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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 both heightened awareness among Vermonters 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 1-800-640-4374. 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 professional 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 the potential to lead healthy lives. In addition, for two indicators, gaps in performance by income, race/ethnicity and insurance were used to gauge equity. Vermont was ranked best state in the nation in three of these indicators:

- Young children at risk for developmental delays – lowest at 16 percent
- Equity – lowest gap between care provided to minority, low-income, uninsured children and privately-insured children
- Children hospitalized for asthma – lowest at 55 per 100,000

The analysis found that across the states, better access to care is closely associated with better quality of care. Seven states – Vermont, Rhode Island, New Hampshire, Connecticut, Wisconsin, Iowa, and Michigan – are national leaders in giving children access to care and ensuring high-quality care.

In addition, the data suggests that there are strong regional patterns in child health system performance. New England states tend to perform well on indicators of health access, quality, 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

Continued on Page 3

Lyme Disease

Continued from Page 1

Lyme Disease Cases with Vermont Exposure*

County	1999	2000	2001	2002	2003	2004	2005	2006	2007	Total
Addison	1	0	0	1	0	4	4	3	5	18
Bennington	0	7	0	3	6	9	16	33	36	110
Caledonia	1	0	0	0	0	0	1	0	0	2
Chittenden	0	0	0	1	0	1	0	6	5	13
Essex	0	1	0	0	0	0	0	0	0	1
Franklin	2	0	0	0	0	1	0	0	2	5
Grand Isle	0	0	0	0	0	0	0	1	0	1
Lamoille	0	0	0	0	0	0	0	0	2	2
Orange	0	1	1	0	0	1	0	1	0	4
Orleans	0	0	0	0	1	0	0	0	1	2
Rutland	1	0	2	2	1	1	2	4	10	23
Washington	0	0	0	1	2	0	0	1	3	7
Windham	1	2	0	2	7	3	5	10	16	46
Windsor	1	1	0	1	0	2	1	3	3	12
Total	7	12	3	11	17	22	29	62	83	246

Lyme Cases with Out-of-State or Unknown Site of Exposure*

	1999	2000	2001	2002	2003	2004	2005	2006	2007	Total
Imported Cases	19	28	15	26	20	16	12	15	21	172
Unknown Exposure Cases	-	-	-	-	6	12	13	28	34	93
TOTAL	26	40	18	37	43	50	54	105	138	

*Only cases that meet the CDC case definition are included (http://www.cdc.gov/ncphi/disss/nndss/casedef/lyme_disease_1996.htm) Cases with Vermont exposure (cases in which it has been determined that infection was likely acquired in Vermont) are noted by county of residence. The number of imported cases (cases in Vermont residents which were determined to have most likely been acquired out of state) are totalled for each year. Unknown cases (cases in which potential exposure could have been both in and out of Vermont) are totalled starting in 2003. Prior to 2003 these cases are included in the number of imported cases. Because the numbers of reported Lyme disease cases in Vermont are small, it is not possible to draw conclusions regarding the variations in the numbers from year to year.

Department of Health Advisory for Diagnosis of Lyme Disease

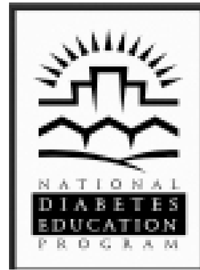
Only about 80% of Lyme disease patients have an erythema migrans rash. The rash may take a bull's-eye appearance (*http://www.cdc.gov/ncidod/dvbid/lyme/ld_LymeDiseaseRashPhotos.htm*).

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) prophylaxis 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.



2008 Pocket Guide for Diabetes Care Now Available Among NDEP's Free Diabetes Clinical Practice Tools For Health Care Professionals

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.YourDiabetesInfo.org* or call 1-888-693-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.

CCHIT Launches EHR Education Site for Physicians

The Certification Commission for Healthcare Information Technology recently launched a new Web site, *www.EHRDecisions.com*, designed to help educate physicians on EHR selection and the value of choosing CCHIT Certified® products. The site will help physicians better determine their readiness for moving to electronic health records, get started on the selection process, and be wiser in the actual purchase and contract negotiations. There also will be advice on how to derive the full potential benefits from an EHR, from both a business and clinical standpoint. The site will provide physician readers with a direct pipeline to Certification Commission leadership and other experts, who will post regularly.

The Web site features news from the Certification Commission, as well as from the electronic health records industry as a whole. Readers will have the ability to post comments and questions regarding EHR certification and adoption issues. The site will be expanded over time from short articles by experts, informal blogs, and news feeds to community forums, podcasts and videos.

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(Make sure to mention the VMS when you call)

The room block will be held until Wednesday, September 1, 2008.

"Not for ourselves do we labor"

AMA Passes VMS Resolution

Continued from Page 2

a required field once organizations that hold data necessary for credentialing move away from storing that information by social security numbers. The VMS believes the AMA can help with this process.

Currently, physicians who do not want to submit their SSN do not have to use the CAQH on-line system. They may use the paper form and it is then up to the individual insurer or hospital to determine whether it will accept the application as complete if the form does not include the social security numbers. This would also apply to the date of birth and city of birth. However, this defeats the purpose of the ease of filling out the on-line credentialing application out once.

At the federal level, H.R. 948 would give the Federal Trade Commission (FTC) rulemaking authority to restrict the sale and purchase of Social Security numbers, and to enforce civil compliance with the bill's restrictions. The bill, which has been approved by the House Energy and Commerce Committee, establishes privacy safeguards while also permitting limited exceptions to the purchase and sale of Social Security Numbers for purposes of law enforcement, in emergency situations to protect the health or safety of an individual and for similar situations.

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/*

New School Entry Immunization Requirements Effective August 2008

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 latter, students must meet the same requirements as for kindergarten (for students entering grade 1-6) or the 7th grade (for students entering grade 8-12). The new requirements also apply to students enrolling into a post-secondary school, though specific schools and students are not required to comply.

Vermont law allows parents and students to exempt out of vaccinations for medical, religious or philosophical reasons. However, the appropriate form must be provided to claim an exemption. This form is available at schools or through the Immunization Program. The American Academy of Pediatrics has developed information that can provide the context for a discussion about the importance of immunizations, and the risks associated with the decision not to immunize. To obtain this form, or for more information call the Immunization Program at (802)863-7638 or (800)464-4343 (ext. 7638).

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:

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 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

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

- 1 Tdap/Td booster administered within the past 10 years
- 2 Measles
- 2 Mumps
- 2 Rubella
- 3 Hepatitis B
- 1 Meningococcal conjugate vaccine (only for first year students living in dormitories)
- 2 Varicella – waived if a student presents a Department-supplied form indicating history of disease

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 30.95 percent attempted submissions. North Dakota had the highest rate at 32.72 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 119 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.*

CMS Centers for **Medicare** & **Medicaid** Services

UVM Faculty to Assume Leadership Roles at Pediatrics Journal

The University of Vermont (UVM) College of Medicine has announced that three members of the department of Pediatrics will serve in national leadership roles as part of an upcoming change at Pediatrics, the peer-reviewed journal of the American Academy of Pediatrics (AAP) and preeminent journal in the world in its field.

Jerold F. Lucey, M.D., Harry W. Wallace Professor of Neonatology at UVM, and Pediatrics editor-in-chief for the past 34 years, will step down and become editor-in-chief emeritus.

Lewis R. First, M.D., Professor and Chair of Pediatrics and Senior Associate Dean for Medical Education at UVM will assume the role of deputy editor. As the deputy editor position requires a 30 percent time commitment, Dr. First will step down from his position as senior associate dean as of January 2009.

Jeffrey Horbar, M.D., the Jerold R. Lucey, M.D. Chair of Neonatal Medicine at UVM, will become one of three new associate editors for the journal. Dr. Horbar currently serves as on-line editor of Pediatrics.

"It has been an honor for the UVM College of Medicine, and for Vermont, to house the editorial office of this prestigious publication, and we are proud to have three of our faculty serving in these leadership roles, "said Frederick C. Morin, M.D., dean of the UVM College of Medicine.

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- 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.
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