

WARREN COUNTY HEALTH SERVICES

ANNUAL REPORT
2007

MAY 2008

Our Agency's Motto:

Do all the Good you can,
by all the means you can,
in all the ways you can,
in all the times you can,
to all the people you can,
as long as ever you can.
John Wesley

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Warren County Health Services is
pleased to present the Annual Report for the Year 2007.

VISION:

Healthy People in Healthy Communities

MISSION:

Promote Physical and Mental Health and Prevent Disease, Injury, and Disability
Maximize the Health Potential of all Residents in Warren County

Working together and committed to excellence, we protect, promote, and provide for
the health of our citizens through prevention, science, services, collaboration,
and the assurance of quality health care delivery.

GOALS:

- Prevent epidemics and the spread of disease
- Protect against environmental hazards
- Prevent injuries
- Promote and encourage healthy behaviors
- Respond to disasters and assist communities in recovery
- Assure the quality provision and accessibility of Health Services in the home
and in the community

WARREN COUNTY HEALTH SERVICES TEAM

Warren County communities remain fortunate to have the expertise of our staff. The quality of our Health Care Services is a direct reflection of continual commitment, dedication, care, and knowledge coupled with the excellent team efforts of the following individuals:

- | | | | |
|-------------------|-------------------------|---------------------|-------------------|
| Marietta Anderson | Cathy Dufour | Heidi Knickerbocker | Stella Racicot |
| Robin Andre | Dan Durkee | Nancy LaFrance | Kelly Richmond |
| Jeannette Arends | Karen Fidd | Mary Lamkins | Lynne Rodriguez |
| Shauna Baker | Rita Flynn | Laura Lane | Nancy Rozelle |
| Jackie Barney | Judy Fortini | John Lemery | Leslie Russell |
| Julie Bauer | Nedra Frasier | Nancy Lempka | Laura Saffer |
| Cheryl Belcher | Cheryl Fuller | Maureen Linehan | Jean Saltsman |
| Patricia Belden | Nancy Gasper | Amber Lynch | Grace Saville |
| Barbara Bennett | Nancy Getz | Jo Marie | Lisa Saville |
| Craig Briggs | Mary Lee Godfrey | Lisa Marlow | Susan Schaefer |
| Rechelle Bullard | Dana Hall | Kathy McGowin | Sharon Schaldone |
| Debbie Burke | Renee Harder | Angela Meade | Patty Skrynecki |
| Gloria Burnham | Kathy Harriss | Kate Meath | Linda Slattery |
| Linda Bush | Patricia Hart | Jackie Merritt | Melody Smith |
| Gwen Cameron | Meg Haskell | Barbara Moehringer | Jean Spencer |
| Francine Chase | Sheryl Havens | Joann Morton | Helen Stern |
| Shannon Clarke | Michelle Hayward | Lisa Morton | Shannon Stockwell |
| Jacqueline Cory | Anne Horwitz | Dorothy Muessig | Patricia Tedesco |
| Tara Cote | Katherine Howard | Linda Muller | Linda Walker |
| Beth Coughlin | Glenda Johnson | Mary Murphy | Sandy Watson |
| Kristi Culligan | Ginelle Jones | Patty Myhrberg | Valerie Whisenant |
| Dawn Decesare | Elaine Kane | Barbara Orton | Diedre Winslow |
| Diane Decesare | Barbara Karge | Diane Pfeil | Donna Wood |
| Jessica Depalo | Cathy Keenan | Nancy Pieper | Jeanne Wood |
| Tawn Driscoll | Michelle Keller-Allison | Patricia Porta | Marilyn Wood |
| | Sue Kerr | Helen Powers | |

I am honored to be their colleague ~ Pat Quier

HEALTH SERVICES COMMITTEE

Warren County Health Services is governed by the Board of Supervisors who are the legislative body for the county. These individuals constitute the Board of Health according to Chapter 55 of the New York State Public Health Law. The board is responsible for the management, operation, and evaluation of the Health Services Agency.

The Board of Supervisors is charged to perform the following overall functions:

- To appoint a Director of Public Health and Early Intervention Official and a Director of Home Care to provide day to day management of programs
- To provide for the proper control of all assets and funds and to adopt the agency's budget and annual audits
- To enter into contracts with individuals and/or facilities to allow for services or reimbursement mechanisms as needed
- To ensure compliance with all applicable federal, state, and local statutes, rules, and regulations

A subcommittee of the full Warren County Board of Supervisors constitutes the Health Services Committee and advises the full Board of Supervisors regarding Health Services concerns. We appreciate the support of the following county supervisors:

Warren County Board of Supervisors
Health Services Committee Members

Richard Mason, Chairman, Glens Falls

Fred Champagne, Queensbury

John Haskell, Thurman

Joseph Sheehan, Glens Falls

Matthew Sokol, Queensbury

Louis Tessier, Lake George

Frank Thomas, Stony Creek

WARREN COUNTY HEALTH SERVICES

2007 ANNUAL REPORT

PURPOSE OF REPORT: This comprehensive Health Services Annual Report is intended to provide an opportunity for the Warren County Board of Supervisors to annually review and evaluate the various Health Services Programs as measured by statistical documentation of the services provided. The report further serves to demonstrate a public record of accountability for the various program areas.

It may also serve as a resource document to:

- provide public record of individual program statistical outcomes and specific program explanations
- display trend information
- motivate change
- provide measures for comparisons

LIMITATIONS OF THE REPORT: While the data contained in this document can serve as a useful resource for discussion regarding specific program areas, those who review this report should be aware of its limitations. There are, for example, many intended standards for care provision that are not measured by statistical information. Among such standards are staff attitudes, which have resulted in the development of these goals.

- Each staff person will continually demonstrate the knowledge, understanding, and appreciation for the program team in which they participate, and will continually develop the skills to express their personal talents.
- Each staff person will respect and practice basic civil values and utilize the skills, knowledge, understanding, and attitudes necessary to provide health and educational services to the community.
- Each staff person will maintain the ability to understand and respect people of different race, sex, ability, cultural heritage, national origin, religion; and political, economic and social background; and their values, beliefs, and attitudes.
- Each staff person will continually develop their general career skills, attitudes, and work habits to promote ongoing self assessment and job satisfaction.

In each of these goals, staff attitudes are critical and directly translate into the quality of services provided to the residents of Warren County.

PROFESSIONAL ADVISORY COMMITTEE

The Professional Advisory Committee is a collaborative committee that meets quarterly to review pertinent concerns regarding current Health Services issues. Membership is composed of a cross section of professional disciplines that routinely interface with Health Services initiatives. Specific program updates are provided at these meetings and consensual advice from members is obtained when needed in this forum.

Patricia Auer, Director of Health Services
Patricia Belden PHN, Communicable Disease Program, Health Services
Barbara Chick, MD, Physician Member
Joseph Dufour, FNP Irongate Family Practice
Dan Durkee, Health Educator, Health Services
Tawn Driscoll, Financial Manager, Health Services
Gerhard Endal, Occupational Therapist
Joan Grishkot, Community Member and Retired Director of Warren County Health Services
Ginelle Jones FNP, Assistant Director Public Health
Candace Kelly, Director Warren Hamilton Counties Office for the Aging
Mary Lamkins, Supervising Nurse, Health Services
Daniel Larson MD, Public Health Medical Director
Richard Leach MD, Medical Consultant for Infectious Diseases
David Mousaw MD, Medical Director for PHCP & Children With Special Health Care Needs Program
Regina Muscatello, Clinical Nurse Supervisor Westmount Health Facility
John Penzer, Executive Director Greater ADK Home Health Aides
Robert Phelps, Warren County Commissioner of Social Services
Sharon Schaldone, Assistant Director Patient Services
Sara Sellig, Speech Therapist
Carol Shippey, Vice President Patient Services and Chief Nursing Officer
Helen Stern, Immunization Program Coordinator, Health Services
Marti Tucker, Physical Therapist

FACTS, FIGURES, AND TRENDS FOR PUBLIC HEALTH & HOME CARE

HEALTH SERVICES STAFFING

Number of Staff Involved with Health Services in 2007: 150

- 69 Full Time
- 14 Part Time
- 16 Per Diem
- 51 Contractual

Administrative Staff: 9 (all full time employees, all non bargaining unit)

- 1 Director of Public Health/Patient Services, also acts as Early Intervention Official
- 1 Assistant Director of Public Health
- 1 Assistant Director of Patient Services
- 1 Fiscal Manager
- 5 Supervising Public Health Nurses

Nursing Staff

- 7 Full Time Public Health Nurses (Grade 21)
- 4 Part Time Public Health Nurses
- 22 Full Time Community Health Nurses (Grade 20)
- 3 Part time Community Health Nurses
- 2 Full Time Registered Nurses (Grade 19)
- 3 Full Time Nurse Technicians (Licensed Practical Nurses) (Grade 9)
- Per Diem Nurses
 - 4 Public Health Nurses
 - 6 Community Health Nurses
 - 3 Registered Nurses
 - 2 Nurse Technician

Other Professional Staff

- 1 Full Time Health Educator (Grade 14)
- 1 Part Time Health Educator
- 2 Part Time Early Intervention/Preschool Service Coordinators (Grade 18)
- 1 Part Time Emergency Preparedness Coordinator (Contractual)
- 1 Part Time Public Health Liaison for Emergency Preparedness (Grade 7)

WIC (Women, Infants, and Children's Nutrition) Program

- 1 Full Time WIC Program Coordinator (non bargaining unit)
- 1 Full Time WIC Assistant (Grade 4)
- 2 Full Time WIC Nutrition Aides (Grade 6)
- 1 Full Time WIC Dietician (Grade 16)
- 1 Full Time WIC Nutrition Facilitator (Grade 16)

HEALTH SERVICES STAFFING

- 1 Full Time WIC Program Aide
- 1 Part Time WIC Program Aide
- 1 Part Time WIC Dietician (Grade 16)

Clerical Support Staff

- 1 Full Time Administrative Assistant (Grade 8)
- 1 Full Time Principal Account Clerk (Grade 10)
- 1 Full Time Office Specialist (Grade 7) (vacant)
- 2 Full Time Senior Account Clerks (Grade 7)
- 2 Full Time Account Clerks (Grade 4)
- 1 Medical Records Clerks (Grade 5)
- 5 Full Time Senior Clerks (Grade 4)
- 2 Full Time Word Processing Operators (Grade 4)
- 1 Part Time Word Processing Operators (Grade 4)
- 1 Full Time Senior Typist
- 1 Part Time Senior Clerk

Contractual Therapists

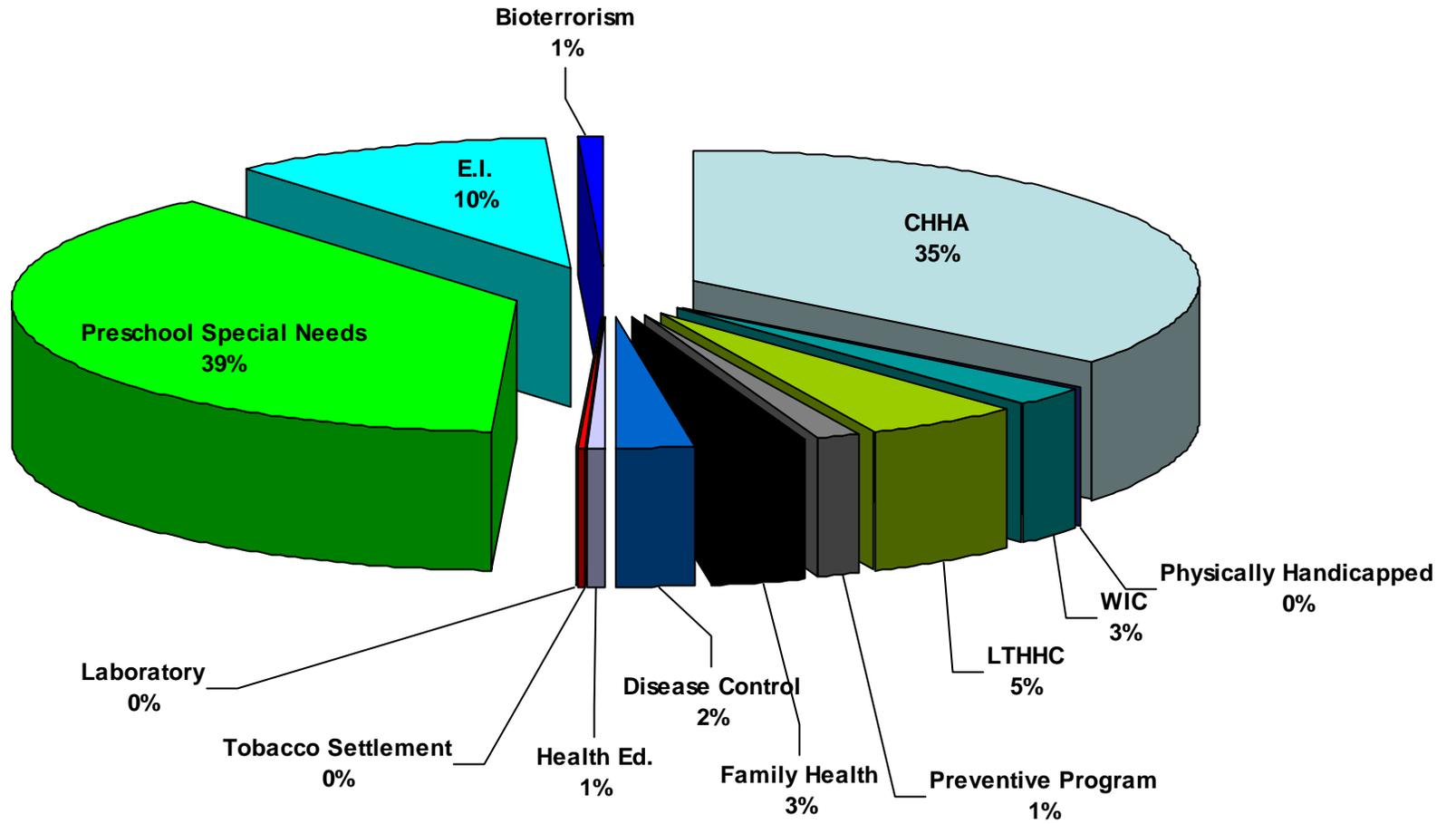
- 20 Physical Therapists
- 7 Occupational Therapists
- 19 Speech Therapists
- 3 Medical Social Workers
- 1 Respiratory Therapist
- 1 Dieticians

Contractual Medical Directors

- 1 Medical Director for Public Health Programs
- 1 Medical Director for Infectious Disease
- 1 Medical Director for Children With Special Health Care Needs
- 1 Medical Director for Home Care/High Technology Services

Medical Consultants are needed per NYSDOH regulations for the operation of our Diagnostic and Treatment Center, Physically Handicapped Children's Program, and the Tuberculosis Program. In addition, Adirondack Pediatrics P.C. provides physician coverage for monthly Queensbury Well Child clinics. The Town of Queensbury covers the cost (\$100.00 per clinic) for the physicians. Peter Hughes MD provides physician coverage for the weekly Sexually Transmitted Disease clinics. The costs for the clinics are divided between Warren and Washington counties at \$100.00 per clinic. Glens Falls Animal Hospital veterinarians and animal handlers provide staffing for Rabies clinics and prepare animal specimens for rabies testing as needed. They receive reimbursement per contractual basis. Particularly for nursing staff, recruitment and retention continue to be an escalating problem with no relief expected any time soon.

2007 BUDGET EXPENDITURES BY PROGRAM



WARREN COUNTY POPULATION

Source: NYSDOH Statistical Data

BIRTHS AND DEATHS IN WARREN COUNTY

**STATISTICAL INFORMATION
COMPARISON TRENDS**

	2003	2004	2005	2006	2007
Births	635	639	672	586	625
Deaths	619	451	598	705	613

EMERGENCY RESPONSE PLANNING

The lessons of the terror attacks on September 11, 2001 and the Gulf Coast hurricanes in September 2005, have changed our world forever. These emerging realities remind us of the importance of having county, state, and nationally coordinated and multidisciplinary comprehensive emergency response plans. To this end, Warren County Public Health brought together a team of local partners to identify and coordinate the communications and response duties of these agencies so that during a real (natural or man-made) event, staff and equipment resources will be effectively and efficiently utilized. Routine planning meetings, joint training sessions, video conferences and educational programs for the public, schools and providers are part of preparedness planning. Ongoing performance goal writing including the completion of the Warren County Pandemic Flu, COOP and Mass Fatality Plans, tabletop/functional and POD drills continued during 2007 to assist in the progress and development of a Warren County Public Health Emergency Response Plan which is reviewed and updated at least annually. Warren County receives a NYSDOH \$85,000 grant to cover administration costs of the program. Activities are reported to NYSDOH quarterly as required. A part-time Public Health Liaison and contract BT Coordinator are responsible for meeting grant objectives.

PUBLIC HEALTH EMERGENCY PREPAREDNESS ASSESSMENT TEAM - 2007

Name	Jurisdiction Represented	Job Title
Patricia Auer	Warren County	Director of Health Services
Patricia Belden	Warren County	PHN for Disease Control
Joseph W. Bethel	City of GF	Chief of Police
Joanne Conley	Warren County	Assistant Tourism Coordinator
Arthur Coon	National Guard	Sergeant 1 st Class/Recruiter
Rick Demers	Warr/Wash/Sara Counties	Mental Health
Mark DeSimone	Warren County	Mortician
Anita Gabalski	NYSDOH District Office	Director – Glens Falls Office
Ginelle Jones	Warren County	Assistant Director of Public Health
David Kolb	NYS Police	Sergeant
Daniel Larson MD	Warren County	Medical Director
Richard Leach MD	Warren County	Medical Director for Infectious Disease
Marvin Lemery	Warren County	Director - Warren County Office of Emergency Services
Amy Manney	Warren County	Deputy Director - Warren County Office of Emergency Services
David Mousaw MD	Warren County	Medical Director for Pediatrics
Cheryl Murphy	Red Cross	Emergency Services Coordinator
John O'Connor DVM	Warren County	Veterinarian
Facilitator; Barbara Orton	Warren County	BT Coordinator
Robert Phelps	Warren County	Commissioner, Social Services
Shane Ross	Warren County	Undersheriff, Sheriff's Office
Sharon Schaldone	Warren County	Assistant Director of Home Care
Gary Scidmore PA-C	Warren County	EMS Coordinator
Thomas Smith	Warren County	Glens Falls Hospital Pharmacist
Laura Stebbins RN MSN	GF Hospital	Director of Emergency Preparedness
Helen Stern	Warren County	Immunization Coordinator
Barbara Taggart	Warren County	Administrator - Westmount Health Facility
William Thomas	Warren County	Chairman, Board of Supervisors
Allison Williams	Warren County	Safety Officer, Upper Hudson Primary Care Consortium
Rob York	Warren County	Director, Office of Community Services

HOME CARE EMERGENCY PREPAREDNESS ASSESSMENT TEAM - 2007

Name	Jurisdiction Represented	Job Title/Description
Cheryl Belcher	Warren County	Nurse
Michelle Benedict	Inter-Lake Health Moses Ludington	Administrator
Liz Boccia	Home Therapy Group	CEO
John Boyce	Fort Hudson Nursing Home	Director of Plant Operations
Betsy Buecking	Adirondack Manor	Director
Maureen Burger/Cynthia Mitchell	Interim Health Care	Directors
Barbara Clements	Westmount Health Facility	Administrator
Lloyd Cote	Eden Park	Administrator
Paula DeLong	Inter-Lakes Medical Supply	Director
Tawn Driscoll	Warren County	Fiscal Manager
Cathy Dufour	Warren County	Nurse
Mary Beth Farmer	Upstate Home Respiratory Equip.	Secretary
Karen Fidd	Warren County	Nurse
Lori Fitzgerald	Albany VNA	Supervisor
Chris Freire	Glens Falls Hospital	Case Manager
Nancy Gasper	Warren County	Nurse
Janet Glenn	Saratoga County Public Health	Assistant Director Patient Services
Mary Lee Godfrey	Warren County	Nursing Supervisor
Wendy Golden	Visiting Nurses Home Care	Coordinator
Donna Gorton	Hudson Headwaters Health Network	Director of Nursing
Brenda Hayes	Countryside Adult Home	Director
Tammy Heckenberg	The Glen @ Hiland Meadows	Administrator
Candy Kelly	Office for the Aging	Director
Diane Krans	Inter-Lake Health Moses Ludington	Administrator
David Lamando	The Stanton	Administrator
Mary Lamkins	Warren County	Nursing Supervisor
Kathy Liddell	North Country Home Services	Office Manager
Barbara Lyons	Anthem Health Services	Vice President
Angela Meade	Warren County	PH Liaison
Joann Morton	Warren County	Supervisor
Barbara Orton	Warren County	BT Coordinator
John Penzer	Greater Adirondack Home Aides	Director
Stella Racicot	Warren County	Nurse
Ann Reynolds	Washington County	Assistant Director Patient Services
Facilitator: Sharon Schaldone	Warren County	Assistant Director Patient Services
John Schroeter	Warren County CASA	Coordinator
Mary Schwalbe	High Peaks Hospice	Office Manager
Peggy Sefcik	Lincare	Sales Representative
Linda Slattery	Warren County	Nurse
Laura Stebbins	Glens Falls Hospital	Director of Emergency Preparedness & Patient Safety
Lori Stiles	Saratoga County Public Health	Long Term Program
Dottie Storey	PA Medical	Office Manager
Bonnie Thomas	The Landing	Admissions
Allison Williams	Upper Hudson Primary Care Cons.	Safety Officer
Karen Woodcock	Adirondack Tri-County	Administrator
Rob York	Office of Community Services	Director

DIVISION OF HOME CARE...

HOME CARE SERVICES

Philosophy: The primary focus of Home Care is the health of individuals and their families as they relate and interact in their community. Home Care recognizes the importance of psychosocial and physical wellness and attempts to correct the circumstances that interfere with the greatest degree of wellness that a person can achieve. Further, the agency respects the autonomy of the patient and family to make decisions and choices affecting their present and future health status.

Home Care is patient centered, outcome oriented, and dependent on multi-disciplinary multi-agency interaction, communication, and coordination.

Goals: As a certified Home Health Agency, we shall provide skilled nursing services, physical, speech and occupational therapy, medical social services, nutrition, and home health aide services to patients within Warren County on an intermittent basis under the direction of a physician. The ultimate aim is to instruct and support the patient and family in self-care and disease management.

In addition, Home Care nurses shall provide health guidance to all ages so that individuals, families, and the community will be helped to achieve and maintain optimum health.

The agency shall participate in ongoing assessment of the community's health, social needs and resources. The agency shall participate in this ongoing assessment together with other providers and consumers of health care services in Warren County. They shall use this information to affect appropriate program planning under the direction of the Board of Supervisors acting as the Board of Health, with the assistance of the Professional Advisory Committee.

The agency will develop, implement and maintain a comprehensive, case managed program for persons who wish to be at home but who would otherwise require nursing home placement to meet their needs for care. This program is known as the Long Term Home Health Care Program.

QUALITY IMPROVEMENT PROGRAM

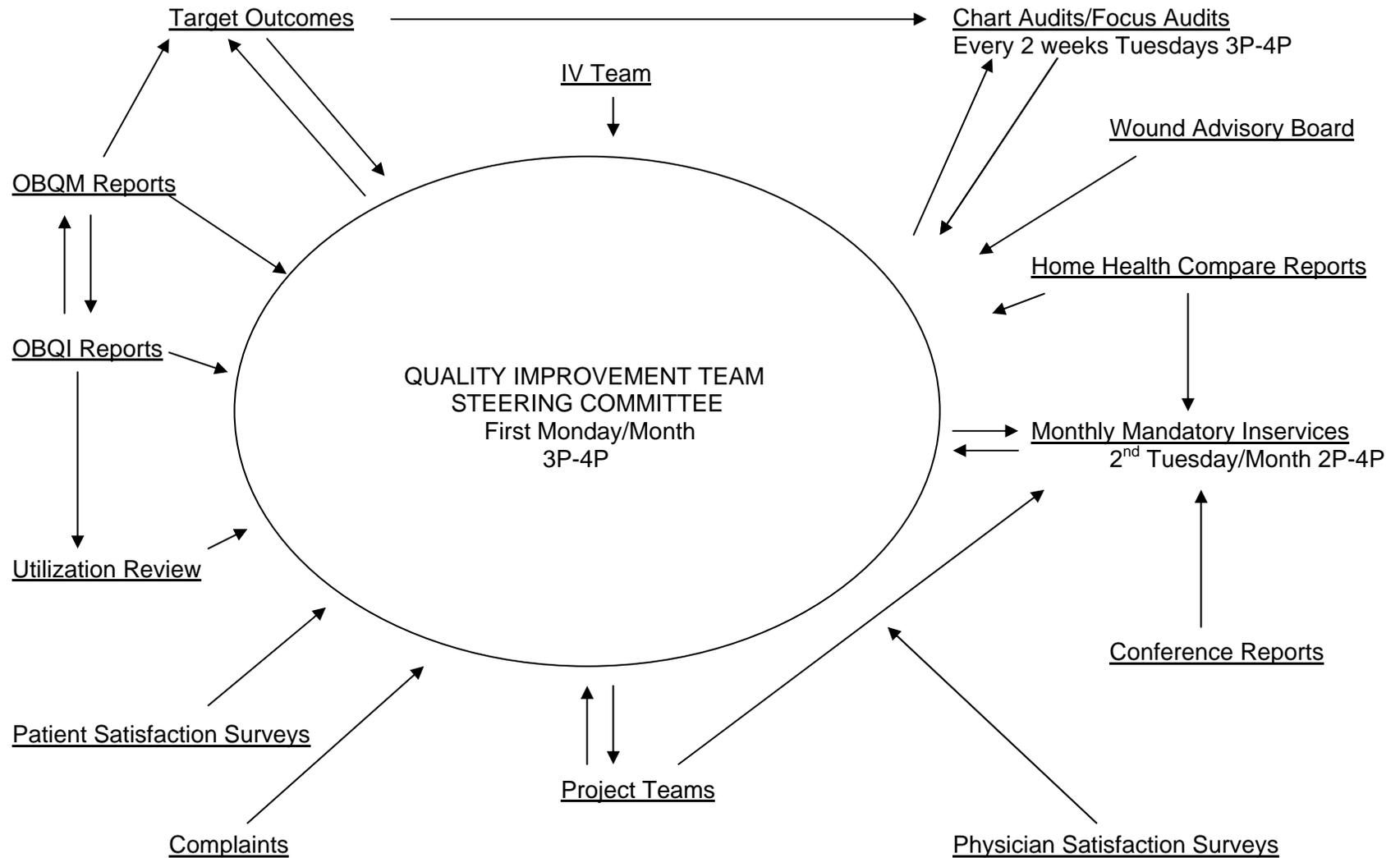
Warren County Health Services Division of Home Care is committed to providing quality health care to all of its clients. The process by which our client outcomes are monitored is through the Quality Improvement Program. This program is comprised of many components that address client outcomes. Two major reports that are the basis of our QI program are the OBQI reports and the OBQM reports. The OBQI reports are patient specific data collected at specific time-points throughout the patient's homecare stay. The OBQI reports monitor the patient's progress in certain areas such as walking, dressing self, wound healing, etc. This data is agency specific and is compared to other agencies nationally. OBQM reports are data collected in the same manner however they are specific to an adverse event. Examples of an adverse event are emergent care for falling at home, for hypo/hyperglycemia, for wound infections, and for deteriorating wound status. Other adverse events are substantial decline in oral medication management, increase in number of pressure ulcers, and development of urinary tract infection. Other agency components monitored for patient outcomes are through chart audits, focus audits, established Target Outcomes, Client Satisfaction Surveys, Physician Satisfaction Surveys, complaints, and Utilization Review findings. These findings are then reviewed by an appointed Quality Improvement team. The Quality Improvement Team Steering Committee consists of administrative staff, clinical staff representatives from nursing, physical therapy, occupational therapy, speech therapy, nutritional, and medical social worker. From this QI Team, project teams are developed to address issues that need to be investigated to improve client outcomes.

The process by which client outcomes are achieved may be changed or enhanced by the project teams. These changes are then instituted to all staff. Monitoring of these changes and their effectiveness are done through the QI Program using chart audits, patient surveys, and review of OBQM and OBQI reports.

It is our goal that all personnel employed by our Division of Home Care be involved and committed to our QI Program.

(See diagram next page.)

QUALITY IMPROVEMENT PROGRAM



Quality Improvement Accomplishments for 2007:

1. The Steering Committee enhanced the agencies disease management protocols of CHF and COPD in 2006. Patients admitted to the agency for CHF and/or COPD are put on the Telemed program and our instructed on the Disease Management protocol. The purpose of these standards is to provide the patient and their caregivers with better knowledge on how to manage these chronic diseases. The Disease Management protocols have become standard practice for all clinicians unless other wise indicated in 2007.
2. The Steering Committee worked in collaboration with IPRO this year (2007) working in the 8th Scope of Work, The Home Health Quality Imitative Campaign. This Campaign assisted us in developing Best Practices Interventions. Areas addressed were:
 - ✚ Emergency Care Planning
 - ✚ Hospitalization Risk Assessment
 - ✚ Front Loading Visits
 - ✚ Telemonitoring
 - ✚ Medication Management
 - a. The Committee developed a Hospitalization Risk Assessment tool based on our agency population characteristics. This is done on ever patient assessed for homecare services. If the patient scores as High Risk the clinician is to use one of two deliveries of cares, 1. Telemonitor or 2. Front load visits three times a week for three weeks, then two times a week for one week. The premises are that all hospitalizations occur within the first three weeks of admission.
 - b. The Committee developed handouts that are given to all admissions identifying when and who to call to prevent unnecessary ER visits.
 - c. The agency notify's the physician that the patient is at risk for hospitalization within the first 24-72 hours of admission.
 - d. All patients' medication profiles are faxed to the Physician for confirmation within 24-72 hours of admission.
3. Annual Oasis training for all professional staff was established in 2007. This training is to assure accurate data for the Home Health Compare Report, the next phase in Pay for Performance (P4P).
4. Certificate of Achievement for Reducing Acute Care Hospitalization in Home Care was awarded to the agency from IPRO for our participation in the project and for reducing our Acute Care Hospitalization rates.
5. A Wound & Continence Nurse Specialist (WCN) is now on staff overseeing all treatments of wounds. She facilitates the Wound Advisory Board which reviews all wound care cases that are high utilization. The agency's wound care cases are 3.5% higher than the National Average for Home Care Agencies.

QUALITY IMPROVEMENT

6. The established Agency Standards of Care continue to be successful in improving our patients' outcomes. This is apparent with the % noted in the 2007 OBQI report:
 - a. Stabilization in Management of Oral Meds: An increase of 2.8% from 2006.
 - b. Improvement in Status of Surgical Wounds: An increase of 3.5% from 2006, 6.2 % higher than the National Average.
 - c. Improvement in Transferring: An increase of 6.1% from 2006, 8.0 % higher than the National Average.
 - d. Improvement in Dyspnea: Is 4.4% higher than the National Average.
 - e. Emergent Care: Is 2.3% lower than the National Average.

7. Utilization Review Overview: The review of 72 records for 2007 revealed that less than 1% of the cases had problems. The committee identified only four cases where there was underutilization of services. These cases were isolated and case managers were counseled individually. There were no problems identified that would require any further investigation or change in the agencies practices of delivering care. The number of active patients on the last day of 2007 was 836, up from 768 in 2006. Utilization of Services Summary:

Adequate Utilization	67
Over utilization	0
Underutilization	4
Inadequate Information	1
Unable to Decide	0

8. Telemedicine Program: This program was launched in November 2005. Acceptance level and program growth continued in 2007. Our initial focus with the Telemed program was to use the monitors with our Disease Management Standard's for Congestive Heart Failure (CHF), and Chronic Obstructive Pulmonary Disease (COPD). This proved to provide better daily disease management with fewer hospitalizations while enhancing patient compliance and cutting costs. In 2007 we expanded the program to include any patient that was identified as High Risk for Hospitalization regardless of diagnosis.

TELEMEDICINE PROGRAM

The Homecare Division started the Telemedicine Program in November 2005. We were awarded a grant of \$106,000.00 from the first round of the NYSDOH Telemedicine Demonstration Program. This grant enabled the agency to start the program which has since been enhanced with another grant from the USDA and with an agency investment of \$100,000.00.

The program was launched after months of preparation which included writing the grant and educating our staff about purpose and approach. We researched all telemonitors available at the time and decided to go with Honeywell Hommed and the non-video unit, feeling our population would be better served. We started with 32 monitors and after 3 weeks had all these units in service. In February 2006 we acquired 32 additional units servicing 60 to 70 clients a month.

We saw dramatic improvement in patient outcomes from the beginning, decreasing the number of nursing visits per episode of care by 30% to 50%. This allowed our clinicians to manage more patients without compromising care standards. Patient quality of life improved with noticeable compliance of Disease Management evident by decreased numbers of hospitalizations. Our agency's hospitalization rate decreased from 38% to 40% for certain diagnosis down to 12% to 14% within the first 6 months.

In September 2006 we were awarded a USDA grant of \$55,000.00 to again expand our program at which time we purchased 26 telemonitors from Honeywell Hommed. To date, we have 89 available monitors servicing 70 to 80 clients per month.

Health Services has had great success in the development and acceptance of the Telemedicine Program due to hard work and staff commitment. We work with NYSDOH on setting reimbursement rates for telemonitoring in New York for the Medicaid population. We were one of the first agencies in New York to use this program in conjunction with Disease Management Programs. We also were one of the first - if not the first agency in New York - to use this Disease Management/Telemedicine Program in our Long Term Care Program and have been very successful in decreasing the number of hospitalizations for that population by 68% in one year.

To date we continue to enhance this program. It is now standard practice within the agency for all patients with Congestive Heart Failure (CHF) and/or Chronic Obstructive Pulmonary Disease (COPD) to receive our Disease Management Programs along with the telemonitors. We also just expanded the use of the monitor to all patients assessed as high-risk for hospitalization. It is standard knowledge in the industry that hospitalizations occur within the first three weeks of service especially if there has been a previous acute care stay. We will be studying the impact of nurses' daily oversight using monitors in conjunction with Disease Management in 2008.

Telemedicine Outcomes:

- Provided comprehensive Disease Management to chronically ill patients with CHF, COPD, and most cardiac diagnosis. In July 2007 we launched the use of monitors with patients identified as high-risk for hospitalizations.
- We averaged 53 clients per month the first half of 2007 and increased to 75 per month in the second half of the year. This was a 45% increase in utilization with the expansion of our disease criteria.
- Average hospitalization rate for clients on monitors was 17.5% in 2007. This was a 3.5% increase from 2006. Hospitalizations were 60% due to respiratory difficulties related to our COPD population, 30% due to pain management and other causes, with only 10% due to cardiac complications.

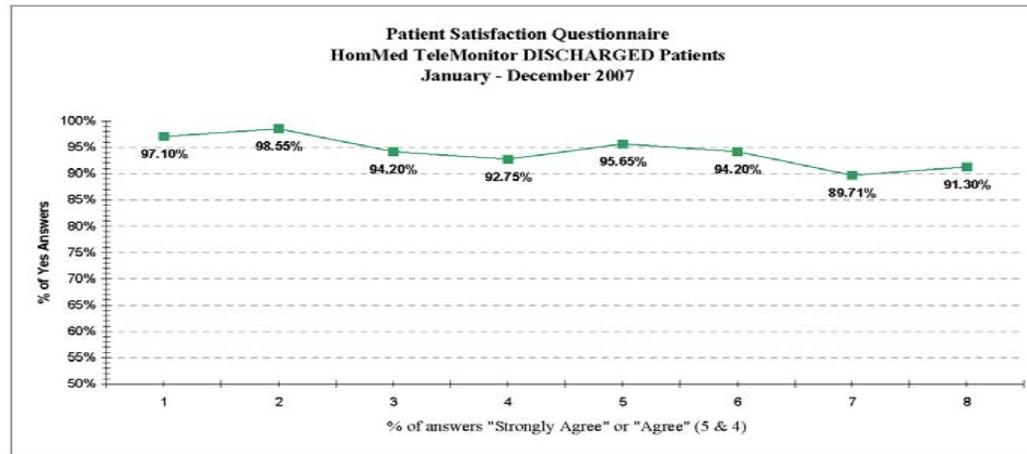
**WARREN COUNTY PATIENT SATISFACTION SURVEY
TELEMEDICINE, January - December 2007**

	Total	4 & 5	Strongly Agree = 5	Agree = 4	No Opinion = 3	Disagree = 2	Strongly Disagree = 1	N/A = 0	
Q1	75.36%	97.10%	52	15	1	1	0	0	69
Q2	71.01%	98.55%	49	19	0	1	0	0	69
Q3	65.22%	94.20%	45	20	2	1	0	1	69
Q4	65.22%	92.75%	45	19	4	1	0	0	69
Q5	63.77%	95.65%	44	22	1	2	0	0	69
Q6	66.67%	94.20%	46	19	2	2	0	0	69
Q7	69.12%	89.71%	47	14	4	2	1	0	68 *
Q8	68.12%	91.30%	47	16	3	2	1	0	69

	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
131 Sent	7	10	16	11	6	11	11	21	10	10	10	8
69 Ret.	2	7	9	5	1	8	7	14	5	3	4	4

52.67% Returned

* One not answered for question # 7.

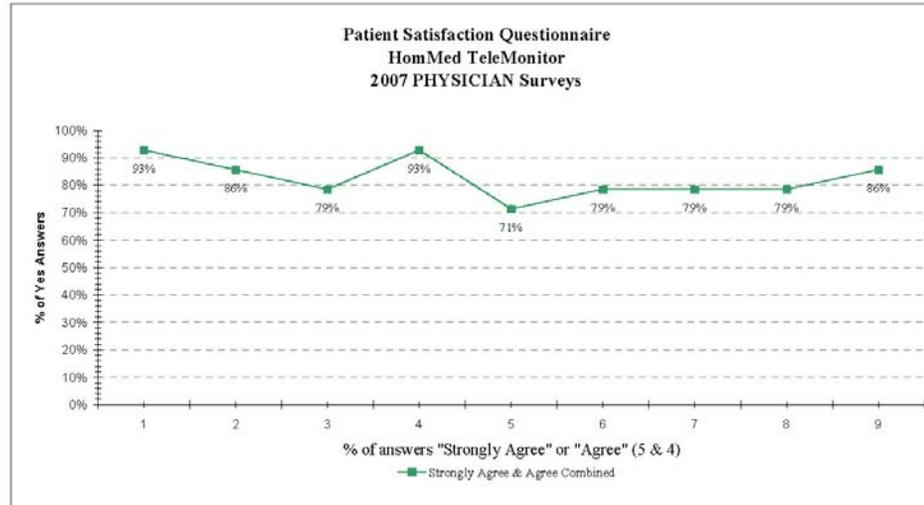


Question Legend

- Q1 I think I was well educated on the use of the Monitoring System.
- Q2 The Monitoring System is easy to use.
- Q3 The Monitoring System is useful in assisting me to manage my health
- Q4 I felt more involved in my care by participating in the monitoring Program.
- Q5 Daily monitoring enhanced the care I received from my home care agency and my physician.
- Q6 Home monitoring provided me with a sense of security and peace of mind.
- Q7 I would use the Monitoring System in the future.
- Q8 I would recommend the use of daily home monitoring to my family and friends.

**2007
Warren County Physician's
HomMed TeleMonitor System Survey**

	5 & 4 Combined	5's	4's	Strongly Agree = 5	Agree = 4	No Opinion = 3	Disagree = 2	Strongly Disagree = 1	Not Answered = 0		
	93%	Q1	86%	100%	6	1	0	0	0	1	7
	86%	Q2	86%	86%	6	0	1	0	0	1	7
	79%	Q3	71%	86%	5	1	1	0	0	1	7
	93%	Q4	86%	100%	6	1	0	0	0	1	7
	71%	Q5	57%	86%	4	2	1	0	0	1	7
	79%	Q6	71%	86%	5	1	1	0	0	1	7
	79%	Q7	71%	86%	5	1	1	0	0	1	7
	79%	Q8	71%	86%	5	1	1	0	0	1	7
	79%	Q9	71%	100%	5	2	0	0	0	1	7
Totals											
Distributed	160										
Returned	8										
Percentage	5.00%										



Question Legend

- Q1 I have been provided with sufficient information regarding the daily home monitoring system and its benefits.
- Q2 Daily home monitoring has enhanced the standard of home care services for my patients.
- Q3 Daily home monitoring provides security and peace of mind for my patients.
- Q4 Involving patients in their care has a positive affect on patient compliance issues.
- Q5 I am satisfied with the communication of patient data.
- Q6 Trend reports are helpful in the development of my patient treatment plans.
- Q7 Daily home monitoring provides early detection and intervention required for my patients.
- Q8 I believe that daily home monitoring assists in reducing ER visits and re-hospitalizations.
- Q9 I would recommend the use of daily home monitoring to other physicians.

HOME HEALTH COMPARE

The Centers for Medicare and Medicaid Services (CMS) has undertaken a quality initiative, Home Health Compare, to track and report data on a variety of measures of Home Care quality. Home Health Compare is part of a larger quality initiative aimed at giving consumers information they can use to make informed choices about their health care.

Warren County Health Services is deeply committed to providing our patients with the highest quality of care and we welcome CMS' efforts to measure and provide information on quality. We are proud and confident of the skills, talents, and dedication of our staff and of the level of services they provide to a wide range of patients with extremely varied medical needs. We will continue to use the data relevant to our agency to help our efforts to improve quality and benchmark our efforts for future improvement as we have for past years.

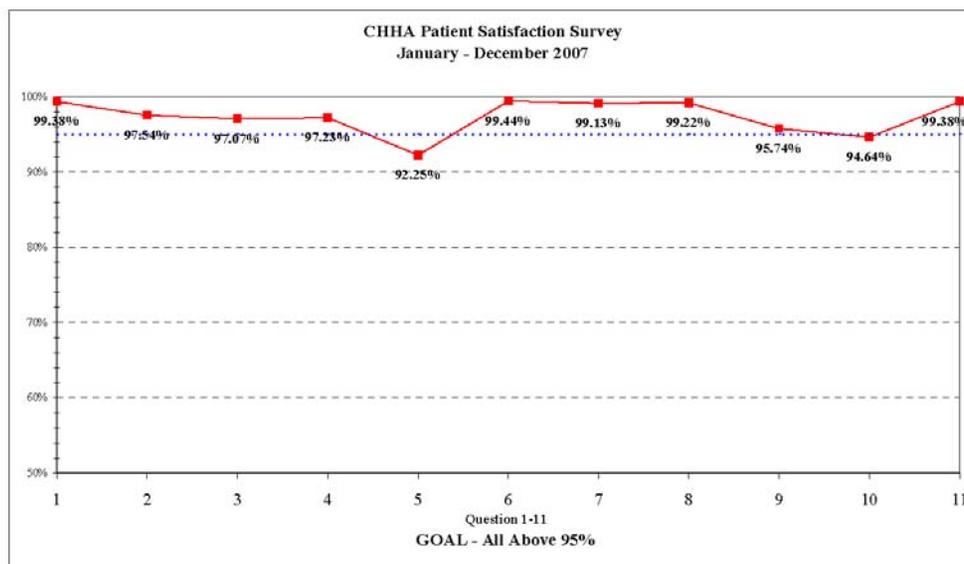
(See chart next page.)

FOURTH QUARTER HOME HEALTH COMPARE REPORT FOR 2007

The Home Health Compare report consists of 12 quality measures all collected via the OASIS data set. This report is updated quarterly and can be found at www.medicare.gov. CMS is proposing that in the near future, agencies will be reimbursed for their professional services based on performance in specific quality measures “Pay for Performance” (P4P). Below is the most recent report for 2007: November 14, 2007

	Percentage for Warren County Health Services CHHA	State Average	National Average
HIGHER PERCENTAGES ARE BETTER			
Patients who get better at walking or moving around	33%	41%	42%
Patients who get better at getting In and out of bed	64%	53%	54%
Patients who have less pain when moving around	56%	66%	64%
Patients whose bladder control improves	55%	55%	50%
Patients who get better at bathing	57%	63%	64%
Patients who get better at taking their meds correctly (by mouth)	33%	45%	43%
Patients who are short of breath less often	67%	64%	61%
Patients who stay at home after an episode of home health care ends	66%	66%	68%
NEW-Percentage of patients whose wounds improved or healed after an operation	82%	77%	79%
LOWER PERCENTAGES ARE BETTER			
Patients who had to be admitted to the hospital	32%	31%	28%
Patients who need urgent unplanned medical care	29%	25%	21%
NEW: Percentage of patients who need unplanned medical care related to a wound that is new, is worse, or has become infected:	2%	1%	1%

WARREN COUNTY PATIENT SATISFACTION SURVEY



54.53% = Percent of Questionnaires Returned

Question Legend

- Q1 When health nurse or therapist visited your home, did you know why she/he was there?
- Q2 Did you and the nurse or therapist arrange a time for the visit which was convenient to both of you?
- Q3 Did the nurse help you to understand what your medication was expected to do for you, and any side effects effects to watch for and report?
- Q4 Did the nurse examine you when she made a visit (I.e. take your blood pressure, pulse, listen to your chest chest with a stethoscope, weight you, take your temperature?)
- Q5 Did the nurse/therapist teach you the possible complications related to your illness?
- Q6 Did you understand when it is important to call your physician?
- Q7 Did you understand what the nurse or therapist was planning to accomplish by visiting you?
- Q8 Did the nurse or therapist visit make it easier for you to remain in your home and care for yourself?
- Q9 Were you aware that the nurse or therapist was going to discharge you from the service?
- Q10 Did you feel you could function on your own when the nurse or therapist discharged you from the service?
- Q11 If you need skilled nursing or therapy in your home at some time in the future, will you contact this agency?
- * Q12 How long did the nurse or therapist usually stay? 10 - 20 - 30 - 40 - 60+ minutes
- * Q13 Did you feel the nursing or therapist visits were Too few / Too Many / Right Number?

* These two questions are not represented in the graph.

PATIENT PROFILE

The average age of our patients is: 76.23 and are 60.46% female.

Payer Sources:	91.56% Medicare	National Average: 93.99%
	11.00% Medicaid	National Average: 10.45%
	19.93% Managed Medicare	National Average: 11.89%

Note that Medicare and Medicaid %'s remain unchanged from 2006 however the Managed Medicare's increased by 6.31% and the HMO'S increased by 6.81% in 2007.

- 60.71% live with family, National Average: 62.73%
- 70.72% of patients had a hospital admission 14 days prior to our agency admission, National Average: 60.22%
 - Discharged from a rehabilitation facility – 4.53% higher than National Average
 - Discharge from nursing home – 9.89% lower than National Average

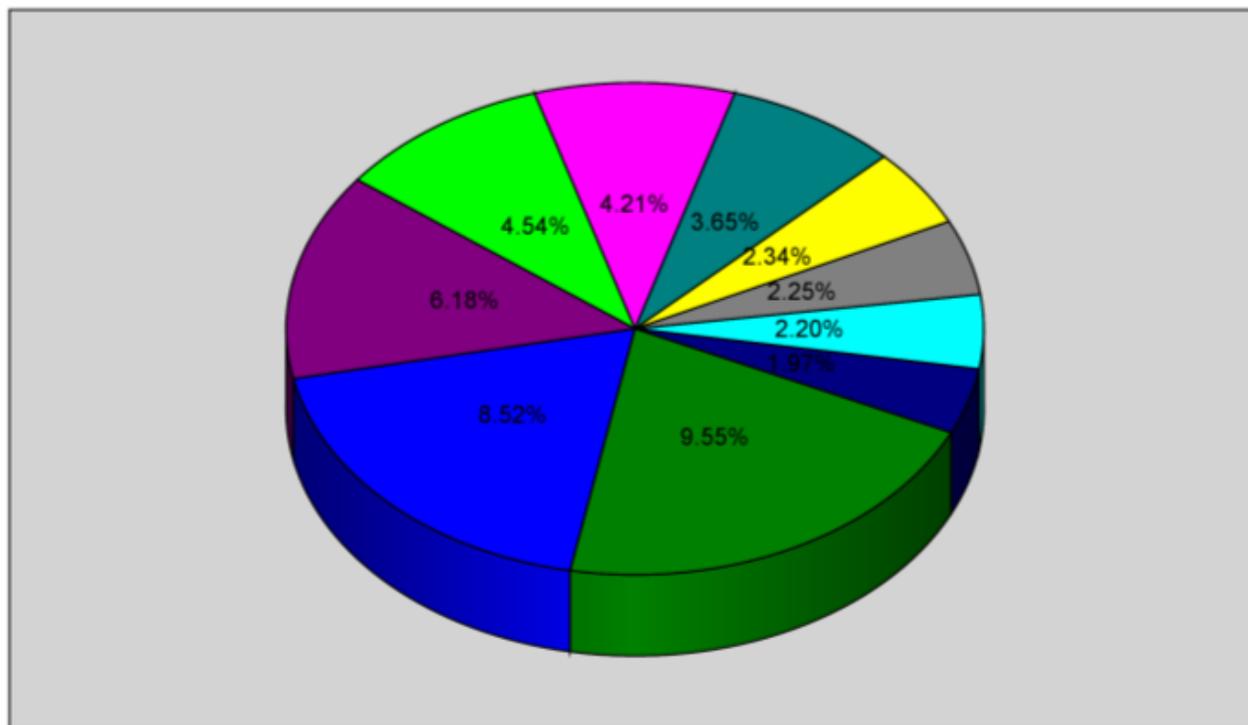
Our patients are more independent in performing their activities of daily living than the national average. Dressing lower body, bathing, and ambulation were the ADLs requiring the most assistance. We see a higher percentage of patients with endocrine, mental, circulatory, respiratory, digestive, and urinary system problems than the national average.

Our patients' average length of stay is about 35.96 days, slightly less than the 38.03 National Average.

Top 10 Primary Diagnosis

For Visits Between 1/1/2007 and 12/31/2007

For CHHA & Long Term Care Programs



■	V57.1 - PHYSICAL THERAPY NEC : TOTAL CASES = 204
■	V54.81 - AFTERCARE FOLLOWING JOINT REPLACEMENT : TOTAL CASES = 182
■	715.90 - OSTEOARTHROS NOS-UNSPEC : TOTAL CASES = 132
■	V58.73 - AFTERCARE OF CIRCULATORY SURGERY : TOTAL CASES = 97
■	491.21 - OBS CHR BRNC W ACT EXA : TOTAL CASES = 90
■	428.0 - CONGESTIVE HEART FAILURE : TOTAL CASES = 78
■	V58.42 - AFTER CARE OF CA SURGERY : TOTAL CASES = 50
■	486 - PNEUMONIA, ORGANISM NOS : TOTAL CASES = 48
■	V58.77 - AFTERCARE OF SKIN AND SUBCUTANEOUS TISSUE : TOTAL CASES = 47
■	427.31 - ATRIAL FIBRILLATION : TOTAL CASES = 42

CERTIFIED HOME HEALTH AGENCY SERVICES BY THE NUMBERS

VISITS BY SERVICE

Services	2006	2007	2006/2007 % (+ or -)
Nursing	22,169	22,923	3%
Physical Therapy	8393	8173	-3%
Occupational Therapy	1420	1029	-28%
Speech Therapy	409	245	-40%
Medical Social Worker	264	166	-37%
Nutrition	97	53	-45%
Home Health Aide	6905	4922	-29%
TOTALS	39,657	37,511	-5%

CASES BY TOWN

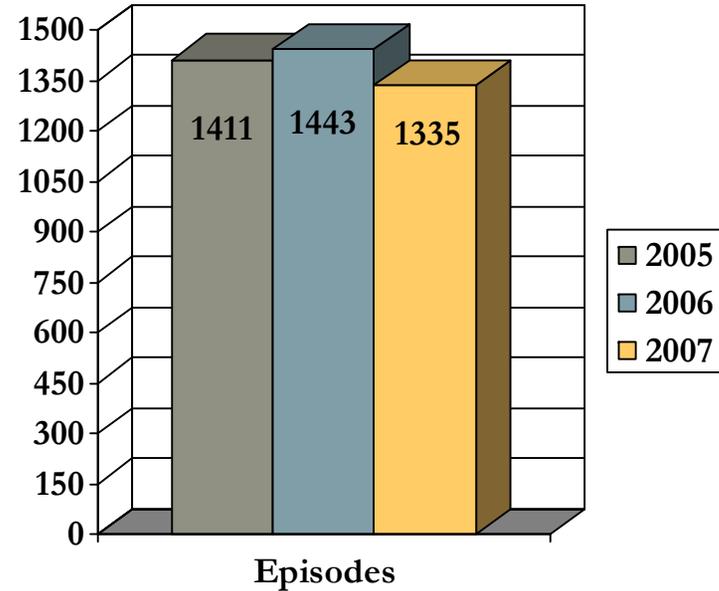
	2006	2007
Bolton	40	44
Chester	84	130
Glens Falls	557	535
Hague	30	34
Horicon	57	51
Johnsburg	94	102
Lake George	143	193
Lake Luzerne	97	80
Queensbury	901	918
Stony Creek	30	24
Thurman	17	13
Warrensburg	201	181
TOTALS	2251	2305

REVENUES & EXPENDITURES

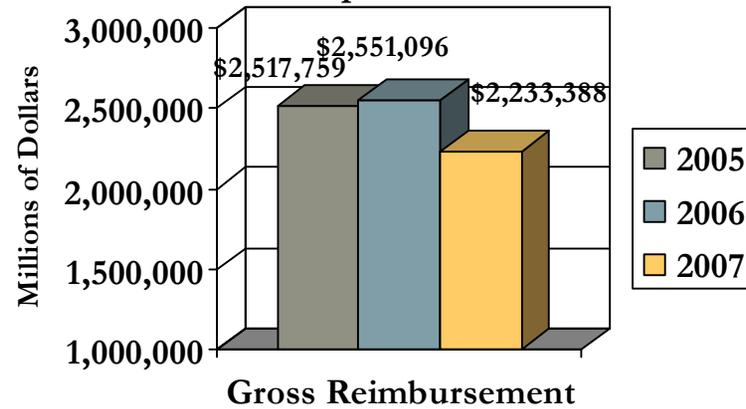
	2006	2007
Revenues	\$5,003,240.00	\$5,017,001.00
Expenditures	\$4,239,393.00	\$4,151,644.00

EPISODES OF CARE

An episode is a 60-day period of time when professional services are provided to a patient. Episodes of Care are specific to CMS (Medicare) and the reimbursement rate is based on the patient's clinical, function and service requirements (OASIS assessment) for the 60-day period.



This exhibit captures our straight Medicare clients. Managed Medicare increased proportionately to cover the decrease in straight Medicare.



THERAPY SERVICES

	2006	2007
Business Associates (see list of associates next page)	55	51
Therapy Referrals for EI/CPSE	299	333
Pre-Admission Teaching Program for Total Knee and Hip Replacements	149	140
Physical Therapy Only Services	144	152
<i>Referrals for Therapy Services in Addition to Nursing: (Unduplicated Patient Count)</i>		
Physical Therapy	1020	999
Occupational Therapy	210	156
Speech Therapy	34	33
Registered Dietician	49	38
Medical Social Worker	66	66

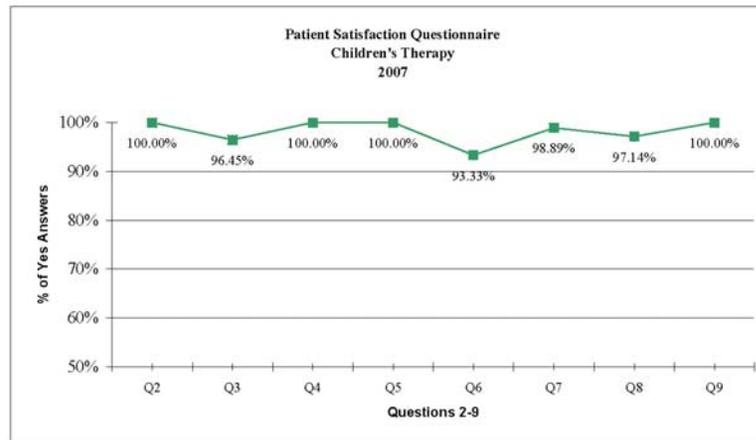
Recruitment of therapists who will service our northern communities continues to be a challenge. An increased reimbursement rate to the northern regions has helped somewhat to increase availability of services to these areas. In 2007 the addition of new PT/OTs servicing our critical long term cases was beneficial. MSW and RD services are still difficult to find for coverage of northern regions however. Therapists have been trying to front-load visits to reduce risk of falls and to improve home safety measures.

EI/CPSE programs have adapted new documentation guidelines and forms which allow parents and therapists to identify and work on specific goals. The new documentation has improved communication and involvement of parents by allowing them to track their child's progress weekly.

Warren County Children's Therapy Surveys 2007

	01/07	02/07	04/07	07/07	10/07	Total
Distributed	25	17	25	25	18	110
Returned	9	3	8	20	9	49
% Returned	36.00%	17.65%	32.00%	80.00%	50.00%	44.55%

	Average	01/07	02/07	04/07	07/07	10/07
Q2	100%	100%	100%	100%	100%	100%
Q3	96%	100%	100%	88%	95%	100%
Q4	100%	100%	100%	100%	100%	100%
Q5	100%	100%	100%	100%	100%	100%
Q6	93%	89%	100%	100%	100%	78%
Q7	99%	100%	100%	100%	100%	94%
Q8	97%	100%	100%	86%	100%	100%
Q9	100%	100%	100%	100%	100%	100%



Question Legend

- * Q1 Please identify what discipline(s) serviced your child. PT __, OT __, ST __.
- Q2 Are you aware of the goals set for your child?
- Q3 Has the therapist provided activities to work on at home?
- Q4 Has the therapist provided relevant information regarding your child's area of need?
- Q5 Are you able to communicate to the therapist your concerns?
- Q6 If there is a concern regarding your therapist or the therapy, are you aware of who to contact?
- Q7 Does your therapist keep scheduled appointments?
- Q8 Are you notified of therapy appointment cancellations?
- Q9 Are you given the chance to reschedule cancelled appointments?

* This question is not represented in the graph.

BUSINESS ASSOCIATES CONTRACTED IN 2007 FOR THERAPY SERVICES

Juliet Aldrich ST
Amy Anderson ST
Karin Ash PT
Laurie Aurelia ST
Natalie Barber PT
Stephen Bassin PT
Dawn Bazan OT
Barbara Beaulac PT
Mari Becker OT
Heidi Bohne ST
Diana Burns PT
Sara Bush ST
Judy Caimano ST
Beth Callahan PT
Nancy Carroll MSW
Deborah Clynes ST
Rebecca Compson PT
Teresa Costin OT
Christine Dee ST
Theresa Dicroce PTA
Stacie DiMezza ST
Maggie Dochak ST
Colleen Downing PT
Melissa Dunbar ST
Gary Endal OT
Stacey Frasier OT

Robert Gautreau PT
Deborah Gecewicz ST
Dorothy Grover PT
Richard Gurney PTA
Joseph Hickey RT
Cheryl Hoffis ST
Kelly Huntley PT
Denise Jackson PT
Karen Kowalczyk PT
Linda LeBlanc ST
Mindy LaVine ST
Jeanine Lawler OT
Rita Lombardo-Navatka MSW
Celeste Mangiardi MSW
Marie McGowan ST
Holly O'Meara ST
Anne Paolano PT
Edward Reed PT
Donna Reynolds OT
Kathleen Ryan PT
Donna Sauer-Jones MSW
Teresa Scotch ST
Marti Tucker PT
Sandra Watson RD
Nicole Willis PT

Health Services staff consider these people to be dedicated professionals – thanks for a job well done!

LONG TERM HOME HEALTH CARE PROGRAM

The LTHHC Program is a NYSDOH Waiver Certified Program that provides case management for multiple services to Medicaid eligible clients who are medically eligible for placement in a nursing home.

Services provided to clients in the program are based on medical needs and can include:

Non-Waiver Services

- Skilled Nursing
- Physical Therapy
- Occupational Therapy
- Speech Therapy
- Medical Supplies and Equipment
- Homemaking
- Housekeeping
- HHA or PCA

Waiver Services

- Medical Social Worker
- Nutrition
- Respiratory Therapy
- Audiology
- Social Day Care (includes Transportation)
- Lifeline
- Respite Care
- Home Delivered or Congregate Meals
- Assistance with Moving
- Home Improvements and/or Maintenance
- Medical Daycare

The focus of this program is to provide a cost-effective comprehensive alternative to nursing home placement for those individuals and their caregivers who prefer this option.

Skilled nursing is the only direct service provided by the agency in this program. All other services are provided on a contractual basis that necessitates a full time coordinator on a supervisory level to be sure these services are timely and appropriate. This supervisor is also responsible for good coordination between all the services a client receives.

	2006	2007
Number of active patients as of 12/31/07	41	41
New Admissions	26	33
Number of Discharges	28	26

NURSING HOME LEVEL OF CARE

Long Term Home Health Care is a budget-driven program dependent upon the individual patient’s level of care. This level of care is measured with a New York State tool - the DMS1. This tool is used by the Department of Social Services to determine the budget cap (SNF vs HRF level). Monthly budget levels are based on 75% of the monthly cost of a facility.

DMS1 Scores: Health Related Facility (HRF) Level Score: 60-180: 33 HRF Patients
 Skilled Nursing Facility (SNF) Level Score: 180 and above: 15 SNF Patients

The Long Term Home Health Care Program is funded primarily by Medicaid. The program will bill Medicare or commercial insurance for any qualified services before Medicaid is billed. There are two different types of Medicaid options for individuals in this program, Community Medicaid and Spousal Impoverishment Medicaid. Spousal Medicaid can only be used for nursing home placement, the Long Term Home Health Care Program, or the Traumatic Brain Injury Waivered Program.

The trend in increasing frequency of client visits continues. We presently have 3 full time nurses working in this program.

PATIENT REFERRAL SOURCES

SOURCE	2006	2007
Medicaid Unit	3	1
Certified Home Health Agency	14	17
Personal Care Aide Program	0	3
Hospital	1	0
Physicians	1	1
Family	1	0
Self-Referral	2	0
Nursing Home	1	1
Central Intake	1	5
Rehabilitation	2	4
Other	0	1
TOTAL	26	33

The largest number of referrals were from the certified agency. These individuals required ongoing care for their chronic health needs. Referrals from Medicaid are for couples in the community who apply for spousal Medicaid and are looking to participate in either the Long Term program or are seeking nursing home placement. Prospective applicants who wish community services are screened by the Long Term program for medical eligibility and are eventually referred for service.

LONG TERM PROGRAM BY THE NUMBERS

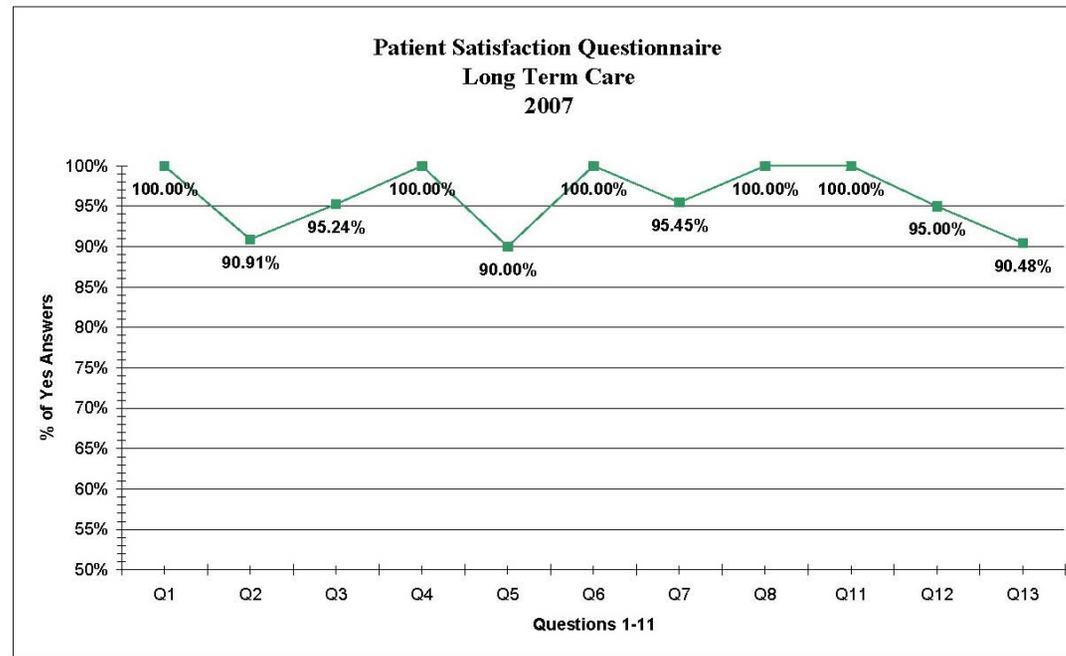
VISITS BY SERVICE

Services	2006	2007	2006/2007 % (+ or -)
Nursing	1682	1637	-3%
Physical Therapy	573	545	-5%
Occupational Therapy	302	353	17%
Speech Therapy	109	88	-19%
Medical Social Worker	72	213	196%
Nutrition	97	54	-44%
Respiratory Therapy	204	195	-4%
Home Health Aide	4727	2166	-54%
Personal Care Aide	6109	5771	-6%
Homemaker	0	0	0%
Audiology	0	0	0%
TOTALS	13,875	11,022	-21%

REVENUES & EXPENDITURES

	2006	2007
Revenues	516,665.00	658,138.00
Expenditures	595,248.00	589,774.00

WARREN COUNTY ANNUAL PATIENT SATISFACTION SURVEY
LONG TERM CARE - 2007



Question Legend

- Q1 When health nurse or therapist visited your home, do you know why she/he is there?
- Q2 Do you and the nurse or therapist arrange a time for the visit which is convenient to both of you?
- Q3 Does the nurse help you to understand what your medication(s) is expected to do for you, and any side effects to watch for and report?
- Q4 Does the nurse examine you when she makes a visit (I.e. take your blood pressure, pulse, listen to your chest with a stethoscope, weight you, take your take your temperature?)
- Q5 Does the nurse/therapist teach you the possible complications related to your illness?
- Q6 Do you understand when it is important to call your physician?
- Q7 Do you understand what the nurse is planning to accomplish by visiting you?
- Q8 Do the nurse and aide visits make it easier for you to remain in your home and care for yourself?
- Q9 Do you understand what your aide is allowed to do?
- Q10 Is your aide service adequate?
- Q11 Does your aide have enough time to complete assigned tasks?
- * Q12 How long does the nurse usually stay? 10 - 20 - 30 - 40 - 60+ minutes
- * Q13 Do you feel the nursing visits are? Too few / Too Many / Right Number?

* These two questions are not represented in the graph.

HOME CARE ACCOMPLISHMENTS AND GOALS

ACCOMPLISHMENTS FOR 2007:

- Developed the Telemedicine Program to be one of the most successful in New York State. We serviced 191 patients and decreased patient hospitalizations in our CHHA and LTC programs. We serviced about 70 to 90 patients per month on the monitors.
- Expanded our Telemed Program to include patients that are at high-risk for hospitalization.
- The role of our agency Certified Wound & Continence Nurse (WCN) on staff continued to grow. This nurse heads the Wound Advisory Board, oversees all complicated wound cases, and assists nurses and physicians with treatment protocols. This has positively impacted our patient outcomes while decreasing our cost per episode.
- Developed a Hospitalization Risk Assessment that identifies patient risk for hospitalization on admission. This identification steers the clinician to either front-load home visits or to place a Telemonitor. The idea is that this Standard of Practice will decrease our agency's hospitalization rate by preventing hospital admissions that are highest in the first 21 days of care.
- We continued to work with Office for the Aging and the Department of Social Services as lead agencies, to develop Warren/Hamilton counties' Point of Entry (POE) / New York Connects. POE will provide unbiased information about options available for long term care regardless of age or income. We established the Long Term Care council, a group of organizations in the community, providing services that would assist individuals and families in preparing for long term care.
- We expanded the role of one of our Community Health Nurses to work as a Liaison at the Glens Falls Hospital to target our readmission population and to facilitate communication between home care, the hospital, patients and families, and providers. This program was started in November of 2007.
- We collaborated with Glens Falls Hospital to connect electronically to allow access to our patients' treatment data therefore enhancing our referral process.
- We were successful in obtaining the support of our Board of Supervisors and funding needed for an Electronic Medical Chart to start in 2008.

GOALS FOR 2008:

- Continue enhancing our Quality Improvement Program.
- Collaborate with IPRO on the 9 Scope of Work Care Transition Project along with the Glens Falls Hospital and Washington County Public Health.
- Continue to develop the county's Single Point of Entry (POE) / New York Connects: Choices for Long Term Care.
- Grow and enhance our Telemedicine Program.
- Implement our Point of Care electronic patient record. This is critical to the growth and future stability of our agency.

COOPERATIVE EFFORTS WITH OTHER COUNTY DEPARTMENTS

This agency has made a commitment to ensuring easy access to health care in Warren County. In an effort to meet this commitment, skilled nursing services have been made available to the Department of Social Services and Office For The Aging in the following programs:

A. PCA – Personal Care Aide Program (DSS)

Agency nurses provide skilled assessment visits to Medicaid clients to ensure they are appropriate for this program. Once a client is admitted to the program, nursing assessments are done every three months and as needed to make sure the client continues to meet program criteria and to supervise the aides placed in the homes to provide patient care. We have seen an increase in the number of patients who are CHHA with PCA services as well as these patients have both skilled and custodial care needs. We currently service 55 patients with the PCA Program.

B. CDPAP (The Consumer Directed Personal Assistance Program)

This program was created as an alternative to the traditional PCA program. The consumer has the opportunity to manage his/her own care at home and directs who provides the care and what kind of care is received. Agency nurses provide skilled assessments to ensure client is appropriate for this program.

VNA and CWI are vendors that provide the consumer with direction and guidance on how to manage their care and assists in recruiting the personal assistant, interviewing and hiring techniques and consultation during the progression of the program.

Warren County Health Services provides the nursing assessment to ensure safe care, review the plan of care, and revisit every six months to repeat the assessment to see if the client's needs have changed and are being met appropriately.

We currently have 86 clients who have opted for this program. This program serves as an alternative to the traditional personal care aide program. There are more parents of children with special needs who are opting for this program as an alternative to services through Prospect Programs, school, or CWI, etc. This offers more flexibility with scheduling needed care.

C. EISEP – Expanded In-Home Services for the Elderly Program (OFA)

Agency nurses provide the same types of services as noted in the personal care aide program, except these clients are not eligible for Medicaid. State funding through Office For The Aging funds the homemaker and nursing services provided to these clients with a small cost share determined by the client's financial situation. Those waiting for evaluation and services to start are encouraged to contact Greater Adirondack Home Aides for private aides, hopefully with subsidy through the agency. Office for Aging only has a contract with Greater Adirondack Home Aides and the Visiting Nurses Association for EISEP clients. Patients on caseload are seen every three months. Referrals to CHHA services are made if any complications develop. EISEP Aide time remains in place while CHHA services provide skilled nursing needs.

Number of patients on caseload	27
Number of new admissions	14
Number of discharge	13

D. TITLE III E (OFA)

This program uses our agency for case management and aide supervision similar to EISEP. The focus with this state-funded program is to provide caregiver respite either by use of aides or short term use of an assistive living facility to allow the caregiver a few days off. This program uses federal funds to provide information in the form of pamphlets, educational program, and in-home respite care. Funds are limited. Currently 2 clients are utilizing this program.

Number of patients on caseload	2
Number of new admissions	0
Number of discharge	0

E. COORDINATED CARE

Agency nurses work jointly with a DSS's CASA (Community Alternative Systems Agency) caseworker doing in-home assessments for individuals who request assistance accessing programs. This program started in 1988 to help those who needed assessment of their medical needs and their financial eligibility for various programs available through the county or the community. This highly-skilled team helps families develop a plan to manage the care of a family member, identify sources of assistance available to them, and help make the connections with these resources.

This team is also qualified to do the necessary paperwork to determine nursing home level of care and can assist families in working through the nursing home process.

CENTRAL INTAKE

The Central Intake nurse screens referrals through telephone contact to determine which referrals required a home visit and which referrals could be resolved with information only. These clients were referred by family, friends and/or neighbors. We wanted to maximize staff resources for those cases that required a home visit. A percentage of home visits are done to assist with nursing home placement or to allow access to nursing home as a back up plan. PRIs and screens are completed and updated every three months for those individuals on the nursing home list. The Central Intake nurse also completes the PRI and screen required by NYSDOH for the Traumatic Brain Injury (TBI) waived program and for NHP patients in adult homes and assisted living facilities.

PRIVATE DUTY NURSING

An assessment of a client's needs is made by CASA and an agency nurse in conjunction with the physician and other interdisciplinary professionals for referral to NYSDOH for authorization of PDN services. Private duty nursing provides care at the RN and LPN level, typically, for skilled care such as ventilator-dependent patients or patients on enteral feedings. There was one case being followed at the end of 2007. These clients are seen every six months to review the plan of care and the client's condition. The RN and LPN staff come from licensed agencies who are responsible for training, scheduling, and employment issues.

DIVISION OF PUBLIC HEALTH..

PUBLIC HEALTH SERVICES

The definition of Public Health is becoming increasingly broader and encompasses many disciplines. The department receives many calls where there are no easy answers to or quick fixes for the questions asked or the requests made.

Our staff always endeavors to exemplify the essence of Health Services philosophies and missions and each service we provide and question we answer in some way demonstrates the importance of multidisciplinary efforts needed to achieve long lasting positive outcomes for the people we serve.

10 ESSENTIAL PUBLIC HEALTH SERVICES:

1. Monitor health status to identify community health problems
2. Diagnose and investigate health problems and health hazards in the community.
3. Enforce laws and regulations that protect health and ensure safety.
4. Inform, educate, and empower people about health issues.
5. Mobilize community partnerships to identify and solve health problems.
6. Link people to needed personal health services and assure provision of health care when otherwise unavailable.
7. Evaluate effectiveness, accessibility and quality of personnel and population-based health service.
8. Assure a competent public health and personnel health care work force.
9. Develop policies and plans that support individual and community health efforts.
10. Research for new insights and innovative solutions for health problems.

MATERNAL CHILD HEALTH PROGRAM

The MCH Program provides services to parents and children of all ages. Referrals are received from a variety of sources, such as hospitals, physicians, WIC, school district personnel, and clients themselves. Referrals are made to the program on all first time mothers, breastfeeding mothers, and mothers and infants with health or social concerns. Telephone contact is made and home visits are offered. If the case appears particularly high risk, a visit is automatically attempted.

In general, visits focus on providing parenting information, physical assessment, nutrition, breastfeeding education, safety, dental health, immunizations, family planning, childhood growth and development information, and encouraging routine primary and preventive medical care. All visits are individualized according to family needs, and the nurses strive to assist families to positively impact concerns they identify for themselves. Nurses work closely with physicians and other service agencies involved with families.

Reimbursement for services is pursued, but clients are not billed for services if insurance does not cover visits. Unfortunately, insurance companies are not eager to reimburse for preventive health care because actual savings of hospital days or other medical care cannot immediately be demonstrated. Visits that are covered, especially with private insurance, require large amounts of documentation for reimbursement.

SUMMARY OF SERVICES

YEAR	NEWBORNS REFERRED	POSTPARTUM CLIENTS REFERRED	HEALTH SUPERVISION CLIENTS REFERRED	TOTAL HOME VISITS	PREMATURELY BORN INFANTS (less than 35 weeks gestation)	% Births Less Than 35 Weeks Gestation
2003	505 (7 sets of twins)	*498 (331 breastfeeding) (93 Primary CS) (64 Repeat CS)	31	884	23 (includes 1 set of twins, 2 single births expired)	3.62%
2004	526 (6 sets of twins)	520 (347 breastfeeding) (80 Primary CS) (58 Repeat CS)	40	727	16 (includes twins)	7.5%
2005	533 (5 sets of twins)	528 (375 breastfeeding) (49 Primary CS) (112 Repeat CS)	26	837	22	4.2%
2006	462 (5 sets of twins)	457 (304 breastfeeding) (51 Primary CS) (76 Repeat CS)	29	937	13	2.8%
2007	481 (7 sets of twins, 1 sets of triplets)	458 (340 breastfeeding) (54 Primary CS) (95 Repeat CS)	15	773	8	1.7%

40 weeks is considered a full term pregnancy. Referral numbers indicate unduplicated numbers referred to the program. Telephone contact only may have been made to some clients, while others may have received more than one home visit. A telephone interview tool is utilized to assure that uniformity is promoted and all the same information is allocated when determining the need for visit. In 2007, referrals were received on 7 young women under age 18 who delivered infants which is 5% of pregnancies referred to this agency.

SYNAGIS ADMINISTRATION PROGRAM

(For the Prevention of Respiratory Syncytial Virus)

Respiratory Syncytial Virus (RSV) is the most common cause of bronchiolitis and pneumonia among infants and children under 1 year of age. Symptoms include fever, runny nose, cough, and sometimes wheezing. Up to 2% of cases may require hospitalization.

Currently, there is no specific treatment for children with RSV other than management of symptoms. Children with severe disease may require oxygen therapy and mechanical ventilation. The majority of children hospitalized for RSV infection are under 6 months of age. Most children recover from illness in 8 to 15 days. Some infections may cause complications, which can cause permanent damage to the respiratory system, compromising pulmonary function.

RSV infections usually occur during annual community outbreaks, often lasting 4 to 6 months, during the late fall, winter, or early spring months. The timing and severity of outbreaks in a community vary from year to year. RSV is spread from respiratory secretions through close contact with infected persons or contact with contaminated surfaces or objects.

Current prevention options include good infection control practices and Synagis prophylaxis for children in high-risk groups i.e. premature infants. Synagis can be given during an RSV outbreak season to prevent serious complications from RSV infection.

Our Public Health Nurses offer home visits to current patients participating in our programs. Monthly home visits are made to administer the Synagis injections, during the outbreak season. Visits are reimbursed by insurance.

Synagis Administration Data

	Injections Given
October through end of 2007	57

LACTATION CONSULTING PROGRAM

The Healthy People 2010 Campaign of The World Health Organization sites the national goal of breastfeeding to “increase to at least 75% of the proportion of mothers who exclusively breastfeed their babies in the early postpartum period and at least to 50% the proportion who continue to breastfeed until babies are 5-6 months old.” It further targets special populations such a low income, under 20 years of age, and black women as needing lactation support services to be successful as they are the least likely to breastfeed.

Public Health lactation support provides breastfeeding education in the prenatal period as well as postpartum support. Telephone assistance within 1-3 days of hospital discharge and follow-up home visits within one week of discharge are offered to all referred mothers. Successful management instills confidence in the mother by supporting her with simple answers to her questions as they arise. Public Health provides lactation counseling as a means of preventing or solving lactation problems before they are detrimental to the health of the child or mother. Lactation support provides a mechanism for the smooth transition to pediatric care of the infant, including good communication between obstetric and pediatric care providers. We are available as an ongoing resource to mother and family as their needs change. Warren County Public Health has one certified Lactation Consultant on staff. Public Health Nurses work in conjunction with Lactation Consultants at Glens Falls Hospital to assure that nursing mothers are provided with consistent information. Mothers are also referred to the LaLeche League for support.

	Postpartum Clients Referred	Referred Clients That Were Breastfeeding	Percentage of Breastfeeding Moms
2003	498	331	66%
2004	520	347	66%
2005	528	375	71%
2006	457	304	67%
2007	458	340	74%

It is suggestive that this is a fairly accurate statistic since arrangements are in place for referrals with Glens Falls Hospital where the majority of births in Warren County occur as well as Saratoga County and Albany Medical Center (where preterm or high-risk births occur). Breastfeeding continues to be promoted in the prenatal period at obstetrical care appointments, at childbirth education classes, WIC clinics, and prenatal home visits to those women enrolled in the MOMS Program. Due to staffing constraints, Public Health Nurses are usually unable to follow breastfeeding women for 6 months so it is difficult to secure an accurate tracking of the number of moms who breastfeed during this time. Working with pediatricians and the WIC clinic may be of assistance in measuring this outcome.

PARENTING PROGRAMS

Parenting skills workshops are facilitated by a Public Health Nurse who has received special training. Programs are conducted in cooperation with the following community agencies:

- | | |
|---|-----------------------------|
| Warren County Family Court | Warren County Youth Bureau* |
| Warren County Department of Social Services | Glens Falls YMCA* |
| Warren County Cooperative Extension | Glens Falls City Schools |
| Glens Falls Hospital | American Red Cross |
| | Independent Living Center |

*Reimbursement is received through grants to cover the cost of nursing time.

Interagency collaboration efforts remain positive and beneficial for our clients. An additional staff nurse and our Special Education Teacher have received training as parenting workshop facilitators. There were 7 conferences held at the Warren County Municipal Center for interagency staff.

Parenting workshops continue to be publicized throughout the county. Head Start and Community Maternity Services also offer programs. The mission remains to provide opportunities for parents to learn ways to enhance parenting skills and learn about children's growth and development.

PARENTING PROGRAMS

Programs	Series Presented	Sessions Provided	Parent Participants	Children Impacted
Parenting Skills Workshops	1	7	10	27
Parenting Apart (divorced families)	2	4	39	62
TOTALS	3	11	49	89

WELL CHILD CLINICS

YEAR	CHILDREN ATTENDING FOR PHYSICIAN VISIT	IMMUNIZATIONS GIVEN
2003	10	12
2004	15	22
2005	26	24
2006	11	22
2007	19	55

During 2007, we wrestled with the idea of closing the Well Child Clinic which is held monthly at the VFW Hall on Richardson Street in Queensbury.

Well Child Clinics are designed for healthy infants and children up to age 6. Infants are checked for proper weight gain and toddlers are measured and weighed to ascertain if growth is appropriate for age. The pediatrician at the clinic does a physical examination and discusses feeding and development with parents. Immunizations are administered according to the CDC recommended schedule.

Vision screenings are included as part of physical exams allowing us to offer pre-kindergarten physicals. This service is provided only for those children who have no insurance to see a private medical care provider and in these instances Child Health Plus is promoted as is the Family Health Plus program if parents do not have health insurance.

Attendance has been declining, 19 children were seen in 2007. 55 vaccines were administered. We shall watch attendance numbers closely and be prepared to close the clinic if the need for it no longer exists.

PRENATAL PROGRAM

SUMMARY OF SERVICES

Referrals to the prenatal program are primarily received from medical care practices on Medicaid eligible women. Physicians may receive an enhanced Medicaid rate if they enroll with New York State Department of Social Services as a "MOMS Provider". Part of this agreement is to refer all Medicaid clients to receive "Health Supportive Services" (HSS). Medicaid Obstetrical and Maternal Services (MOMS) and Health Supportive Services (HSS) are preventive health services that are delivered by designated Article 28 hospitals and diagnostic treatment centers and Article 36 certified home health agency providers. They are monitored by the Office of Public Health of the New York State Department of Health. MOMS and HSS are intended to supplement obstetrical services provided by private medical practitioners, through the provision of health supportive services including nutrition, psychosocial assessment and counseling, health education, and coordination of other services needed by Medicaid eligible women during pregnancy and for a period of up to 60 days after delivery. As coordinator of the client's health supportive services, the Health Supportive Services Provider (HSSP) must work closely with the MOMS medical practitioner to ensure that every opportunity is provided for clients to receive comprehensive and continuous prenatal care. The clinical aspect of obstetrical care will be provided by a MOMS medical provider in the medical provider's office while the HSS will be provided by the MOMS HSSP in the client's home or on-site at an Article 28 facility.

Managed care programs are now being required to "demonstrate" that more positive outcomes for various diagnoses, i.e. pregnancy, are being achieved and specifically the factors which are contributing to positive outcomes, or what measures are in place to minimize negative outcomes. Public Health nursing services identify these goals by the extensive histories taken and the care plans established based on needs. Nursing services can assist managed care organizations to demonstrate one means in which outcome goals and objectives for clients are approached.

Other referrals are received on prenatal clients identified at risk for less than optimal outcomes of pregnancy from agencies such as WIC, Community Maternity Services, health centers, Glens Falls hospital or clients themselves. Although reimbursement for services is pursued, no client is turned away because of inability to pay. Public Health Maternal Child Health Program nurses periodically visit obstetrical practice staff to review Public Health programs and discuss ways to improve client service. This endeavor has been viewed as positive by medical care providers and their staff and contributes to more collaborative and comprehensive client care effort. In addition, an annual MOMS Program meeting is held to network with providers and other referral sources, and other interested agencies.

In late 2007, the MOMS Program was transferred to an electronic record, thanks to the efforts of Jeremy Scime, IT Department. Information charting is done on-site making this information up-to-date which will facilitate communication with clients and network collaborating agencies. We look forward to reports and data that will be accessible and useful for the QA process and client-targeted education. Our nurses have done a great job transitioning to this system and working with IT to improve the program. Kudos to everyone!

Note: None of the statistics in the Prenatal Program address or reflect information related to women who voluntarily terminate their pregnancies. Although this information is supposed to be anonymously reported to counties, reports appear incomplete, sporadic, and likely reflective of inaccurate information. (To date, information does not appear accurate enough to provide specific trends for the annual report. This is unfortunate because it is both a Public Health and a social concern.)

Maternal Child Health Program chart documentation is continuously reviewed and updated to reflect nursing standards and measure outcomes of service.

PRENATAL PROGRAM DATA

	CLIENTS REFERRED (UNDUPLICATED COUNT)	CLIENTS REFUSING SERVICES/UNABLE TO BE CONTACTED AFTER REFERRAL	PRENATAL HOME VISITS MADE	TOTAL BIRTHS	TEEN PREGNANCY TRENDS (ENDING IN LIVE BIRTHS) <18YRS OLD
2003	178	97	136	635	16 (3% of Total Births)
2004	212	156	101	639	16 (2.5% of Total Births)
2005	212	141	259	672	19 (3% of Total Births)
2006	166	116	169	586	8 (1.3% of Total Births)
2007	182	110	259	625	13

Prenatal home visit numbers are significant but not totally reflective of the prenatal program for the following reasons:

- "Not home not found" numbers are significant and a common occurrence
- Visits are also made at school, WIC clinics, or other sites i.e. friend's or relative's home due to unusual family circumstances
- Much more telephone time (and not home/not found time) is spent tracking down clients since addresses frequently change
- Many pregnant women referred are interested in participating in the Childbirth Education Classes but not the MOMS Program

CHILDBIRTH EDUCATION CLASSES

Warren County Health Services has 4 certified Childbirth Educators who alternate teaching the Childbirth Education Classes. The classes are held at the Municipal Center in Lake George. The programs are offered either as a 6-week session with 2-hour classes one evening a week or a weekend class Friday evening and all day Saturday. This allows flexibility to accommodate participants' differing schedules. Classes are routinely publicized throughout the county and participants are requested to preregister for the program. A fee of \$35.00 (or \$20.00 for WIC or Medicaid clients) is requested but is waived if it is a financial hardship.

When the program was first developed in 1993, it was specifically targeted for teens, low income, and Medicaid eligible clients but as the classes have evolved, a mix of socioeconomic status women have participated with no concerns noted. Individuals do not need to be Warren County residents but preference is given to those living in Warren County. Women are requested to bring their anticipated delivery coaches to classes with them (husbands, relatives, significant others) so they may learn about labor and delivery as well. The course content encompasses:

- Preparation for childbirth information including labor and delivery, breathing techniques, and exercises
- Discussion on medications and Caesarian Section
- Tour of The Snuggery at Glens Falls Hospital
- Focus on postpartum and infant care
- Breastfeeding

Special classes for breastfeeding, infant first aid/safety, childbirth refresher courses, and class reunions/parent support are also available for those parents who are interested.

YEAR	COMPLETE PROGRAMS	PARTICIPANTS Reflects pregnant women only, not their coaches who accompany them to classes.
2003	13 (7 weekend/6 6-week)	59
2004	15 (9 weekend/6 6-week)	79
2005	16 (10 weekend/6 6-week)	56
2006	12 (8 weekend/4 6-week)	61
2007	14 (10 weekend/4 6-week)	60

COLLABORATIVE INITIATIVE WITH WARREN WASHINGTON COUNTIES MENTAL HEALTH ASSOCIATION

1 or 2 hour weekly health education and guidance sessions are provided for the Warren Washington Counties Mental Health Association. Nurses see clients on a one to one basis and in group sessions at Genesis House and the East Side Center. Nurses weigh participants, check their blood pressure and pulse, and discuss normal ranges and individual ranges. They are available to answer medical questions regarding blood pressure medications. The nurses also provide supportive listening. Health education information is also provided to the staff. This program continues to be extremely well received with client encounters at the South Street Center and Genesis.

Clinic Site	Blood Pressure and Weights Taken
East Side Center	About 15 people are seen weekly
Genesis House	About 5 people are seen weekly

Approximately 20 people are seen by Public Health Nurses during their weekly visit to the centers. In May 2005, these nurses received the Dorothea Dix Community Service Award in recognition of their "commitment and compassion" to these people, awarded by Warren Washington Association of Mental Health.

WIC PROGRAM

(Women, Infant and Children Nutrition Program)

Warren County WIC celebrated its 30th anniversary in 2007. During the first year of operation, the program served 82 participants at 4 locations. At the close of 2007, the annual caseload exceeded 2000. We operated 18 clinics a month at 9 different locations and the average monthly caseload was distributed as follows:

Christ Church Methodist	285
Main Site – Gurney Lane	200
North Creek Firehouse	81
Horicon Community Center	104
Warrensburg Town Hall	181
Lake Luzerne Courthouse	101
Queensbury VFW Post	277
Queensbury Masonic Historical Society	103
Glens Falls National Bank Community Room	236
Total:	1568

In 1977, all tasks were performed by hand, including the issuance of food vouchers. In 2007, 88,419 food vouchers were issued thankfully, with the aid of laptops and printers. Warren County vendors redeemed our vouchers, along with many from neighboring counties, to the sum of \$1,214,237.30 during 2007. The screening process has become more intricate, as has documentation requirements. Yet the general atmosphere of WIC remains the same. Clinics continue to be lively with eligibility determination going on in one corner, education demonstrations in another, blood tests and health assessments going on in the back corner, and individual counseling sessions occurring in more private areas of the room. Energetic babies and toddlers are scattered throughout, providing additional confidentiality with their noisy interactions. Despite the organized chaos, parents still came to WIC because they believe it is a good thing to do for their children. Staff still know them by name and individual circumstance.

One component, the education program, had some significant changes in 2007 with the help of additional funding. The New York State Health Department awarded Warren County \$8,140.00 and approval to pilot some innovative approaches to nutrition education. This program was expanded beyond on-site counseling sessions to include a variety of home study packets. Parents selected an area(s) to work on at home between their WIC appointments. Major areas are outlined below:

The Butterfly Project was developed “to help children take flight”. It educated parents about developmental milestones that could be anticipated for their children from birth to 5 years of age. Parenting skills were practiced through the use of small teaching tools and simple lesson plans.

The Recipe Challenge was developed to encourage young families to cook and eat together. It helped young cooks experience success in the kitchen, motivating them to try new foods and prepare healthier meals. Parents took pleasure in sharing recipes they had found to be healthy, economical and easy to prepare.

Great Moves was developed to exercise mind and body through various activities. There were 9 different programs – one for women, four for infants and five for children. “Seesaw” was especially relevant for breastfeeding and postpartum women who wished to get back into shape. “Flip Pads” contained age appropriate activities to do with infants and toddlers. A Frog Game was given to three and four year olds who participated in 10 or more prescribed physical activities.

The Lending Library provided a variety of books and videos that could be of interest to our families. Participants were free to sign out materials at one appointment and return them at the next one.

Ducks helped families get better organized by “getting their ducks in a row”. Some of the focus areas included Preparing for Emergencies, Keeping a Calendar, To-Do Lists, Finances, Important Documents, Health Records and Cupboards/Closets.

From these five projects alone, we had 3,056 successful outcomes.

Additionally, we were able to increase the percentage of women who initiated breastfeeding through the Pen Pal Program. This program provided numerous mailings to prenatal and breastfeeding women to help promote breastfeeding and it’s benefits. Promotion, support, and maintenance of breastfeeding were also provided through on-site counseling and phone calls to new mothers. The percentage of women who initiated breastfeeding in 2007 rose from 62.5% to 67.6%. In comparison, the end of the year percentage for WIC Programs in our region averaged 56.3%.

Once again, Warren County WIC was the recipient of children’s books from the BOOKS (Books Offer Opportunities, Kids Succeed) Program. This allowed us to give families a gift wrapped book for each participating child just prior to the holiday season. Parents were encouraged to place special significance on these valuable teaching tools. The grant reinforced our efforts to help parents read to their children for 15+ minutes a day.

Reducing childhood obesity remained a primary focus in 2007. We used a variety of strategies to assist parents in this effort. One such strategy was to encourage the consumption of lower fat milk. Data from 2007 showed 61.9% of our clients accepting lower fat milk on their WIC food vouchers in comparison with 43.8% of the WIC clients statewide.

Staff felt good about empowering parents to make changes in their children’s lives. Families took great pride in their accomplishments and were spurred on by previous successes. The upbeat “vibes” that were present in the clinics of 1977 are still going on 30 years later. To quote a phrase often used in Congress, WIC remains “one of the best government interventions ever created”. We couldn’t agree more.

CHILD FIND

The Child Find Program is a statewide program to assure that children, ages 6 months to 3 years, are identified through periodic developmental screenings to receive the help and services needed for the best growth and development in their early years. Referrals to the EI Program are based on the screening results. Children can be referred based on their birth history/diagnosis, and/or by MDs, parents, or other social service and health professionals with concerns regarding the child's development. Funding for this program is received through an annual contractual grant with the New York State Department of Health.

Since the major publicity efforts associated with the Early Intervention Program, parents and other service providers have a heightened awareness to developmental expectations for children and want them monitored, although they may not meet eligibility criteria for Early Intervention Services. Child Find continues to be a very cost-effective program and allows a great deal of opportunity for parent education. Physicians, pediatricians, and family practices in Warren County are very invested in the Child Find Program because of the ability the nurse has to do screenings in the home. Much documentation between Child Find nurse and physician is evident in this program. New York State Department of Health encourages physicians to do developmental screens on children during routine comprehensive well child care. Unfortunately, some of the most high risk children do not see physicians regularly for preventive care, only episodic acute care for illness. Thus, the important service provided by the Child Find nurse must be continued as a valued part of the Child Find Program.

YEAR	CHILDREN ENROLLED	CHILDREN ACTIVE	CHILDREN SERVED
2003	67	As of 12-31-03: 74	135
2004	51	As of 12-31-04: 79	126
2005	75	As of 12-31-05: 77	132
2006	66	As of 12-31-06: 79	141
2007	61	As of 12/31/07: 73	146

EARLY INTERVENTION PROGRAM

The Early Intervention Program (EIP) is a statewide program that provides a wide variety of services to eligible infants and toddlers with disabilities, and their families. This program helps parents to meet the special needs of their child. Parents help choose the services and the places where services will be provided depending on the child's needs. Whenever possible, these services are provided in the home or in a community setting such as a day care center.

EARLY INTERVENTION SERVICES

Early Identification, Screening, and Assessment Services	Occupational Therapy
Medical Services for Diagnostic and Evaluation Purposes	Physical Therapy
Service Coordination	Psychological Services
Health Services Necessary for the Child to Benefit from EI	Nutritional Services
Nursing Services	Social Work Services
Family Training, Counseling, Home Visits, Parent Support Groups	Vision Services
Special Instruction	Assistive Technology Devices & Services
Speech Pathology and Audiology	Transportation

In addition to these Early Intervention Services, respite services also may be provided. These services can include in-home or out-of-home respite. Parents play an important role in planning on how these services, if needed, will be provided.

If a child is found to be eligible, and the parent wishes to have these services, an Individualized Family Service Plan (IFSP) is developed. This plan describes the Early Intervention services the child will receive, and how often and where the services will be provided. When deciding on where the child will receive services the Early Intervention Program Service Coordinator, when appropriate for the child, arranges to have these services provided. Only the services the parent consents to are provided.

TO BE ELIGIBLE FOR EARLY INTERVENTION SERVICES A CHILD:

1. Must be under 3 years of age and have a developmental delay or a diagnosed physical or mental condition that has a high probability of resulting in delay in the following areas:
 - Physical Development (including vision and hearing)
 - Cognitive Development (thinking process)
 - Communication (understanding and expressing language)
 - Social or Emotional Development (relating to others)
 - Adaptive Development (self-help skills)
2. Does not need to have a certain income or need to be a U.S. citizen.

EARLY INTERVENTION COSTS

Since 1993, when the Early Intervention Program became an "Entitlement" for children between birth and three years old, the numbers of children enrolled in the program have escalated significantly each year. This has added annually to the county's financial burdens. Although Medicaid and private insurances are pursued to the fullest extent possible and NYSDOH is billed according to specified methodology, it is difficult to predict the appropriation needed for the program since the number of referrals and intensity of services for children eligible are unknown.

NYS Association of Counties continues to work with NYSDOH to determine a new methodology for payment for Early Intervention Program services. Currently, nothing has been finalized.

EARLY INTERVENTION STATISTICS

	2003	2004	2005	2006	2007
Referrals Received	128	112	157	153	153
Children Served	237	208	250	274	281
Dollars Received From NYS	186,407.71	194,097.77	298,131.66	307,449.24	307,792.25
Dollars Received From Medicaid	191,691.82	252,901.49	275,684.70	305,619.46	403,277.54
Dollars Received From Private Insurance	56,823.62	38,541.55	52,178.46	51,583.84	74,972.70
Costs Before Reimbursement	649,689.02	661,271.60	945,383.40	1,103,066.52	1,200,556.86
Amount Appropriated	782,726.00	834,346.00	856,202.00 (Over budget by 89,181.40)	941,692.00 (Over budget by 161,374.00)	1,003,153.00 (Over budget by 197,403.86)
Expenditures For County After Reimbursement Received	214,766.43	175,730.79	319,388.58	438,413.98	414,514.37
Average Cost to County Per Child Served	906.19	844.86	1,277.55	1,600.05	1,475.14
Births in County	635	639	672	586	625

Note: Although the number of children served by the Early Intervention Program has increased each year, as shown by the available financial tracking information, the cost per child served will vary depending upon the reimbursement potential for each individual.

PRESCHOOL PROGRAM FOR CHILDREN WITH DISABILITIES

Serving Children 3-5 Years Old

All potentially eligible children are referred to the Committee for Preschool Special Education (CPSE) in the child's home school district. Parents are given the list of approved evaluators for Warren County (presently Prospect Child & Family Center, Glens Falls Hospital, BOCES, and Psychological Associates) and select the agency they wish to test their child. Following the evaluation the CPSE meets to discuss the child's needs. Recommendations for services are made at that time if indicated. A representative from Warren County Health Services, representing the municipality, attends all CPSE meetings as a voting member. Other voting members are the school district CPSE Chairperson, and the parent representative. Parents have the right to appeal the committee decision should they wish. All CPSE committee recommendations must be approved by the school district's Board of Education before services may begin. All children are identified as a "Preschool Child With a Disability". Specific classification does not occur until the child is school age. Preschool special education services are voluntary on the part of the parent and a child may be withdrawn from any program at any time at the parent's request. Fiscal audits of agencies providing preschool services are conducted periodically. This process is expected to continue in order to assure financial and service accountability. NYSED reimburses at 59.5% for tuition. Additionally Medicaid and private insurances are billed for related health services (therapies, nursing, and counseling) and transportation on all Medicaid eligible children. All possible avenues are attempted in order to maximize reimbursement and assist in defraying Warren County's fiscal responsibility as much as possible. The Preschool budget and payment processes are extremely complicated and not timely. It takes much dedication on the part of many county staff to assure all reimbursement measures are pursued and accurate paperwork is submitted to NYS Department of Education and the Medicaid office on a timely basis.

SPECIFIC SCHOOL DISTRICT DATA

	SCHOOL YEAR 2002-2003	SCHOOL YEAR 2003-2004	SCHOOL YEAR 2004-2005	SCHOOL YEAR 2005-2006	SCHOOL YEAR 2006-2007
Children Served	334	341	339	358	357*
Evaluations Only	85	77	72	97	85
Tuition Program Costs Approved	\$2,284,253.00	\$2,321,856.57	\$2,523,901.41	\$2,612,951.83	\$3,045,732.27
Tuition Program/Evaluations Costs Paid	\$2,168,359.00	\$2,138,498.53	\$2,278,945.05	\$2,572,781.63	\$2,843,524.11
Transportation Costs Approved	\$556,117.00	\$449,675.60	\$445,199.13	\$548,757.76	\$768,504.28
Transportation Costs Paid	\$500,274.36	\$415,415.06	\$422,065.12	\$533,415.65	\$731,085.60
Average Cost Per Child Before Reimbursement	\$7989.92	\$7,489.48	\$7,967.58	\$8,676.53	\$10,012.91
Amount of Medicaid Received	\$183,075.84	\$343,294.16	\$227,918.28	\$271,485.28	\$82,108.99**
Amount State Aid Received	\$1,633,718.00	\$1,529,794.24	\$1,617,905.10	\$1,848,187.30	\$2,263,097.57
Administrative Costs Received	\$25,050.00	\$25,757.00	\$20,025.00	\$19,575.00	0***
Administrative Costs Paid to School Districts	\$9,088.57	\$13,981.00	\$37,301.00	\$966.00	\$37,266.00
Program Costs After Reimbursement	\$832,878.09	\$669,049.19	\$872,462.79	\$967,915.70	\$1,266,669.15
Average Cost Per Child After Reimbursement	\$2,493.65	\$1962.03	\$2573.64	\$2,703.68	\$3,548.09

*For school year 2006-07, as in previous years, enrollment in 12-month programs continued to rise.

**A hold was put on for most of 2007 Medicaid billing for transportation, speech, counseling, and evaluations. We were finally allowed to bill in February 2008 for all 2007 services therefore revenue totaling \$179,913.75 was received April 2008 and is not reflected above. The amount of Medicaid Received would have been \$262,022.74 for 2007 otherwise.

***Administrative Reimbursement was received in 2008 in the amount of \$14,407.33 for year 2005-06. Also we had to rebill \$13,052.00 for year 2004-05. We expect \$7765.94 in 2008.

CHILDREN QUALIFYING FOR AND RECEIVING SERVICES
(Does not include children receiving evaluation services only.)

SCHOOL DISTRICT	School Year 2002-2003	School Year 2003-2004	School Year 2004-2005	School Year 2005-2006	School Year 2006-2007
Abe Wing	11	16	8	6	0
Bolton	4	6	6	8	7
GF City	55	59	57	49	65
Hadley Luzerne	17	12	10	13	18
Johnsburg	16	19	14	9	11
Lake George	26	25	24	26	20
Minerva (child resided in Warr. Co.)	1	1	0	0	0
No. Warren	9	15	21	19	16
Queensbury	89	89	100	99	96
Ticonderoga (Hague)	0	0	0	0	0
Warrensburg	21	22	27	32	39

ADMIN. COSTS
PAID TO
SCHOOL DISTRICTS
DURING 2007

Bolton	2005-06	4370.00
Johnsburg	2005-06	3854.00
Queensbury	2004-05	13,052.00
Queensbury	2005-06	15,990.00
TOTAL		37,266.00

RATE RECONCILIATIONS*

	2006	2007
Paid Out to Providers	206.00	187,863.31
Received from Providers	0	0

BUDGET
APPROPRIATION FOR
CONTRACTUAL
SERVICES**

2003	\$2,528,480.00
2004	\$3,030,790.00
2005	\$3,104,750.00
2006	\$3,255,000.00
2007	\$3,420,910.00

*Program costs after reimbursement includes administrative costs paid to school districts and reconciliations paid or received.

**Not all school districts submit administrative costs to the New York State Education Department for reimbursement approval. Without state education approval school districts cannot bill the county. Often by the time they are approved by the State Education Department, the numbers actually reflect the previous school year.

PHYSICALLY HANDICAPPED CHILDRENS' PROGRAM

	2003	2004	2005	2006	2007
CHILDREN PARTICIPANTS IN PHCP	0	4	3	3	4
ADULT PARTICIPANTS WITH POLIO DIAGNOSIS	0	0	0	0	0

The Physically Handicapped Children's' Program (PHCP) is a county-based program administered by the Bureau of Child and Adolescent Health part of the New York State Department of Health. The major purpose of PHCP is to ensure access to quality health care for chronically ill and physically disabled children. The program serves children from birth through age 21 years old, as well as adults with a diagnosis of polio. In order for a child to be eligible for the program he or she must have a medical diagnosis and have been denied Medicaid. Children with other forms of medical insurance may be eligible for the program but the PHCP is the payer of the last resort. In these cases, PHCP is helpful to children and families in assisting with insurance deductibles or where insurance only covers a portion of the medical bill. Warren County Health Services has a program eligibility fee schedule based on family income. Income dependent families share, if indicated, in payments made by the PHCP.

Examples of services covered by the Physically Handicapped Children's' Program:

- | | |
|---|--|
| Hospital Inpatient | Hearing Aids (including batteries) |
| Hospital Outpatient Clinic/D&T Center | Transportation |
| Ambulatory Surgery | Drugs |
| Physician Office (visits for reasons re: medical diagnosis) | Out of State Authorizations for Special Procedures (limited basis) |
| Home Health Services | Special Diagnostic and Evaluation Services |
| Durable Medical Equipment (lease/purchase/repair) | |

These occur on a limited basis and must have child's primary care physician's authorization and rationale; and review or signature of the PHCP Medical Director. Generally, these referrals have been for speech and hearing evaluations where private health insurance does not cover. Reimbursement is made by the PHCP for services at the Medicaid rate.

FINANCIAL DATA

In all cases where children have no medical insurance and families are not eligible for Medicaid, referrals are made to Child Health Plus. Since the Child Health Plus initiative has been significantly expanded with much more funding available including inpatient hospital care, it is expected that many more children will benefit and the Physically Handicapped Children's Program will be used to a greater extent to assist families with co-pays or deductibles for their health insurance.

Often times, after a family has started with our program, they end up acquiring insurance and do not need financial assistance or just need partial assistance from us.

These costs do not reflect the salary expenses for personnel involved in the program but personnel are also responsible for all of the tasks related to the Early Intervention and Preschool Programs as well as the Physically Handicapped Children's Program.

	2007
Program Budget Allocation	\$6000.00
Program Expenditures	\$373.18
Program Revenues (NYS Reimb. 50%)	0
Patient Co-pays	\$449.25
Program Cost to County	0

DIAGNOSIS AND EVALUATION COMPONENT

One dimension of services handled through the Physically Handicapped Children's Program is the provision for children without any Medicaid or insurance to receive diagnostic and evaluation services for specific health problems. This program is totally reimbursed by state funding and billing is done directly by the medical evaluator. Generally, these circumstances occur when a child has a specific condition needing follow up while other payment options are pursued i.e. Child Health Plus or Medicaid application, or parent in job where not eligible yet for insurance. This program is beneficial as it provides a means so a child does not have to have services delayed. These referrals are usually received by a child's primary care physician but must be authorized by the Medical Director for the Physically Handicapped Children's Program. The PHCP has a contractual medical director who reviews and approves all program requests. Whenever possible families are assisted in securing other types of medical insurance coverage for services.

	2004	2005	2006	2007
Diagnosis and Evaluation Services Requested	0	1	0	0

CHILDREN WITH SPECIAL HEALTH CARE NEEDS PROGRAM (CSHCN)

A Historical Perspective

For children with special health care needs, the effects of lack of access to health care are felt more keenly than the general childhood population, resulting in increased morbidity and mortality and decrease quality of life.

In New York State, it is estimated that between 800,000 and 1.6 million children have special health care needs. These children account for the majority of pediatric health care expenditures in New York State.

In October 1996, the Commissioner of Health appointed a CSHCN work group to determine what role state and local public health agencies should play in improving the system of care for CSHCN. The work group discussed the key issues associated with the delivery of health care that impact CSHCN and their families:

- Lack of insurance or lack of comprehensive insurance for CSHCN
- Enrollment of CSHCN in managed care
- Multiple service needs of CSHCN
- Supportive services that families need to help them cope with caring for a child with special health care needs
- Involvement of parents as partners in improving the systems of care for CSHCN

The work group discussed the necessary elements of a comprehensive, integrated private and public health system that would improve the health of CSHCN by addressing the key issues.

The work group adopted the following definition of children with special health care needs: Children with special health care needs are those children 0-21 years of age who have or are expected to have a serious or chronic physical, developmental, behavioral or emotional condition and who also require health and related services of a type or amount beyond that required by children generally. This definition is broader than the definition currently used by the Physically Handicapped Children's Program (PHCP).

New York State has a long history of concern for the health of all children including those with special health care needs. The health department's involvement with children with disabilities dates back to polio clinics held in the beginning of the century. As we approach the end of the century, it is time to assess our programs for children and align our public health and children advocate stakeholders with the broader child health vision.

the state is committed to continuously improving the infrastructure for delivery of health services to mothers and children. A major focus of this infrastructure building is the developing of the system's capacity to:

- Regularly report on the health status of CSHCN
- Ensure access to medical homes for CSHCN
- Develop local capacity to address comprehensive needs of CSHCN
- Assist families in accessing the necessary health care and related services for their CSHCN
- Develop a partnership with families of CSHCN that involves them in program planning and policy development

New York State Department of Health continues to provide funding to counties to facilitate the transition process of the Physically Handicapped Children's Program (PHCP) to the Children With Special Health Care Needs (CSHCN). Counties are responsible for submitting quarterly data to the NYS Department of Health that identify the types of children's health problems involved with children participating in the PHCP. The goal is to identify "gaps" with insurance coverage for children's services i.e. what types of things are not covered by insurance plans and what is the resultant impact on the involved child's health. At this point, the CSHCN Program is additional funding with additional clerical and reporting responsibilities for the county. The PHCP reimbursement mechanism remains unchanged.

The CSHCN staff at New York State Department of Health continues to be available to assist when children's insurance companies deny payment for services that are needed by the child. This program has the potential to identify important gaps in children's health services.

HEALTH EDUCATION

In previous years health educators focused on reaching out to all elementary schools in the county, with quality programs that offered simple yet effective messages about basic health practices. In 2006 health educators began rethinking strategies for reaching and educating the general public as well. After several brainstorming sessions a decision was made to continue offering programs to elementary schools with the understanding that more had to be done for the general public. Several reasons were recognized why a change was needed. First, schools have been put under enormous pressure to fulfill testing obligations and other mandates, leaving less time for outside programs. Second, many elementary school students were becoming saturated with the same information year after year leading teachers to stop requesting some of the programs and focus class time on more pressing issues. Lastly, it was realized that even though we were reaching a vast number of people (mainly school children and their parents), we needed to do more to reach other parts of the population.

Due to small changes in our approach to health education there was an obvious decline in the number of elementary and pre-school students that were directly impacted (see chart). With little time to develop and promote new programs for the general population we saw only moderate increases in the number of people impacted by presentations or programs. However, we were able to greatly increase visibility to the general public through participation in community and school health fairs. It is difficult to figure how many people attended these programs and if they are now aware of our health education programs. A conservative estimate would be exposure to several thousand people through participation in these community endeavors.

CORE PROGRAMS

Preschool/Elementary	Dental Health Hand Washing Tobacco Education	Nutrition Heart Health Poison Prevention	Injury Prevention Sun Safety
Adolescents	Personal Hygiene	Heart Health Nutrition and Eating Disorders	Summer Safety
Adults/Parents	Nutrition Safety	Communicable Disease Parenting	Emergency Preparedness for Families
Seniors	Heart Health	Nutrition	
Other Programs	CPR/First Aid	Emergency Preparedness	Programs as Requested

PRESCHOOL ELEMENTARY and ADOLESCENT PROGRAMS

Program	Programs	Attendance
Dental Health	6	187
Nutrition	11	444
Injury Prevention	6	263
Hand Washing/Hygiene	7	486
Exercise/Heart Health	4	296
Sun Safety	3	155
Poison Prevention	3	60
Tobacco Education	18	853
TOTAL	58	2744

ADULTS PARENTS and SENIORS PROGRAMS

Program	Programs	Attendance
CPR	18	163
First Aid (certified & non-certified)	6	102
Family Emergency Preparedness	5	120
ERP/Pan Flu (town hall meetings/colleges)	12	235
School Nurse Training	1	28
Blood Borne Pathogens Training	3	99
Employee Training	1	18
TOTAL	46	765

Above charts are not all-inclusive. Some programs may not have been included because of size and/or nature of the program. These charts do not include community or school health fairs.

HIGHLIGHTS OF 2006

- Attended 11 conferences and trainings.
- Attended over 70 meetings with community partners.
- Programs supplied educational materials and staff to over 10 school, community, and employee health fairs. These events encompassed a variety of health topics including: child safety, nutrition, hand washing, physical activity, and careers in public health.
- Created several reusable display boards focusing on topics like: Lyme Disease, West Nile Virus, and Immunizations.
- Took part in several Emergency Preparedness Drills including a county wide POD (Points Of Distribution) drill, testing mass vaccination capabilities in a major disease outbreak.
- Completed another successful year of the tobacco free education program Tar Wars.

NETWORKING WITH THE COMMUNITY

American Red Cross	Adirondack Community College	Capital Region BOCES Health Services
Communities That Care	Cornell Cooperative Ext. of Warren County	Council for Prevention
Domestic Violence Committee	Healthy Living Partnership	Hudson Headwaters HIV Network
Interagency Council	NYS Department of Injury Prevention	Queensbury Safety Awareness Fair
Rural Health Network	Safe Kids Coalition	Seven Counties Diabetes Network
Southern ADK Tobacco Free Coalition	Upper Hudson Prenatal Network	Warren County Senior Citizens Council
West Glens Falls Fire Department	Youth Coalition	

GRANT PROGRAMS

Diabetes Grant: NYSDOH Grant (October 1, 2004 – September 30, 2009) that helped form the Seven County Diabetes Network of which we are a partner.

Second Year Goals and Activities

- Goal: Increase community awareness of Network and partners. Activities: Distribution of 7000 placemats throughout the seven counties at meal sites and restaurants. Diabetes information placed on 80,000 Stewart's milk cartons in March 06.
- Goal: Increase community awareness about risk factors and prevention strategies related to Type 2 DM. Activities: Presented prevention program in Warren and Washington Counties, 2 and 1 respectively, and distributed pedometers and dynabands to encourage increased physical activity.
- Goal/Activity: Educate people with diabetes about self-management skills and the importance of good self-care practices.
- Goal/Activity: Support efforts of network partners to provide quality diabetes education and information to their communities.

Healthy Heart Grant: NYSDOH grant that is a partnership with the Glens Falls Hospital and Washington County Public Health. The goal is to improve cardiovascular health of the people of Warren and Washington Counties by encouraging physical activity and better nutrition

Program Highlights

- 4 Scavenger Hunts – Big Cross Elementary School scavenger hunt identified dangers around Glens Falls elementary schools that made it difficult for students to walk to school. Dangers were reported to proper authorities and changes are budgeted for and expected to occur in spring 2007. Proposed changes include better signage, improved sidewalks and curbs, and better crosswalks thereby increasing walkability and physical activity. Other hunts took place at the Aviation Mall, and Stony Creek, and Salem.
- Healthy Heart Bumper Sticker Contest - raised awareness about pedestrian and bike safety among students through a classroom program and student-created bumper stickers. Engaged public through distribution of the winning bumper stickers. 600 students at 11 schools participated.
- Fit WIC program - designed to encourage physical activity by supplying needy families with a bag full of toys and games: jump ropes, balls, hopscotch, etc. The program was presented at the CDC's National Health Promotion Conference.

Tobacco Grant: Southern ADK Tobacco Free Coalition (SATFC) of which we are a partner. Is funded by a NYSDOH grant.

Long Term Goals

- Decrease social acceptability of tobacco use.
- Eliminate exposure to secondhand smoke and promote cessation of tobacco use.

Program Highlights

- Conducted our third community tobacco survey. Covered Warren, Washington, Saratoga County catchment area.
- Conducted media campaigns focusing on dangers to pets exposed to secondhand smoke.
- Attended community events and functions and distributed educational materials.

MATERIAL DISTRIBUTION

General Public: Materials covering over 20 different public health topics are made available at health fairs, community clinics, display tables at entrance to DMV, and information distribution racks located near DMV lobby and outside of the Public Health Office.

Rabies: Distribution to MD offices, rabies clinics, animal control officers, veterinarians, and camp directors.

West Nile Virus: Distributed to MD offices, rabies clinics, animal control officers, veterinarians, and per request.

Infectious Disease: Programs are available to camp staff, schools, camp directors, and at STD clinic.

Pediculosis (head lice): Distributed education packets to family referrals with pediculosis infestations. General information was also provided to schools, preschools, school nurses, and to others who requested information.

OTHER PROGRAMS

Tar Wars Tobacco Free Education: This is a yearly program done in conjunction with the American Academy of Family Physicians that includes a poster contest and is presented to all 4th and 5th grade students. The classroom program focuses on all aspects of tobacco use including illness caused by tobacco, dangers of secondhand smoke, addiction, and advertising techniques used by tobacco companies. Programs were presented to 7 of 10 school districts. Warren County had three students finish 3rd, 4th, and 5th in the state poster contest. Winning posters from each school were presented at a Board of Supervisors meeting and each student was recognized individually and received their awards from Board Chairman, William Thomas.

HEALTH EDUCATION

Warren County Employee Wellness Program: 2006 was a busy year for the Wellness Committee. Employees were given the opportunity to participate in 2 six-week programs focusing on increasing physical activity, improving nutrition, and tracking important health indicators i.e. blood pressure, BMI, amount of physical activity. An employee health fair was held to promote program participation, discounts to fitness centers, and offer health education materials. Over 150 employees participated.

School Nurse Training: This training was done at the end of August and offered school nurses a chance to meet with fellow school nurses and public health staff with whom they are in contact with throughout the year. Several guest speakers were present to offer information and answer questions including Mark Amyot, NYSDOH Immunization Program; Alyson Reising, Hudson Headwaters Health Network; Mark Sullivan, WSWHE BOCES Health Safety/Risk Management. Program updates were given by public health staff regarding program needs, reporting, and addressing any concerns the nurses might have.

LEAD POISONING PREVENTION PROGRAM

Warren County has a Lead Poisoning Prevention Program funded by a NYSDOH \$25,000.00 grant. Key components of the program include education, screening, and follow-up. A Public Health Nurse is responsible for submitting the annual work plan and quarterly/annual reports.

Lead poisoning can cause damage to the neurological system. Lead exposure at low levels has been known to cause anemia, growth and development deficiencies, mental impairment, irritability, and hyperactivity. Decreased IQ scores have also been associated with lead exposure. High levels can be severe and cause seizures, coma, and death.

Lead exposure is preventable if common sources are known. In addition, routine screening (blood tests) can diagnose cases prior to onset of symptoms, providing an opportunity to remove the hazard before serious complications. Prevention and screening are the focus of educational efforts.

Education: Health care providers are contacted annually to encourage screening and reporting of cases. Childcare providers are educated on lead, possible sources, and screening requirements. Parents are targeted through associations, health fairs, and informational calls to Public Health. Many pamphlets are available.

Screening: NYSDOH and CDC require lead testing (blood test) for all 1 and 2 year olds for lead exposure. Medical care providers are encouraged to test children 6 months to 6 years old with risk of lead exposure and are required to test all 1 and 2 year olds. Child care providers are encourage to educate parents on lead screening if the child has not been screened prior to enrollment. Public Health will make arrangements for the test and cover the cost if there is a financial hardship preventing the family from getting a child tested.

Follow-up: All children are tracked in the NYSDOH Web-based LeadWeb system. All labs are entered in the system electronically which updates the program as results are received.

- Lead level 0-9mcg/dl (normal): A normal letter is mailed when results are received in addition to a reminder letter when the child is 2 years old
- Lead level 10-14mcg/dl: An elevated letter and educational packet is sent. A reminder letter is sent every 3 months for retest until the child is considered stable (2 tests within normal limits or 3 lower than 15mcg/dl)
- Lead level 15-19mcg/dl: Same as for 10-14 level with the addition of a phone call to family to complete a lead risk assessment and exposure history. A home visit is also offered for education and prevention information.
- Lead level 20mcg/dl or higher: Same as above with the addition of an environmental referral to NYSDOH District Office for testing.

LEAD PROGRAM

Services offered by Pubic Health are at no cost to the family. The Lead Poisoning Prevention Program provides a great service to the community especially to affected families. Despite educational efforts, services are not fully utilized. Referrals are received from a variety of sources i.e. parents, medical care providers, child care providers, Head Start, WIC, other Public Health programs, Well Child/Immunization Clinics.

LEADTRAC DATA

VENIPUNCTURE CONFIRMED (MAY BE CARRIED OVER FROM ONE YEAR TO ANOTHER)	2003	2004	2005	2006	2007
Normal <10mcg/dl	616	562	755	835	675
10-14mcd/gl	11	17	7	4	3
15-19mcg/dl	6	3	4	2	1
20-25mcg/dl	3	1	0	0	0
>25mcg/dl	1	0	0	0	0
TOTAL ELEVATED RESULTS	21	21	11	6	4

(Note: The elevated numbers reflect the highest lab result using active & closed files for specified year.)

COMMUNICABLE DISEASE CONTROL

INFECTION CONTROL EFFORTS

Warren County Health Services works closely with physicians, health centers, and Glens Falls Hospital to consistently encourage and assure timely reporting of laboratory confirmed and or clinically suspected cases of reportable communicable diseases. The agency also works in collaboration with the district office of the New York State Department of Health in this endeavor. A Public Health Nurse follows up with clients either by telephone or home visits, to offer needed information to assure appropriate treatment of infected individuals and prevent exposure to contacts as appropriate, therefore protecting the health of the public. Occasionally Warren County incurs the costs of necessary medications if the individual has no other payment source and out of pocket expense is a financial hardship. Clients are also followed to ensure tests of cure are done if indicated by the specific disease. Appropriate and timely reports are made to the New York State Department of Health. Infection Control Committee meetings are held periodically with the Preventive Program Medical Advisor to review infection control protocols and policies.

Health Services also has agency wide Infection Control, Exposure Control, and Respiratory Protection Plans in place. Staff receives annual in-services to review these plans.

Since "9/11", Emergency Response/Preparedness planning continues to develop important and ongoing initiatives. Program staff respond to the needs of the community 24/7. Public Health staff answers phone calls and serves as a resource to individuals, health care providers, businesses, schools, special needs population, and other organizations. Emergency Response and Preparedness Committee and Influenza Pandemic Committees were formed and provide guidance for community planning to address anticipated needs. NYSDOH also provides guidelines. We remain grateful for the opportunity to collaborate with law enforcement, EMS, veterinarians, morticians, emergency management, Glens Falls Hospital Infection Control and Emergency Care Center, Infectious Disease Specialist, Long Term Care facilities, and school/business representatives. Public Health staff has participated in numerous conference calls, conferences, and meetings to receive and monitor updates.

During 2007, the Emergency Response and Preparedness Program continued to expand. Its staff continues to address issues associated with isolation and quarantine, mass vaccination, continuity of operations and pandemic flu. The part time Bioterrorism Coordinator addressed all 2007 performance goals and participated in table top exercises, drills, etc. required by NYSDOH.

DISEASES REPORTED FROM LABORATORY CONFIRMATION

DISEASE ENTITY	2003	2004	2005	2006	2007
Amebiasis	0	0	0	1	0
Brucellosis	---	---	---	1	0
Camphylobacteriosis	11	6	7	7	6
Chlamydia	69	82	111	115	96
Cryptosporidiosis	4	3	3	1	3
E. Coli	1	0	0	1	0
EHEC (not serogrouped)	---	---	---	1	0
Giardiasis	12	6	3	4	3
Gonorrhoea	8	7	12	9	6
Haemophilus Influenzae Inv No	1	0	0	1	0
Hepatitis A	0	1	0	0	0
Hepatitis C (chronic)	29	75	73	56	46
Hepatitis B (acute)	0	0	0	1	0
Hepatitis B (chronic)	6	4	10	3	5
Influenza, A	---	---	3	7	2
Influenza, B	---	---	---	---	1
Influenza, unspecified	---	---	22	8	1
Influenzae (Haemophilus) Invasive not Type B	---	---	2	0	0
Legionellosis	0	0	1	1	2
Lyme Disease	0	11	11	16	26
----- Ticks Tested/Confirmed Deer Ticks	81/68	68/55	89/85	119/96	117/97
(continued next page)					

DISEASE ENTITIY	2003	2004	2005	2006	2007
Meningitis (bacterial)	1	0	0	0	2
Meningitis (viral)	7	1	1	1	3
Mumps	---	---	---	1	0
Pertussis	4	11	2	0	0
Psittacosis	---	---	---	1	0
Rocky Mountain Spotted Fever	---	---	1	0	0
Salmonellosis	5	8	5	4	3
Strep Pneumo Invasive Sensitive	---	2	5	3	5
Strep Pneumo Invasive Drug Resistant	---	1	0	2	1
Strep Pneumo Invasive Intermed	---	---	---	2	1
Streptococcus Pneumoniae (Unknown)	---	1	1	2	0
Strep Group A Invasive	---	2	3	2	3
Strep Group B Invasive	---	4	5	3	2
Syphilis, primary	0	2	0	1	1
Syphilis, secondary	---	---	1	0	0
Syphilis, early latent	---	---	---	1	2
Syphilis, late latent	---	---	---	1	0
Syphilis, unknown latent	---	---	---	2	0
Tuberculosis	2	1	2	1	0
West Nile Virus	1	0	0	0	0
Yersiniosis	0	0	0	1	1
Total NYS Reportable	161	228	284	261	221

These Diseases Are Reportable, However There Were No Recent Positive Lab Tests for Them In Warren County

Anthrax	Foodborne Illness	Plague
Babesiosis	Hantavirus Disease	Rabies (see rabies data)
Botulism	Hemolytic Uremic Syndrome	Rubella
Chancroid	Hepatitis A in Food Handler	Rubeola
Cholera	Hepatitis B (in pregnancy)	Shigellosis
Cyclospora	Hepatitis C (acute)	Tetanus
Diphtheria	Listeriosis	Toxic Shock Syndrome
Ehrlichiosis	Lymphogranuloma Venereum	Trichinosis
Encephalitis	Malaria	Tularemia
	Measles	Vibriosis

DISEASES REPORTED FROM SCHOOL DISTRICTS

	2002-03	2003-04	2004-05	2005-06	2006-07
Bacterial Meningitis	0	0	0	0	0
Chicken Pox	204	97	26	41	3
Conjunctivitis	355	440	257	297	146
Coxsackie Virus	0	2	4	0	0
Fifth Disease	49	161	37	35	4
Giardia	0	0	0	0	0
Impetigo	24	30	11	20	10
Mononucleosis	67	41	60	100	42
Pediculosis	439	329	236	320	226
Pertussis	0	4	1	0	0
Pinworms	0	0	0	0	0
Pneumonia	63	64	112	51	30
Ringworm	42	28	15	33	18
Scabies	7	5	4	18	6
Scarlet Fever	15	9	8	9	3
Shingles	47	5	11	15	5
Strep	991	518	920	689	386
Viral Meningitis	0	0	0	0	0

All School Nurses in the county are requested to submit monthly reports of physician diagnosed diseases and conditions that are tallied at the end of the school year. We appreciate their diligence and cooperation in caring for our school age population. It should be noted that this information only represents those student health concerns reported to the school nurse. Hopefully, diseases reported are physician diagnosed but Public Health has no way to be sure. There were also 631 visits to the health office related to asthma.

RABIES PROGRAM

Warren County has a Rabies Prevention Program that follows up on all animal bites/exposures, provides rabies pre vaccination immunizations and draws blood titers for veterinarians and animal control officers, provides approval for rabies post exposure vaccination, approves rabies specimen testing, serves as a resource for providers and the community, and offers rabies vaccination clinics for pets. All animal bites/exposures are mandated by Public Health Law to be reported to the victim's county of residence.

As of November 2002, a new rabies law went into effect requiring dogs, cats, and ferrets all be vaccinated against rabies by four months of age. Counties must offer at least one rabies clinic every four months. Warren County offers two clinics a month from February through November. Unvaccinated pets involved in a bite/exposure incident must be confined for ten days at an approved facility such as a veterinarian's office at the owner's expense. Any vaccinated pet involved in a bite/exposure may stay at home for the ten-day confinement period.

Warren County continues to diligently strive by public education efforts and ongoing communication with medical providers, animal control officers, and veterinarians, to assure that the public health is protected as related to rabies.

RABIES DATA FOR 2007

Town	Not Vaccinated			Vaccinated			Out of Town			Stray		
	Cats	Dogs	Ferrets	Cats	Dogs	Ferrets	Cats	Dogs	Ferrets	Cats	Dogs	Ferrets
Bolton		1		3	4						1	
Chester	2	7			8			2		2	1	
Glens Falls	2	10		5	28		1	3		9	4	
Hague					6			1				
Horicon					1							
Johnsburg	1	2		2	4					3	1	
Lake George	3	2		4	7			1				
Lake Luzerne		5			4			2		1	1	
Queensbury	8	13		5	46			9		11	1	
Stony Creek		1		1								
Thurman		1			4							
Warrensburg	1	5		2	13			2		3		
TOTALS	17	47		22	125		1	20		29	9	

BITES REPORTED BY MONTH

	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Total
2004	12	9	13	12	30	25	25	25	24	11	14	19	219
2005	9	8	15	17	24	18	17	17	16	13	15	10	179
2006	6	15	15	24	30	16	28	27	25	24	11	23	244
2007	13	19	12	20	31	24	31	32	18	26	21	23	270

RABIES STATISTICS

	2003	2004	2005	2006	2007
Confirmed Rabid Animals	1 bat	1 bat/1 fox	0	1 raccoon	1 cat 1 raccoon 1 skunk
Animal Specimens Submitted for Testing	60	73	65	89	69
Animal Bites	242	219	179	244	270
Patients Receiving Pre-Exp. Vacc. (3 Injections) or Booster Vacc. Private Pay: \$188.00/Dose	6 Titers Drawn: 19	5 Titers Drawn: 5	7 Titers Drawn: 10	8 Titers Drawn: 16	13 Titers Drawn: 20
Patients Receiving Post-Exp. Vacc. Series @ GF Hosp. (All RIG and First Injections are Given at GF Hospital)	14	36	49	32	49
Patients Receiving Post-Exp. Vacc. Series @ P. Health (All RIG and First Injections are Given at GF Hospital)	3	3	2	10	2
Animal Clinics	20	22	25	23	20
Animals Receiving Rabies Vaccinations	1205	976	884	1150	850

Amount paid in relation to Rabies Program:	\$25,150.73	
Amount of reimbursement from New York State:	\$17,320.53	
Rabies Clinic Revenue	4,931.25	
Total program cost to Warren County:	\$2,898.45	(There are still insurance claims pending for 2007 for people who received post-exposure treatment.)

TUBERCULOSIS PROGRAM

PPD testing is offered by appointment to any Warren County resident requesting it on Tuesdays, Wednesdays, and Fridays. A fee of \$18.00 per test is requested, but is waived if it is a financial hardship. Agencies whose personnel must be screened for tuberculosis also may request screening by Warren County Public Health.

Warren County Health Services provides payment for preventive therapy medication for individuals who convert as a result of a tuberculosis test or have active tuberculosis and have no insurance to cover the cost of medication. This holds true for any test conversion, not just those done by Warren Co. This is done in attempt to assure compliance with prescribed treatment. Richard Leach MD is the contractual medical consultant for the program and follows those individuals needing treatment who do not have their own physician. Warren County maintains an agreement with a local pharmacy whereby the agency is billed at the Medicaid rate for the medications.

Amount Paid for Tuberculosis Medications	
2003	\$4,028.03
2004	\$366.78
2005	\$7,846.73
2006	\$566.84
2007	\$31.60

YEAR	INDIVIDUALS TESTED	POSITIVE CONVERTERS	ACTIVE TB CLIENTS DURING YEAR
2003	159	8	2
2004	185	2	2
2005	203	10	2
2006	237	7	1
2007	268	0	0

2003: An individual was diagnosed as having extra pulmonary TB which is not contagious. PHNs provided direct observed therapy (DOT) as recommended by NYSDOH. Medical and staff costs were covered by patient's health insurance. This patient was seen through October 2004 when treatment was complete.

2004: Public Health had a new pulmonary TB case in December 2004 that required DOT. Patient had no health insurance therefore Public Health covered expenses. This patient had Rifampin resistant pulmonary TB in 2002. The patient reactivated in January 2005 and was multidrug resistant. DOT was performed everyday until the patient passed away in November 2005.

2005: Public Health had a foreign born patient with pulmonary TB who was INH resistant. DOT was done until patient moved out of county before finishing.

2006: The case diagnosed in 2006 moved out of the county before DOT could be started.

SEXUALLY TRANSMITTED DISEASE AND HIV CLINIC FOR 2007

	Clinics Held	Total Clinic Attend	HIV Test Only	STD Test Only	STD HIV Test	Age Range		Sex M F		Counties				STD Phone Results	HIV* Not Tested
										Warr.	Wash.	Sar.	Other		
Jan	5	45	13	11	15	14	65	27	18	32	7	4	2	13	5
Feb	4	28	5	4	13	18	71	17	11	13	9	4	2	11	1
Mar	4	30	5	2	15	19	63	20	10	17	4	6	3	16	0
Apr	4	37	4	11	14	18	58	26	11	12	11	11	3	9	0
May	5	32	7	4	14	15	57	18	14	14	6	9	3	10	1
June	4	16	2	7	6	18	58	9	7	6	7	2	1	8	0
July	5	39	9	11	16	14	58	25	14	21	8	9	0	12	5
Aug	4	40	9	6	19	15	63	24	16	18	12	8	2	13	3
Sept	4	22	6	1	8	16	56	10	12	11	4	6	1	12	0
Oct	5	32	8	4	14	16	57	21	11	19	7	5	1	9	0
Nov	4	34	7	11	12	17	64	29	5	13	12	9	0	9	1
Dec	3	13	1	1	5	15	53	8	5	5	5	3	0	13	0
Totals	51	368	76	73	151	14	71	234	134	181	92	76	18	135	16

*Represents clients requesting HIV test but due to lack of counselor availability or late arrival, were not tested.

STD & HIV CLINIC
(continued)

										Positive Results			
	Hep B			Hep A		Twinrix (Hep A & B)			Genital Warts	Gonorrhea	Chlamydia	Syphilis	
	#1	#2	#3	#1	#2	#1	#2	#3					
Jan						5	1	1	2	1	1		
Feb					1		2		2	3			
Mar				1	3	6	2	1	2		1		
Apr						1	2		1		1		
May					1			3	2				
June						1	1	1					
July		3		2		1	1	3	2			1	
Aug						2		3			3		
Sept				2	1	2	2	2	2				
Oct				1		2	2	1	3			1	
Nov				1		1	1		3		1		
Dec						1	3		1				
Totals	0	3	0	7	6	22	17	15	20	4	7	2	

STD Clinic attendance was slightly higher in 2007. The HIV Clinic continues to be held in conjunction with the STD Clinic each Tuesday evening at the McEchron House in Glens Falls. This walk-in clinic is free and is staffed by Warren County. Cost of laboratory tests and doctor fees are shared by Warren and Washington Counties. NYSDOH recommends the medical supply company that offers prescribed medications at a deep discount.

The STD Clinic participates in the NYSDOH Free Hepatitis Program. Hepatitis vaccines are offered to all clients. An important component of the clinic is education regarding safer sex practices. A DVD program is offered in the waiting room to provide pertinent information regarding STD and HIV.

HUMAN IMMUNODEFICIENCY VIRUS (HIV)

Since June 2004, Warren and Washington County have worked collaboratively to bring free Rapid HIV Testing to the Greater Glens Falls Area. Since incorporating Rapid HIV Testing into the weekly free STD/HIV clinic and training three staff to administer the rapid HIV testing, the number of people getting tested for HIV has remained high.

Activities 2007

- Partnered with Washington County Public Health to offer free rapid HIV testing at 51 clinics and testing of 227 people.
- Provided a clinic site for rapid HIV testing administration.
- Continued to provide clinic coverage for Washington County Health Educators as needed.
- Purchased AV equipment, chairs for the waiting room, and a heater for clinic use.
- Tried to develop a more efficient way of recording HIV statistics (needs further review)

Concerns:

- We still had a small number of people unable to receive a rapid HIV test at a particular clinic. However that number was down 38% from 2006.
- In June clinic went to one HIV Test Counselor (down from two). One counselor may not always be able to meet clinic demands.

2008 Outlook

Goals:

- Continue to offer free rapid HIV testing for anyone who want/needs it.
- Make sure that the people who are unable to receive a rapid test at a particular clinic are given alternatives.
- Research the possibility of having a test counselor available at Warren County Public Health Office to do HIV testing by appointment.
- Research the possibility of making an HIV test counselor available to do testing in county jail.

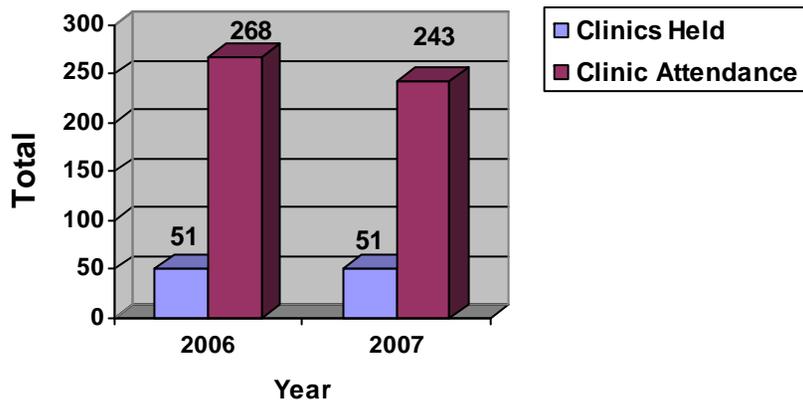
Warren County Public Health will continue to work with Washington County Public Health to ensure free rapid HIV testing for anyone wishing to get tested. Warren County will continue to offer a site for rapid HIV testing to be administered as well as provide coverage for those times when Washington County is unable to supply a test counselor.

Warren County Public Health will continue to help raise awareness about the rapid HIV testing by disseminating educational materials and referring anyone looking for HIV testing to the weekly clinics held in Glens Falls.

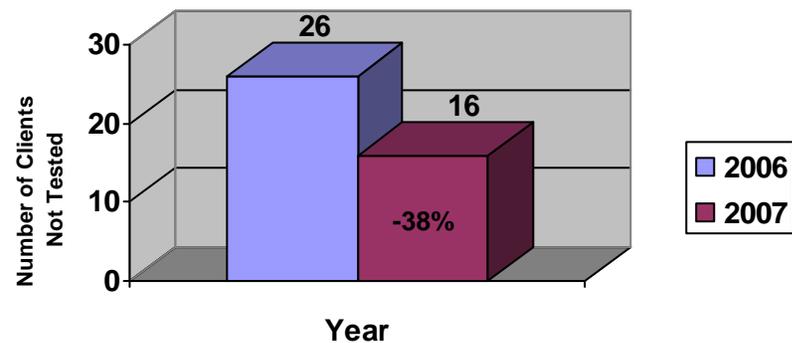
For more information about the free Rapid HIV Testing Program contact Warren County Public Health (761-6580). For more information about HIV/AIDS go to www.nyhealth.gov/diseases/aids.

2007 HIV CLINIC BY THE NUMBERS

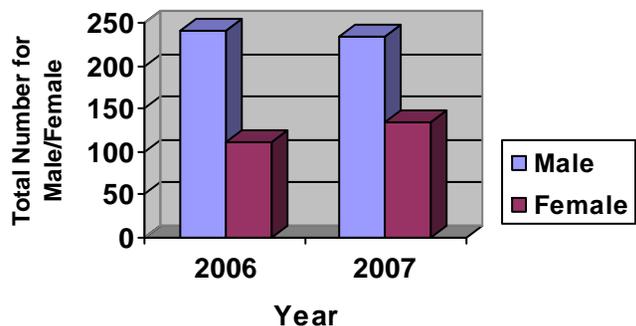
Clinic Attendance



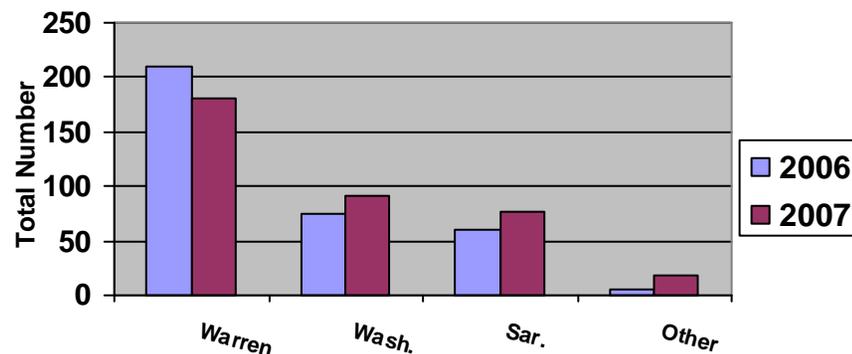
Clients who Wanted an HIV Test But Didn't Receive One



STD/HIV Clinic Use by Gender*



STD/HIV Clinic Patients. Where They Come From*



* The graphs "clinic use by gender" and "where they come from" represent the total number of patients that attend the STD/HIV clinic. These numbers are not exclusive to people seeking only HIV testing/information. Anyone attending the clinic for HIV or STD or a combination of HIV/STD testing/information is included in these numbers.

PERINATAL HEPATITIS B

Women are routinely screened for Hepatitis B as part of prenatal bloodwork. In the event the pregnant woman tests positive for Hepatitis B the information is transferred to the hospital where the mother plans to deliver to assure that the infant receives treatment after birth, before the child is discharged. In these cases, a mechanism is in place where a referral is made to the local health department to assure that the child continues to receive Hepatitis vaccine on a timely basis. Reports are submitted for statistical tracking to New York State Department of Health whenever a case is identified.

There have been no cases of pregnant women identified as Hepatitis B carriers and therefore no infants receiving Hepatitis prophylaxis since the beginning of year 2002.

Hepatitis B is a virus that affects the liver. It is transmitted through contact with infected blood and body fluids. Pregnancy and Hep B combined can put the baby at risk for contracting the virus. Pregnant women are tested for many diseases during pregnancy. The Hep B test is important because there are interventions to prevent or minimize the baby's chance of contracting Hep B. When women are identified, they are followed through pregnancy and up to a year after delivery. During the pregnancy, goals include promoting a healthy pregnancy and preventing transmission to her partner and others. The women are given the opportunity to verbalize fears and ask questions. Information on the virus, transmission, prevention, and general health are discussed and reinforced. Also during pregnancy possible contacts are identified and offered prophylaxis. The goal at delivery is to prevent transmission to baby. Within twelve hours of delivery, the baby receives Hepatitis B Immune Globulin and the first dose of the Hep B vaccine series. The other two are given at one month and 6 months of age. When the child is 1 year old, a blood serology is done to determine the effectiveness of the prophylaxis. If there are adequate antibodies, the case is discharged. If there are insufficient antibodies, a booster dose is administered or the series is started again. This will prevent or minimize the child's chances of contracting Hep B. Public Health has an exciting role in the prevention of Hepatitis B transmission from mother to baby. Through educational efforts and prophylaxis, disease can be prevented.

IMMUNIZATION ACTION PLAN

Warren County Health Services continues to participate as one of the members of a seven county consortium whose mission is to address the immunization status of our children. The Upper Hudson Primary Care Consortium serves as the contractor for this endeavor. County health department officials meet regularly with Upper Hudson Consortium staff to review progress of the objectives and to identify changes and concerns as they occur.

Each county individualizes the objectives to meet their own county's needs. Funding is allocated to each county based on individual needs.

The objectives identified for the Immunization Action Plan are as follows:

1. Collaboration: to establish and/or maintain a collaborative effort which includes public and private health care providers, businesses, community leaders, ethnic, racial, and religious organizations, voluntary and service organizations, and media affiliates to improve immunization rates and to coordinate service delivery.
2. To utilize PBII (Provider Based Immunization Initiative) assessments and follow-up visits with private health care providers for the purpose of assessing immunization rates and the standards of pediatric immunization practices.
3. To assess county public clinic immunization rates annually and to report results.
4. Conduct education and outreach activities to inform health care professionals, daycare providers, and other interested groups, and the public about the benefits of up-to-date immunization for children and adolescents.
5. To collaborate with the county lead screening program to provide physician education to improve lead screening practices.
6. Increase awareness of the benefits of adult immunization against influenza, pneumococcal, hepatitis B, Td, and varicella diseases.
7. Increase awareness of the benefits of hepatitis A and B vaccination for high-risk adults through participation in the "Adult Hepatitis Vaccination Program".
8. Foster and support the state's effort to implement a statewide immunization registry.
9. To provide immunization services in locations and at hours that facilitate immunization of children and adults in targeted communities.
10. To provide a resource for the community to obtain information on routine vaccines as well as vaccines for travel.

IMMUNIZATIONS BY APPOINTMENT
(Provided At Warren County Public Health Office)

VISIT TYPE	FEE	2003	2004	2005	2006	2007
Hepatitis A	33.00 (adult)	58	71	69	104	46
Hepatitis B	40.00 (adult)	232	158	153	167	89
HPV	15.00 (under 18)	---	---	---	4	46
Influenza	20.00 or Medicare	139	169	321	201	170
IPV	15.00	0	0	5	4	5
Menomune/Menactra	100.00	106	107	84	76	29
MMR	15.00	91	55	62	47	38
Pneumonia	36.00	9	9	24	3	4
Post-Rabies	No charge	8	11	5	33	8
PPD	18.00	159	155	203	237	185
Pre-Rabies	188.00	9	8	13	21	11
Tdap (Tetanus w/Pertussis)	48.00	---	---	---	16	48
Tetanus (Td)	25.00	50	40	38	23	6
Twinrix	52.00	19	25	293	429	58
Varicella	15.00	17	12	12	39	19
Zostavax (Shingles Vaccine)	163.00	---	---	---	---	120
TOTALS	---	897	820	1282	1404	882

There is no charge if immunization is for Communicable Disease Control of a specific known case. Also Blood Pressure checks and Green Thumb exams are given at no charge. Their numbers are not specifically tracked. They are generally walk-ins or county employees.

There are also immunization clinics that take place off-site (see table next page).

IMMUNIZATION CLINICS COUNTY-WIDE

CLINIC SITES	DAYS/TIMES HELD
Public Health Office	Monthly: 2nd Thursday 6:00-7:00pm
WGF Community Chapel	Monthly: 3rd Friday 9:00-11:00am
Public Health Office By Appointment	Tuesdays, Wednesdays, and Fridays

VFC (Vaccine For Children Program) vaccine is used exclusively for children's immunizations. A \$15.00 fee is requested for each child - which is waived if there is financial hardship. Adult immunizations are priced as stated in table on previous page. The number of children attending clinics held throughout the county has decreased with the institution of the VFC Program and rural health clinics. Large numbers of vaccine are given to physicians as Warren County continues with distribution of VFC vaccines to pediatric and family practices, including community health centers. (See below.)

PNEUMOVAX ADMINISTRATION

Pneumovax is offered to the public to protect against pneumococcal infection. This vaccine is particularly recommended for the following groups of individuals:

- People over two years of age identified by physicians as at increased risk of acquiring systemic pneumococcal infection due to other specific health problems
- Senior citizens
- Individuals with chronic cardiovascular, pulmonary, or liver disease
- Households with members who are specifically susceptible

Pneumovax is indicated only once if the individual is over 65 years of age. Medicare covers the cost of vaccine or there is a charge of \$36.00 per injection if no Medicare. Unlike influenza (flu) vaccine, Pneumovax may be given at any time of the year and is promoted as part of the Adult Immunization Initiative.

PNEUMOVAX VACCINES DOSES ADMINISTERED	
2003	122
2004	15
2005	135
2006	136
2007	111

ADULT HEPATITIS B CLINICS

Hepatitis B immunizations and pre-vaccination education sessions are offered through a contractual agreement to agencies in Warren County requesting the service. A fee of \$40.00 per injection is charged, and may be billed to the agency or an individual may pay privately. The training for bloodborne pathogens, that is part of Exposure Control Plans, is not specifically charged as the cost is considered part of the service, along with nursing expenses for vaccine administration. This service assists in communicable disease control in our community. Agencies call when new employees are added and must be offered the vaccine. Most employees elect to receive the Hepatitis vaccine series.

WARREN COUNTY SHERIFF'S OFFICE JAIL DIVISION HEPATITIS INITIATIVE

Since 2003, New York State Department of Health has encouraged local health departments to participate in a state-funded Hepatitis A and B Vaccine Program in county jails. In September 2005 we were given permission for Public Health Nurses to go to the Warren County Sheriff's Office Jail Division and begin administering vaccine to inmates on a weekly basis. A database is kept of vaccine administration and each week the vaccine is offered to new inmates and former inmates as appropriate. The Twinrix vaccination (a combination of Hepatitis A and B) is used most frequently however Hepatitis A (two-dose series) and Hepatitis B (three-dose series) vaccines are used separately if indicated. Twinrix is also a three-dose series vaccination.

We are very pleased to be able to offer this program and are appreciative of the cooperation of the Warren County Sheriff's Office.

VACCINATIONS ADMINISTRATION FOR 2007

MONTH	Hep B	Hep A	Twinrix
January			18
February		2	27
March		4	33
April			36
May		1	27
June		1	22
July	1		30
August		1	21
September		3	21
October			32
November	1	1	16
December			24

INFLUENZA CLINICS

Trivalent influenza vaccine is offered each year in the fall. The groups most considered at risk for complications related to influenza or "flu" are senior citizens and adults and children with chronic illness requiring regular medical follow up, especially diabetes. Health education for the public is targeted to heighten individual awareness for the need to prevent and control the impact of influenza. Individuals may receive this immunization through their physician, Public Health clinic, or through other types of sponsors such as employers. Medicare Part B covers the cost of the influenza vaccine as do some other types of insurance.

Healthcare workers were urged to receive the vaccine and there was an increase in the percentage of Public Health Nurses who complied. Flu vaccine was offered at clinics held at meal sites or town halls throughout the county. Appointments were made for the earliest clinics but as the population was inoculated and the supply of vaccine was found to be adequate, appointments were not necessary and restrictions on who qualified for vaccine were lifted.

Warren County Health Services obtains information and clients' signatures from those eligible at flu clinics and bills for reimbursement. Volunteers are used to collect this information. For non-Medicare eligible clients a \$20.00 fee was requested but was waived if there was a financial hardship.

This year FluMist, the nasal spray flu vaccine, was offered as an alternative to the injected flu vaccine. It was not received with enthusiasm but we were able to use all that we ordered.

Volunteers have proved to be an essential component of Public Health Clinics. Flu Clinics are the setting for mammoth volunteer activity. Volunteers help the elderly with required paperwork and maintain order during the chaos of large clinics. Many volunteers have helped for several years and consider it a privilege to be asked to participate. We are very grateful to all our volunteers!

INFLUENZA VACCINE ADMINISTRATION

	2003	2004	2005	2006	2007
Clinics Offered Throughout the County	42	11	37	44	46
Vaccine Doses Administered at Clinics	3000	2346	3614	3477	2550
CHHA/Long Term Home Visits For Administration	114	147	175	210	122
Homebound Visits For Administration	24	20	20	14	26
Miscellaneous Administration i.e. PH Appointments and Other Home Visits	(not broken out in previous years)				199

BLOOD PRESSURE CLINICS

BP Clinic Site	2003	2004	2005	2006	2007
Bolton Meal Site	73	77	88	92	86
Chester Meal Site	100	70	106	91	77
Cronin HighRise	78	90	92	125	75
Johnsburg	167	173	166	183	114
L.Luzerne Meal Site	149	116	122	134	116
Presb. Church (GF)	---	---	---	84	89
Queensbury Center	220	157	144	156	110
Solomon Heights	167	155	137	169	134
Stichman Towers	43	43	45	34	30
Warrensburg	131	79	71	67	59
TOTALS:	1128	960	971	1135	890

Clinics are offered at no charge. Physicians are notified regarding clients with elevated blood pressures to assure appropriate medical follow up. General health education materials are available at these clinics and the Health Educator works in conjunction with Warren County Office for the Aging staff to develop and implement health education programs at various sites. A Public Health Nurse also attends the annual Senior Citizen Picnic held in Lake George to take blood pressures, answer health related questions, and distribute health education materials. A library of appropriate health education resources is available to residents. Reimbursement is received from Warren County Office For The Aging to cover a portion of the services provided to the senior population.

QUALITY ASSURANCE

Public Health has a three level Quality Assurance Program.

- Level 1 utilizes the standard Chart Component List. The staff ensures the charts are complete prior to discharge. The Assistant Director reviews all the charts at discharge as well for completion.
- Level 2 utilizes peer input with the intention of sharing creative interventions amongst staff and streamlining documentation.
- Level 3 utilizes subjective input from community referral sources on appropriateness of services and care rendered to families.

2007 UR Committee members for their participation and dedication to Public Health and its services to the community:

Thank you for your participation and dedication to Public Health.

Mary Anne Allen PNP, Moreau Family Health
Robin Andre PHN, MOMS/MCH Program*
Pat Auer RN MA, Director Health Services
Pat Belden PHN, Communicable Disease
Judy Budner RN, Warrensburg Health Center
Janet Cicarelli, Case Manager at GFH
Stacie Dimezza PT, Glens Falls Rehabilitation Center at GFH
Karen Doering RN Lactation Consultant, GFH Snuggery
Judy Fortini RN, EI Program*
Nedra Frasier RN, MCH/MOMS Program*
Nancy Getz RN, MOMS/MCH Program*
Pat Hunt ADPH, Washington County Public Health
Joan Grishkot RN MS Past Director Health Services
Gina Johnson RN, Women's Care
Ginelle Jones RN, MSN FNP Assistant Director Public Health
Dr. Dan Larson, Medical Director, Provides Oversight to QA/UR Program
Patty Myhrberg PHN, Child Find Program
Maureen Schmidt CS, Supervisor Preventive Services, DSS
Pat Tedesco PHN Clinic Nurse
Sandy Watson, Registered Dietician, WIC Program

* Public Health Program Staff rotate attendance at the meetings.

Charts Reviewed in 2007: 63

Meeting Date	MOMS	MCH	Synagis
3/8/07	7	19	N/A
6/14/07	12	12	N/A
9/13/07	1	12	2
12/13/07	(No meeting in December)		

Summary of Findings: Appropriate

63 charts were reviewed and overall the findings were appropriate. The QA policies that were changed several years ago are now apparent in the documentation. The charts are well organized and documented in a professional manner. The committee found interventions and documentation of efforts to be appropriate. Strengths included staff persistence in contacting clients, referring to appropriate agencies, and rendering adequate intervention in regard to contacts and frequency.

Patty Hawley, Warren County’s Record Consultant, will review a sample of charts from each program in early 2008.

Areas Needing Improvement:

A few areas were found by the committee to need improvement. Most were not a reflection of care rendered to the client, but demonstrated an issue with the documentation.

- A MCH chart did not have documentation of a d/c or a discharge quick reply to the provider. The same chart utilized an abbreviation (OTA) not on the approved abbreviation list. The program nurses were reminded of the procedure.
- A MCH chart did not document plan for long-term follow up when discharged. This was discussed at a program nurse meeting. All agreed it should be documented in the future.
- A MCH chart, where patient required wound care from CHHA, updates were not documented in MCH chart, making it appear care was fragmented. This issue was discussed with the MCH nurses and all agreed to document in the future on the narrative.

2008 GOALS

1. Continue with the current QA Program- It appears to be working.
2. Have all staff review applicable policies, program forms, and packets every January, to ensure updates are made.
3. Continue with Synagis chart reviews.
4. Implement Electronic for MOMS and possibly MCH charts.

(Will be Presented to: Dr. Larson 1/22/08, UR Committee 1/22/08, Health Services Committee 1/25/08, PAC 2/13/08)

CONTINUING CHALLENGES FOR WARREN COUNTY HEALTH SERVICES IN 2008

Our mission remains helping people to help themselves - to make a difference in the human condition. This is not an easy task. We realize gains may be slow, unpredictable, and not often immediately visible or measurable.

Our challenge for 2008 will be to continue to plan and deliver programs that do not serve abstract purposes but are tangible and reach out to individuals, families, neighborhoods, and institutions at the community level. Through collaboration with many multidisciplinary service providers we seek to foster personal responsibility - not dependency on others. We know, however, various strategies must be constantly employed to assist and educate people with many diverse health care needs and agendas. We will continue to expand and utilize technology to optimize patient health outcomes, prevent and/or reduce the number of unnecessary hospitalizations, and use our nursing and support staff time more efficiently.

During 2008, the agency will be transitioning to an electronic medical record system that will interface with the existing Telemonitoring Program.

In the Public Health and Home Care arena the mission remains consistently identifiable and visible: to assure Warren County residents are protected from all undue risks of contracting communicable or vaccine preventable diseases and, in conjunction with other service providers, to recognize and design intervention strategies targeted to impact social concerns that ultimately affect public health and to provide home health care that assists our citizens to manage many health problems and diagnoses. As well, the need cannot be overstated for increasing collaboration between human service provider agencies and medical care providers to obtain the most appropriate and cost effective use of resources.

For further information or questions regarding the
Warren County Health Services
Annual Report:

1-800-755-8102

or

518-761-6415 for Home Care
518-761-6580 for Public Health
1340 State RT 9
Lake George, NY 12845

Email: auerp@co.warren.ny.us
Website: www.co.warren.ny.us