QUARTERLY MORBIDITY REPORT

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The Alphabet Soup of Health Information Technology / Provider Incentives: EMR, EHR, HIE, HIO, RHIO…

Health care in the US is often disconnected and difficult to navigate. To improve health care coordination across settings, we look towards information technology (IT) which can:

- Enable providers to give the best possible care by providing accurate and complete patient's health information
- Better care coordination especially for patients with chronic conditions.
- Enable secure information sharing with patients and caregivers
- Provide information to help doctors diagnose health problems sooner, reduce medical errors, give safer and cost effective care.

With the advent of IT, healthcare providers have been introduced to many new terms. Here are some of the ingredients to this alphabet soup: "Electronic Medical Record" (EMR), "Electronic Health Record" (EHR), "Heath Information Exchange" (HIE), & "Health Information Organization" (HIO).

EMR and EHR are often used interchangeably, but they are significantly different. EMRs are "medical," used mostly for diagnosis and treatment. EHR covers a wider definition of "health" relating to "the condition of being sound in body, mind, or spirit; especially…freedom from physical disease/pain…the general condition of the body."

As digital versions of patient medical and treatment history in Care Delivery Organization (CDO). EMRs can:

- Track data over time
- Easily identify patients due for preventive screenings/checkups
- Check patients' progress on parameters such as HbA1C, BP etc
- Monitor and improve overall quality of care within the CDO

Information in EMRs doesn't travel out of the CDO, unless it is connected to Electronic Health Records (EHRs). EHRs go beyond standard clinical data collection in the hospital/provider's office. They are built to share information with other healthcare providers, such as laboratories and specialists. They contain information from all the clinicians involved in the patient's care. The information moves with the patient to the specialist, hospital, nursing home, across states or the country. EHRs are designed to be accessed by all involved in the patient's care, including patients themselves.

Health Information Exchange (HIE) facilitates the multi-directional electronic exchange of health-related information between providers, health plans, employers, consumers etc. HIE provides access and retrieval of patient information to authorized users. This "information highway" allows healthcare providers and patients to make timely decisions that reduce medical errors, redundant tests,improve coordination, and quality of care. The results are in an improved quality of health care, reduction in costs and improvement in the health outcomes.

Health Information Organizations (HIO) are formed by stakeholders in a specific area/region to provide technology, governance and support for HIE efforts. In New York, it is called the State Health Information Network for New York or SHIN-NY. The Hudson Valley region has the Taconic Health Information Network and Community (THINC RHIO). As key stakeholders it is imperative for the healthcare providers in the area to network and build a relationship with SHIN-NY and THINC RHIO. EHR Benefits: Members of the team have ready access to the latest information for better coordinated, patient-centered care.

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The Dutchess County Department of Health's Mission is to protect and promote the health of individuals, families, communities, and the environment.

We are committed to the core functions of public health: Assessment, Assurance, and Policy Development.

We strive to deliver the essential services necessary for people to live healthy lives.

We are increasingly data-driven in our priority setting, applying our resources in ways that optimize prevention and risk reduction.

ON THE INSIDE

GI/Norovirus Alert - DCDOH has seen an increase of vomiting and diarrhea in the community signaling the likely presence of norovirus, a viral gastrointestinal (GI) illness. It is strongly recommended for ill persons to remain at home until 48 hours after symptoms resolve. If you suspect clusters of illness that appear to be associated with specific schools, workplaces, or institutions, please contact the DCDOH at 845-486-3402.

DC Government offers a variety of online resources including Prescription Discount Drug and Dental Discount Programs as well as ChildHealthPlus, FamilyHealthPlus and Medicaid providers. Please visit http://bit.ly/DCDOH and select the "Options for the Uninsured and Under Insured."

COMMUNICABLE DISEASES[1]

Disease Incidence * (rate per 100,000 population	Jan - Dec 2011		Jan - Dec 2010		Jan - Dec 2009		Jan - Dec 2008		Jan - Dec Avg ('08-'10)	
	Freq	Rate	Freq	Rate	Freq	Rate	Freq	Rate	Freq	Rate
ARTHROPOD-BORNE DISEASES										
Babesiosis [2]	56	19.1	38	12.9	56	19.1	62	21.1	52	17.7
Ehrlichiosis [3]	59	20.1	77	26.2	117	39.9	128	43.6	107	36.4
Lyme Disease [3]	n/a**	n/a**	519 †	174.5 †	979 †	329.8 †	1141	385.1	880	296.3
BLOOD-BORNE PATHOGENS										
Hepatitis B, Chronic	32	10.9	23	7.8	27	9.2	34	11.6	28	9.5
Hepatitis C, Chronic	583	198.6	302	102.9	270	92.0	354	120.6	309	105.3
SEXUALLY TRANSMITTED INFECTIONS										
Chlamydia	658	224.1	763	259.9	707	240.8	633	215.6	701	238.8
Gonorrhea, total	104	35.4	124	42.2	122	41.6	87	29.6	111	37.8
Early Latent Syphilis	6	2.0	5	1.7	3	1.0	5	1.7	4	1.4
Primary/Secondary Syphilis	2	0.7	2	0.7	3	1.0	2	0.7	2	0.7
GASTRO-ENTERIC INFECTIONS										
Campylobacteriosis[3]	34	11.6	37	12.6	35	11.9	26	8.9	N/A ††	N/A ††
Cryptosporidiosis[2]	1	0.3	0	0.0	0	0.0	2	0.7	1	0.3
E.Coli 0157:H7	5	1.7	3	1.0	6	2.0	3	1.0	4	1.4
Giardiasis	27	9.2	28	9.5	19	6.5	34	11.6	27	9.2
Salmonellosis	55	18.7	32	10.9	40	13.6	34	11.6	35	11.9
Shigellosis	1	0.3	6	2.0	6	2.0	3	1.0	5	1.7
RESPIRATORY INFECTIONS										
Pertussis [3]	13	4.4	12	4.1	5	1.7	7	2.4	8	2.7
Streptococcus pneumoniae, invasive	20	6.8	30	10.2	38	12.9	31	10.6	33	11.2
Tuberculosis [4]	4	1.4	11	3.7	4	1.4	7	2.4	7	2.4

HIV and AIDS				
Cases diagnosed, **Excluding** prison inmates	2009 Prevalence [5]		2010 Incidence [6]	
	Frequency	Rate per 100,000	Frequency	Rate per 100,000
HIV	237	79.8	*21*	*7.2*
AIDS	388	130.7	13	4.4

1 Based on the month the case was created. The 2010 and 2011 rates and numbers will likely be adjusted as lab reports become available.
2 Confirmed and probable cased counted as of 2011
3 Confirmed and probable cases counted; Campylobacter as of 2010
4 Numbers subject to change
5 Cases reported and confirmed through December 2010. Cases presumed living with through December 2009
6 Data as of August 4, 2011
** Rates are incidence rates (based on number of new cases for the reporting period)*
*** Estimate for 2011 is not available at this time*
† Estimates are provided by NYSDOH annually. Starting from 2009, only a sample of positive Lyme Disease lab reports is investigated.
††2008-2010 average is not calculated since definition is changed in 2010
Data Source: New York State Department of Health, Division of Epidemiology & Bureau of HIV/AIDS Epidemiology.

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- Critical, life threatening patient information from primary care provider is shared with the ED clinician even when he/she is unconscious.
- Patient can log on to his/her own record to see lab results and trend over time.
- Recent lab results are available for all providers to view which avoids duplicate testing.
- The hospital discharge notes and instructions are available to other providers and patients for follow-up care and smooth transition.

The Health Information Technology for Economic and Clinical Health (HITECH) Act of 2009 offers incentives to help support providers adopt EHRs. Doctors and other eligible professionals qualify for incentive payments up to $44,000 through Medicare or $63,750 through Medicaid. Hospitals qualify for incentive payments up to $2 million or more. The use of EHR must be in ways that can be measured in quality and in quantity. These incentives are available to providers who demonstrate "Meaningful Use" of certified EHR with three main components:

- Use in meaningful manner, such as e-prescribing.
- Use for electronic exchange of health information to improve quality of care.
- Use to submit clinical quality and other measures.

For additional information and resources please visit for the following websites:

http://www.himss.org/content/files/2009DefiningHIE.pdf
http://healthit.hhs.gov/portal/server.pt/community/healthit_hhs_gov__home/1204
https://www.cms.gov/ehrincentiveprograms/30_Meaningful_Use.asp
http://www.health.ny.gov/technology/technical_infrastructure.htm
http://thincrhio.org/providers.html

Health Care Reform: The Patient Protection and Affordable Care Act

The Patient Protection and Affordable Care Act and the Healthcare and Reconciliation Act present many challenges to physician practices. One of the primary goals of healthcare reform is to improve quality of care and increase patient access to care while controlling healthcare costs. In order to achieve these goals, the reform legislation has laid out several initiatives, for example: ten percent Medicare bonus payments to primary care physicians as well as general surgeons working in rural areas from 2011 to 2016; implementation of a relative value based modifier to enable physician payments based on quality metrics; and, various expanded regulatory compliance and disclosure requirements.

Beginning in 2011, CMS launched the "Physician Compare" website, designed to disseminate provider quality measures reported through the Physician Quality Reporting Initiative (PQRI). From 2011 to 2014, participation in the PQRI will be voluntary and CMS will provide Medicare incentive payments (one percent in 2011 and 0.5 percent from 2012-2014) for providers who participate in the program. However, beginning in 2015, failure to participate in the PQRI will result in a 1.5 percent reduction in Medicare payments.

In order to increase quality and lower costs, healthcare reform encourages the coordination of patient care. The ACA provides for demonstration projects and new delivery models to test the effectiveness of reform initiatives, including Accountable Care Organizations (ACOs) and bundled payment structures. If these small scale developments prove successful, the law provides for the extension and expansion of the programs on a national scale. Industry experts are encouraging physicians and small group practices to align themselves with other healthcare enterprises now in order to best position themselves to take advantage of the benefits offered by the Medicare Shared Saving Program, which are scheduled to take effect in 2012.

Healthcare reform is also addressing the shortage of primary care providers. To encourage more medical students to concentrate on primary care, healthcare reform provides for expanded funding for scholarships and loan repayments for primary care providers working in underserved areas beginning in 2011. To supplement workforce shortages, reform initiatives will also expand primary care and nurse training programs, such as the Medicare Graduate Medical Education Program, started in 2011. Primary care providers (pediatricians, family physicians, and internists) will also receive increased Medicaid payments starting in 2013, gradually increasing to Medicare payments levels by 2014.

The ACA ensures patient access to preventive care services. As such, several provisions require insurance providers to expand coverage to include these types of services. In addition, no payments or deductibles will be required under Medicare for annual wellness visits or for the development of personalized prevention plans. This focus on prevention will provide the opportunity to not only improve the health of Americans but also control health care spending. By concentrating on the underlying drivers of chronic disease, the Affordable Care Act (ACA) helps us move from today's sick-care system to a true "health care" system that encourages health and well-being.

Amid the looming uncertainty of reform, one thing remains clear – healthcare reform must be viewed as a process rather than as a single event.

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CLINIC SERVICES AND HOURS:
LOG ON TO WWW.DUTCHESSNY.GOV (HEALTH DEPT - SERVICES & PROGRAMS) OR
WWW.CO.DUTCHESS.NY.US/COUNTYGOV/DEPARTMENTS/HEALTH/HDINDEX.HTM

TELEPHONE NUMBERS: MAIN 845.486.3400 TTY 845.486.3417
EMAIL: HEALTHINFO@CO.DUTCHESS.NY.US

Communicable Disease Control Division	845.486.3402 (tel) 845.486.3564 (fax) 845.486.3557 (fax)
Tuberculosis Reporting & Info	845.486.3423
West Nile Virus Info Line	845.486.3438
Lyme Disease Info Line	845.486.3407
Rabies Prevention Program	845.486.3404
HIV Partner Notification Assistance	845.486.3452
HIV Testing & Counseling	845.486.3401
HIV Info Line	845.486.3408
STD Clinic	845.486.3401
Travel Immunizations	845.486.3504
Immunization Program	845.486.3409
Flu Info Line	845.486.3435

NEW YORK STATE DEPARTMENT OF HEALTH
COMMUNICABLE DISEASE REPORTING REQUIREMENTS

Reporting a suspected or confirmed communicable diseases is mandated under the New York State Sanitary Code (10NYCRR2.10a). The primary responsibility rests with the physician; moreover, laboratories (PHL 2102), school nurses (10NYCRR 2.12), day care center directors, nursing homes/hospitals (10NYCRR 405.3d) and state institutions or other locations providing health services (10NYCRR 2.12) are also required to report. Case reporting forms can be downloaded from our website or by calling 845.486.3401.

Call 845.486.3402 for more information about reporting a communicable disease.

Any Comments or Suggestions?
healthinfo@co.dutchess.ny.us

Dutchess County Government Cares.
Service, Support and Information
www.dutchessny.gov

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