing information about the program to its members”, said Dr. Kassler. “No one else invested the same amount of time and effort.”

The PQRI was designed to improve the quality of care provided to Medicare beneficiaries. Implemented in 2007, the PQRI creates a quality reporting system that includes and incentive payment for satisfactorily reporting data on quality measures for covered professional services delivered to Medicare beneficiaries. Under the 2007 PQRI, eligible professionals who satisfactorily reported data on quality measures for covered professional services provided during the second half of 2007 will receive an incentive payment in mid-2008. The payment, subject to a cap, will be 1.5% of their total allowed charges for the covered services during the reporting period.

According to Dr. Kassler, CMS has learned a lot during this first reporting period and is making changes to the program to make it easier for those physicians who may have been thinking about it to participate. CMS is providing more reporting options and decreasing burdens on physicians for participating. The 2008 PQRI program allows the use of 139 measures that were published in the Physician Fee Schedule for 2008. Of that number, 117 are clinical performance measures, such as the percentage of patients who received necessary cancer screenings and flu shots, and two are structural measures. The structural measures focus on the use of electronic health records and electronic prescribing technology.

For 2008, in addition to submitting PQRI measure data as part of their Medicare claims submissions, eligible professionals may report data on quality measures to a medical registry, and these registries will then report that data to CMS. In addition to providing new flexibility for submitting data, registry-based reporting will provide more ways for eligible professionals to qualify for an incentive payment. Participants can choose to report data on either individual measures or on groups of measures that capture a number of data elements about common care processes for diabetes, kidney disease, and preventive medicine. Additional reporting periods are also available.

The additional reporting periods and alternative criteria for satisfactorily reporting through registries are designed to boost physician participation in the program, as well as generate more data on the quality of physician services in Medicare. There are, however, additional benefits to physicians for participating. In addition, to the possible 1.5 percent bonus payment, physicians will be able to assess their performance on PQRI quality measures and to identify the most effective ways to use the quality measures in their practices. CMS will provide confidential feedback reports near the time of bonus payment and quality data will not be publicly reported.

The new PQRI reporting period begins July 1, so there is plenty of time to join in.

To learn more about PQRI and the new options for 2008 reporting, go to: www.cms.hhs.gov/PQRI.

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**Vermont Educational Loan Repayment Program for Primary Care Practitioners**

2009 Applications available in late July!

Contact the UVM AHEC Program Office for an application:
- Call (802) 656-2179
- E-mail Rebecca Dubois at rebecca.dubois@uvm.edu
- www.vtahc.org

Requirements (see application for full details):
- The recipient must be a VT resident and a primary care nurse practitioner, physician assistant, psychiatric nurse practitioner, certified nurse midwife, physician (family practice, OB/GYN, internal medicine or pediatrics), hospitalist trained in primary care, or a psychiatrist practicing at least 20 hrs per week in VT.
- The region must have a need for the practitioner, or be an underserved area, as defined by the Program.
- Recipients must meet a one-year service commitment.
- Funds are available to recruit and retain primary health care practitioners. Funds are taxable to the recipient.

**APPLICATION DEADLINE: SEPTEMBER 19, 2008**

Vermont’s Educational Loan Repayment Program is administered by the Vermont AHEC Network.