

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 2008.

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
Robin Andre
Jeannette Arends
Shauna Baker
Jackie Barney
Julie Bauer
Julia Beecher
Cheryl Belcher
Patricia Belden
Barbara Bennett
Craig Briggs
Rechelle Bullard
Debbie Burke
Gloria Burnham
Linda Bush
Gwen Cameron
Shannon Clarke
Jacqueline Cory
Tara Cote
Beth Coughlin
Kristi Culligan
Dawn Decesare
Diane Decesare
Jessica Depalo
Tawn Driscoll
Cathy Dufour

Dan Durkee
Karen Fidd
Rita Flynn
Judy Fortini
Nedra Frasier
Christine Fritch
Cheryl Fuller
Nancy Gasper
Nancy Getz
Diana Gillis
Nichole Gillis
Mary Lee Godfrey
Dana Hall
Kathy Harriss
Meg Haskell
Sheryl Havens
Michelle Hayward
Anne Horwitz
Evelyn Iisley
Cheryl Inglis
Glenda Johnson
Ginelle Jones
Elaine Kane
Barbara Karge
Cathy Keenan
Michelle Keller-Allison
Sue Kerr

Laura Krill
Nancy LaFrance
Mary Lamkins
Laura Lane
Nancy Lempka
Maureen Linehan
Amber Lynch
Jo Marie
Lisa Marlow
Erik Mastrianni
Kathy McGowin
Angela Meade
Kate Meath
Jackie Merritt
Barbara Moehringer
Joann Morton
Lisa Morton
Dorothy Muessig
Linda Muller
Mary Murphy
Patty Myhrberg
Barbara Orton
Bethany Paquette
Diane Pfeil
Kristen Phinney
Nancy Pieper
Helen Powers

Stella Racicot
Kelly Richmond
Lynne Rodriguez
Marjorie Rosen
Nancy Rozelle
Leslie Russell
Laura Saffer
Jean Saltsman
Lisa Saville
Susan Schaefer
Sharon Schaldone
Pamela Silva
Patty Skrynecki
Linda Slattery
Melody Smith
Jean Spencer
Helen Stern
Shannon Stockwell
Patricia Tedesco
Linda Walker
Sandy Watson
Valerie Whisenant
Diedre Winslow
Donna Wood
Jeanne Wood
Marilynn Wood

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

Matthew Sokol, Chairman, Queensbury

Fred Champagne, Queensbury

Michael O'Connor, Glens Falls

John Haskell, Thurman

Joseph Sheehan, Glens Falls

Louis Tessier, Lake George

Frank Thomas, Stony Creek

WARREN COUNTY HEALTH SERVICES

2008 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
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
Richard Mason, Former Warren County Board of Supervisors Official
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, Retired May 2008
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
Sheila Weaver, Warren County Commissioner of Social Services, Started May 2008

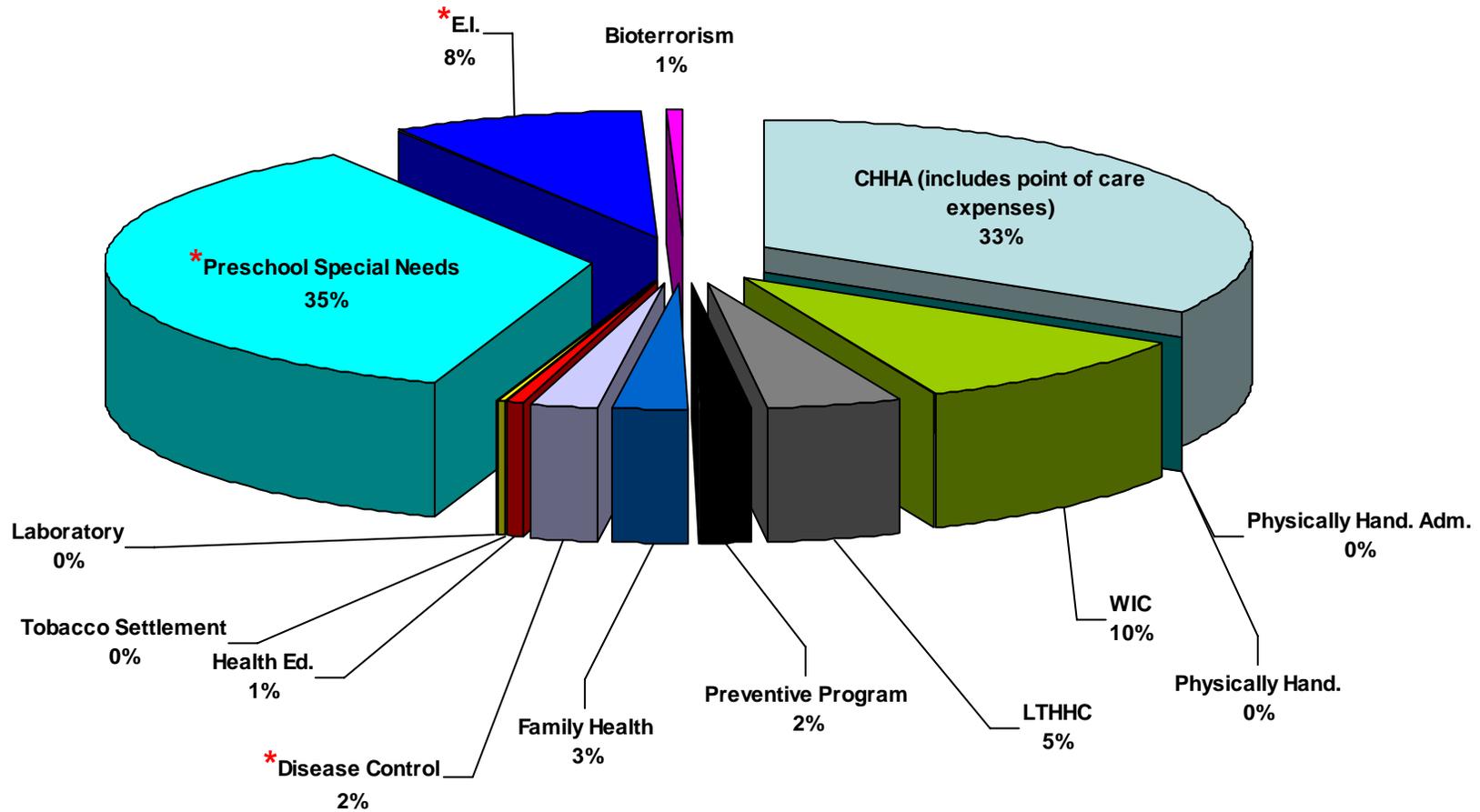
FACTS, FIGURES, AND TRENDS FOR PUBLIC HEALTH & HOME CARE

HEALTH SERVICES STAFFING

<p>Number of Staff Involved with Health Services in 2008: 162 69 Full Time 15 Part Time 24 Per Diem 54 Contractual</p> <p>Administrative Staff: 10 (all FT employees, all non-bargaining) 1 Director of Public Health/Patient Services, also acts as EI Official 1 Assistant Director of Public Health 1 Assistant Director of Patient Services 1 Clinical Fiscal Informatics Coordinator 1 Fiscal Manager 5 Supervising Public Health Nurses</p> <p>Nursing Staff 9 Full Time Public Health Nurses (Grade 21) 4 Part Time Public Health Nurses 23 Full Time Community Health Nurses (Grade 20) 3 Part time Community Health Nurses 1 Full Time Registered Nurse (Grade 19) 3 Full Time Nurse Technicians (LPNs) (Grade 9)</p> <p>Per Diem Nurses 5 Public Health Nurses 7 Community Health Nurses 5 Registered Nurses 2 Nurse Technicians</p> <p>Other Professional Staff 1 Full Time Health Educator (Grade 14) 1 Part Time Health Educator 2 Part Time EI/Preschool Service Coordinators (Grade 18) 1 Per Diem Early Intervention/Preschool Service Coordinator 1 Part Time Emergency Preparedness Coordinator (Contractual) 1 Part Time Public Health Liaison for Emergency Preparedness</p>	<p>WIC (Women, Infant, and Children's Nutrition) Program 1 Full Time WIC Program Coordinator (non bargaining) 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) 1 Full Time WIC Program Aide 1 Part Time WIC Program Aide 1 Part Time WIC Dietician (Grade 16)</p> <p>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) 3 Full Time Account Clerks (Grade 4) 1 Full Time Medical Records Clerk (Grade 5) 3 Full Time Senior Clerks (Grade 4) 2 Full Time Word Processing Operators (Grade 4) 2 Per Diem Word Processing Operators 1 Full Time Senior Typist 2 Per Diem Senior Clerks</p> <p>Contractual Therapists 20 Physical Therapists 8 Occupational Therapists 20 Speech Therapists 3 Medical Social Workers 1 Respiratory Therapist 2 Dietician</p> <p>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</p>
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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.

2008 ACTUAL EXPENDITURES BY PROGRAM



Total Expenditures: \$13,714,658.69

*Mandated Programs Account for 45% of Total Actual Expenditures

WARREN COUNTY POPULATION

Source: NYSDOH Statistical Data

BIRTHS AND DEATHS IN WARREN COUNTY

**STATISTICAL INFORMATION
COMPARISON TRENDS**

	2004	2005	2006	2007	2008
Births	639	672	586	625	655
Deaths	451	598	705	613	558

EMERGENCY RESPONSE PLANNING

World wide natural disasters, a rise in terrorist type events and emerging viral/bacterial illness around the globe have changed our lives 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 - 2008

Name	Jurisdiction Represented	Job Title
Dan Albert	NYS Office of Homeland Security	Project Assistant
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
Terry Blanchfield	BOCES	Assistant Superintendent
Bob Condon	The Post-Star	City Editor
Joanne Conley	Warren County	Assistant Tourism Coordinator
Arthur Coon	National Guard	Sergeant 1 st Class/Recruiter
Mark DeSimone	Warren County	Mortician
Joyce Flower	Irongate Family Practice	LPN
Anita Gabalski	NYSDOH District Office	Director – Glens Falls Office
Bruce Hersey	Adirondack Emergency Community Chaplains	Coordinating Chaplain
Ginelle Jones	Warren County	Assistant Director of Public Health
Margaret M Jones	Warren County	UHPCC Safety Officer
Bill Keller	CR Bard, Inc.	Facilities Manager
Marjorie Kelly	ACC	Director, Human Resources Dept.
Geoffrey Kent	FBI	Special Agent, WMD Coordinator
David Kolb	NYS Police	Sergeant
Brian LaFlure	Warren County	Director - Warren County Office of Emergency Services
Daniel Larson MD	Warren County	Medical Director
Richard Leach MD	Warren County	Medical Director for Infectious Disease
Amy Manney	Warren County	Deputy Director - Warren County Office of Emergency Services
Fred Monroe	Warren County	Chairman - Board of Supervisors
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
Anthony Palangi	ACC	Facilities Director

Name	Jurisdiction Represented	Job Title
Monty Robinson	Harrisena Community Church	Pastor
Shane Ross	Warren County	Chief Deputy, Sheriff's Office
Sharon Schaldone	Warren County	Assistant Director of Home Care
Gary Scidmore PA-C	Warren County	EMS Coordinator
Michael Shaw	NYSDOH District Office	Senior Engineer, Supervisor
Thomas Smith	Warren County	Glens Falls Hospital Pharmacist
Laura Stebbins RN MSN	Glens Falls Hospital	Director of Emergency Preparedness
Helen Stern	Warren County	Immunization Coordinator
Mark Sullivan	BOCES	Safety Specialist
Barbara Taggart	Warren County	Administrator - Westmount Health Facility
Sheila Weaver	Warren County	Commissioner - Social Services
Rob York	Warren County	Director, Office of Community Services

HOME CARE EMERGENCY PREPAREDNESS ASSESSMENT TEAM - 2008
(Committee disbanded at October 16, 2008 meeting)

Name	Jurisdiction Represented	Job Title/Description
Janet Barcus	High Peaks Hospice	Office Manager
Cheryl Belcher	Warren County	RN
Michelle Benedict	Inter-Lake Health Moses Ludington	Administrator
John Boyce	Fort Hudson Nursing Home	Director of Plant Operations
Maureen Burger/Cynthia Mitchell	Interim Health Care	Directors
Lloyd Cote	Eden Park	Administrator
Brooke Daley	The Stanton	Administrator
Paula DeLong	Inter-Lakes Medical Supply	Director
Tawn Driscoll	Warren County	Fiscal Manager
Cathy Dufour	Warren County	PHN
Mary Beth Farmer	Upstate Home Respiratory Equip.	Secretary
Karen Fidd	Warren County	RN
Lori Fitzgerald	Albany VNA	Supervisor
Joe Flacke	Home Therapy Group	
Chris Freire	Glens Falls Hospital	Case Manager
Nancy Gasper	Warren County	RN
Janet Glenn	Saratoga County Public Health	ADPS
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
Margaret Jones	Upper Hudson Primary Care Consort.	Safety Officer
Candy Kelly	Office for the Aging	Director
Diane Krans	Inter-Lake Health Moses Ludington	Administrator
Mary Lamkins	Warren County	Nursing Supervisor

Kathy Liddell	North Country Home Services	Office Manager
David Lovelace	Adirondack Tri-County	Administrator
Barbara Lyons	Anthem Health Services	Vice President
Angela Meade	Warren County	PH Liaison
Heather Mercure	Adirondack Manor	Director
Joann Morton	Warren County	Supervisor
Barbara Orton	Warren County	BT Coordinator
John Penzer	Greater Adirondack Home Aides	Director
Stella Racicot	Warren County	RN
Ann Reynolds	Washington County	ADPS
Sharon Schaldone	Warren County	ADPS
John Schroeter	Warren County CASA	Coordinator
Peggy Sefcik	Lincare	Sales Representative
Linda Slattery	Warren County	RN
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
Barbara Taggart	Westmount Health Facility	Administrator
Bonnie Thomas	The Landing	Admissions
Lori Warner	Greater Adirondack Home Aides	
Kathy Wyka	Home Therapy Group	CEO
Rob York	Office of Community Services	Director

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
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%
2008	502 (6 sets of twins, 3 sets of triplets)	496 (365 breastfeeding) (76 Primary CS) (87 Repeat CS)	14	681	10	1.53

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 2008, referrals were received on 7 young women under age 18 who delivered infants which is 6% 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
2008	79

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
2004	520	347	66%
2005	528	375	71%
2006	457	304	67%
2007	458	340	74%
2008	496	365	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 4 multi-disciplinary meetings in 2008 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
Strengthening Families	1	7	7	15
Parenting Apart (divorced families)	1	4	9	21
TOTALS	2	11	16	36

WELL CHILD CLINICS

YEAR	CHILDREN ATTENDING FOR PHYSICIAN VISIT	IMMUNIZATIONS GIVEN
2004	15	22
2005	26	24
2006	11	22
2007	19	55
2008	17	60

The Well Child Clinic is now held at the Queensbury Central Fire House on Lafayette Street. We continue to ponder closing the clinic but as more people lose health insurance, we are reluctant to do so. Hopefully, the new Child Health Plus insurance will make the clinic unnecessary. Attendance does continue to decline however we find that children who attend are often new to the area and have not yet established with a primary care provider.

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.

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. Reports and data are 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
2004	212	156	101	639	16
2005	212	141	259	672	19
2006	166	116	169	586	8
2007	182	110	259	625	13
2008	119	61	176	655	7

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 \$45.00 (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 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.
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
2008	10 (5 weekend/5 6-week)	44

WOMEN, INFANTS AND CHILDREN NUTRITION PROGRAM
(WIC)

In many respects, 2008 was a year of preparation. Major changes had been scheduled, requiring education and training for families, physicians, and vendors as well as staff. Changes to the food package included switching participants (with the exception of 1 to 2 year olds) to low or non fat milk. The amount of juice was decreased when the amounts of fruits and vegetables were increased. Infant formulas and infant cereals were also changed. WICSIS, our computer system, was reworked and there were many changes pertaining to federal and state regulations. Criteria for determining eligibility were revised. Fortunately, there were only minor changes in staffing.

Our assigned target for caseload was 1428 participants per month. Programs are encouraged to aim higher and penalized for dropping 5 or more percent below their target. We exceeded our goal in each of the 12 months, averaging 103.75% above target. We operated 18 clinics a month at 9 different locations. Average monthly caseload was 1481 and distributed as follows:

Site	Average Caseload	Percentage
Christ Church Methodist – Glens Falls	222	15.0
Main Site - Gurney Lane	259	17.5
North Creek Fire House	67	4.5
Horicon Community Center	82	5.5
Warrensburg Town Hall	162	11.0
Lake Luzerne Court House	88	6.0
Queensbury VFW Post	230	15.5
Queensbury Historical Society	104	7.0
First Baptist Church – Glens Falls	267	18.0

We continue to offer expanded clinic hours to provide more convenient times for our families. Staff voluntarily work flex hours and are available from 8:00am to 7:00pm several days each month, though not at every site. Our administrative budget totaled \$477,497.00. The redemption value of WIC benefits provided to Warren County participants was \$1,043,690.60.

The education component remains the heart of the WIC Program. Staff work hard to develop innovative ways to assist our families in changing lifestyle habits. We experience our greatest successes when we place emphasis on addressing concerns and issues that are most relevant and meaningful to participants which is often easier said than done. Overall, parents want what is best for their children and see the WIC staff as allies. Together, the staff finds ways to help parents succeed in meeting the daily challenges at this critical stage in life. The early years are where it's at!

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
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
2008	88	As of 12/31/08: 68	128

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. This has added 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

	2004	2005	2006	2007	2008
Referrals Received	112	157	153	153	130
Children Served	208	250	274	281	260
Dollars Received From NYS	194,097.77	298,131.66	307,449.24	307,792.25	370,995.30
Dollars Received From Medicaid	252,901.49	275,684.70	305,619.46	403,277.54	481,521.68
Dollars Received From Private Insurance	38,541.55	52,178.46	51,583.84	74,972.70	52,794.26
Costs Before Reimbursement	661,271.60	945,383.40	1,103,066.52	1,200,556.86	1,153,028.34
Amount Appropriated	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)	1,133,861.00 (Over budget by 19,167.34)
Expenditures For County After Reimbursement Received	175,730.79	319,388.58	438,413.98	414,514.37	247,717.10
Average Cost to County Per Child Served	844.86	1,277.55	1,600.05	1,475.14	952.76
Births in County	639	672	586	625	655

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. Dollars received are based on actual cash in for the year, not revenues booked. Private insurance payments are down due to insurance policies changing their benefit requirements, therefore many are no longer paying for EI services rendered.

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. NYSED reimburses at 59.5% for tuition. Additionally Medicaid is 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 2003-2004	SCHOOL YEAR 2004-2005	SCHOOL YEAR 2005-2006	SCHOOL YEAR 2006-2007	SCHOOL YEAR 2007-2008
Children Served	341	339	358	357	365
Evaluations Only	77	72	97	85	110
Tuition Program Costs Approved	\$2,321,856.57	\$2,523,901.41	\$2,612,951.83	\$3,045,732.27	3,727,728.73*
Tuition Program/Evaluations Costs Paid	\$2,138,498.53	\$2,278,945.05	\$2,572,781.63	\$2,843,524.11	3,723,342.40*
Transportation Costs Approved	\$449,675.60	\$445,199.13	\$548,757.76	\$768,504.28	824,325.43*
Transportation Costs Paid	\$415,415.06	\$422,065.12	\$533,415.65	\$731,085.60	827,346.47*
Average Cost Per Child Before Reimbursement	\$7,489.48	\$7,967.58	\$8,676.53	\$10,012.91	12,467.64
Amount of Medicaid Received	\$343,294.16	\$227,918.28	\$271,485.28	\$82,108.99*	212,925.33**
Amount State Aid Received	\$1,529,794.24	\$1,617,905.10	\$1,848,187.30	\$2,263,097.57	2,461,154.14
Administrative Costs Received	\$25,757.00	\$20,025.00	\$19,575.00	0	54,600.00
Administrative Costs Paid to School Districts	\$13,981.00	\$37,301.00	\$966.00	\$37,266.00	0***
Program Costs After Reimbursement	\$669,049.19	\$872,462.79	\$967,915.70	\$1,266,669.15	1,876,609.40
Average Cost Per Child After Reimbursement	\$1962.03	\$2573.64	\$2,703.68	\$3,548.09	5,141.40

*Source: General Ledger/Accounts Payable Reports and Budget Performance Report.

**Medicaid reimbursement decreased because services were unbillable due to inappropriate documentation from provider.

***Total administration costs to school districts of \$44,183.47 for school year 2006-07 were paid 1st quarter 2009.

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

SCHOOL DISTRICT	School Year 2003-2004	School Year 2004-2005	School Year 2005-2006	School Year 2006-2007	School Year 2007-2008
Abe Wing	16	8	6	0	14
Bolton	6	6	8	7	6
GF City	59	57	49	65	73
Hadley Luzerne	12	10	13	18	18
Johnsburg	19	14	9	11	7
Lake George	25	24	26	20	18
Minerva (child resided in Warr. Co.)	1	0	0	0	0
No. Warren	15	21	19	16	17
Queensbury	89	100	99	96	99
Ticonderoga (Hague)	0	0	0	0	0
Warrensburg	22	27	32	39	45

Administrative Costs Paid to School Districts During 2008*	
Queensbury	0
Johnsburg	0
Had Luz	0
Bolton	0

Rate Reconciliations**	2007	2008
Paid Out to Providers	187,863.31	356,422.70
Received from Providers	0	0

Budget Appropriation for Contractual Services***	
2004	3,030,790.00
2005	3,104,750.00
2006	3,255,000.00
2007	3,420,910.00
2008	4,600,000.00

*Costs for 2006-07 totaled \$44,183.47 however were not paid until 2009 with no payments in 2008.

**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

	2004	2005	2006	2007	2008
CHILDREN PARTICIPANTS IN PHCP	4	3	3	4	2

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.

	2008
Program Budget Allocation	\$6000.00
Program Expenditures	\$101.43
Program Revenues (NYS Reimb. 50%)	0
Patient Co-pays	\$50.00
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.

	2005	2006	2007	2008
Diagnosis and Evaluation Services Requested	1	0	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

Warren County Health Educators expanded their reach in 2008 to a variety of community groups. This is one of the long-term goals for the health education program. There was a drop in the number of school based programs that the health educators conducted in 2008. There were several factors that contributed to this. First, the scope of the school based program was narrowed from K – 5th grades to K – 3rd grades (however programs were still conducted for older students if it was requested but the programs were not actively promoted to the older students. This was done to allow for more programs to be offered to the community. Warren County Health educators saw an increase in the number of people seeking information about rabies and ticks and Lyme disease.

The Warren County Health Education program will continue to offer outreach to variety of school and community groups. Also, the Health Education program will continue to try and improve the reporting and evaluation of its programs to help guide the program in a direction that best serves the people of Warren County.

2008 Activities

Program News

- Continued with school based health programs focusing on pre-k thru third grade student (see chart below)
- Offered a variety of health programs to community organizations as per request.
- Increased outreach to community groups.

Community Events

- Attended more than a dozen community events (National Night Out, Warrensburg Career Day, Warrensburg Health Fair, several health fairs)

Trainings/Conferences

- Attended a Worksite Wellness Training hosted by the New York State Department of Health

Networking

- Continued to work with community partners by attend meetings and offering assistance with community events planning and implementation (material distribution for 7 Counties Diabetes, Southern Adirondack Tobacco Free Net. etc.)
- Attended over 50 networking meetings

Worksite Wellness

- Continued to produce monthly Wellness Newsletter
- Continued to work with human resources department to strengthen worksite wellness

Miscellaneous

- Disseminated educational materials on a variety of health topics through tabletop displays in front of DMV, display racks and at community events.
- Created several new educational brochures and had them posted on the county website and in hard copy form for the public to use.

PRESCHOOL ELEMENTARY and ADOLESCENT PROGRAMS

Program	Attendance 2006	Attendance 2007	Attendance 2008
Dental Health	187	173	183
Nutrition	444	1039	386
Injury Prevention	263	523	367
Hand Washing/Hygiene	486	1427	1020
Exercise/Heart Health	296	520	381
Sun Safety	155	620	473
Poison Prevention	60	18	71
Tobacco Education	853	609	910
Ticks & Lyme Disease	*	*	382
Rabies Awareness	*	*	534
TOTAL	2744	4929	4707

ADULTS, PARENTS and SENIORS PROGRAMS

Program	Attendance 2006	Attendance 2007	Attendance 2008
CPR/First Aid	265	205	185
School Nurse Training	28	28	29
Blood Borne Pathogens Training	99	65	52
Employee Training	18	54	99
Senior Health/Fall Prevention	*	*	68
TOTAL	765	761	433

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.

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	Seven Counties Diabetes Network
Rural Health Network	Glens Falls Hospital	Warren County Senior Citizens Council
Southern ADK Tobacco Free Coalition	Upper Hudson Prenatal Network	American Academy of Family Physicians
Aviation Mall	Youth Coalition	

(We have tried to include any and all of our community partners we have worked with. However, we know this list is not all inclusive. We would like to apologize to any community partner that has been left off this list.)

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.

2008 Outcomes

- Increase at risk individuals knowledge and/or adoption of healthy behaviors and lifestyles to prevent or delay the occurrences of diabetes
- Improve an individuals ability to manage their diabetes through appropriate self/health care
- Increase health care provider's ability to serve individuals with promotion of Diabetes Prevention Management Toolkit (DPCP).
- Increase public awareness of diabetes burden, risk, prevention and control and opportunities to support healthy lifestyles.
- Contribute towards sustainable policy, environmental and/or systems change to support healthy lifestyles leading to reduced risks of diabetes and its complications.

Healthy Heart Grant: The grant was completed in 2008. A final report will be completed and submitted to the state by the Healthy Heart coordinator.

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.
- Reduce to amount of tobacco advertising in the retail environment

Program Highlights

- Conducted media campaigns focusing on point of purchase advertising in retail stores
- Attended community events and functions and distributed educational materials.
- Reduce tobacco promotions in sporting, cultural, entertainment, art and other events in the community, region, and state.

MATERIAL DISTRIBUTION

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

Rabies: Sent out yearly mailings to all the health care providers, vets and relevant professional with information about reporting to the county. Conducted a school aged rabies program at an environmental field days hosted by Cornell Cooperative Extension. Distributed educational materials to all of the participants.

Lyme Disease: Conducted tick and Lyme disease education for elementary students at an environmental field days hosted by Cornell Cooperative Extension and at two community health fairs. Distributed educational materials to all of the participants.

West Nile Virus: Was incorporated into a summer safety program that was presented to school and community groups.

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.

Lead: Distributed information to daycares in Warren County. Offered free lead poisoning prevention trainings to daycare providers and parents. Distributed informational booklets to paint stores in Warren County. Continued to provide lead information too new moms enrolled in the Warren County prenatal/postnatal program.

OTHER PROGRAMS

Tar Wars Tobacco Free Education: Saw an increase in the number of students and schools that decided to be a part of the "Tar Wars" program. The number of students that participated in the program was up 50% for the year before. We also saw the number of classroom teachers inviting us in to do the program increase as well which is one of the reasons for the rise in student participation.

Warren County Employee Wellness Program: 2008 saw very little happen in terms of actual program for employees. A newsletter continued to be done on a monthly basis. Also, there has been an attempt to establish a collaborative effort between the Wellness Committee and Human Resources to enhance employee wellness.

School Nurse Training: Held at the end of August. There were several guest speakers covering topics such as communicable disease reporting, STD/HIV testing, health education and many more. The event was well attended with each school district having at least one representative.

Community Outreach: Health Educators attended 7 large community outreach programs and a dozen smaller community programs. This helped to expand our role in the community which was a goal for 2007.

LEAD POISONING PREVENTION PROGRAM

Warren County has a Lead Poisoning Prevention Program funded by a NYSDOH \$24,500.00 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)	2004	2005	2006	2007	2008
<10mcg/dl	562	755	835	675	753
10-14mcd/gl	17	7	4	3	5
15-19mcg/dl	3	4	2	1	0
20-25mcg/dl	1	0	0	0	0
>25mcg/dl	0	0	0	0	0
TOTAL ELEVATED RESULTS	21	11	6	4	5

(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 2008, the Emergency Response and Preparedness Program continued to expand. Its staff continues to address issues associated with mass fatality, Strategic National Stockpile and Alternate Care Site Plan, mass prophylaxis capability, and pandemic flu. Our part time Bioterrorism Coordinator addressed all 2008 performance goals and participated in table top exercises, trainings, and drills as required by NYSDOH.

DISEASES REPORTED FROM LABORATORY CONFIRMATION

DISEASE ENTITY	2004	2005	2006	2007	2008	DISEASE ENTITY	2004	2005	2006	2007	2008
Amebiasis	0	0	1	0	1	Influenza, B	---	---	---	1	19
Brucellosis	---	---	1	0	0	Influenza, unspecified	---	22	8	1	2
Camphylobacteriosis	6	7	7	6	4	Influenzae (Haemophilus) Invasive not Type B	---	2	0	0	0
Chlamydia	82	111	115	96	100	Legionellosis	0	1	1	2	1
Cryptosporidiosis	3	3	1	3	5	Lyme Disease	11	11	16	26	23
E. Coli	0	0	1	0	2	Ticks Tested/Confirmed Deer Ticks	68/55	89/85	119/96	117/97	142/118
EHEC (not serogrouped)	---	---	1	0	0	Meningitis (bacterial)	1	0	0	0	2
Giardiasis	6	3	4	3	9	Meningitis (viral)	1	1	1	3	0
Gonorrhea	7	12	9	6	18	Mumps	---	---	1	0	0
Haemophilus Influenzae Inv No	0	0	1	0	1	Pertussis	11	2	0	0	2
Hepatitis A	1	0	0	0	0	Psittacosis	---	---	1	0	0
Hepatitis C (acute)	---	---	---	---	1	Rocky Mountain Spotted Fever	---	1	0	0	0
Hepatitis C (chronic)	75	73	56	46	42	Salmonellosis	8	5	4	3	8
Hepatitis B (acute)	0	0	1	0	0	Shigellosis	---	---	---	---	1
Hepatitis B (chronic)	4	10	3	5	4	Strep Pneumo Invasive Sensitive	2	5	3	5	0
Influenza, A	---	3	7	2	35	Strep Pneumo Invasive Drug Resistant	1	0	2	1	0

(continued next page)

DISEASE ENTITIY	2004	2005	2006	2007	2008	DISEASE ENTITIY	2004	2005	2006	2007	2008
Strep Pneumo Invasive Intermed	---	---	2	1	1	Syphilis, primary	2	0	1	1	1
Strep Pneumo Invasive, unknown	---	---	---	---	1	Syphilis, secondary	---	1	0	0	0
Strep Pneumo Invasive, sensitive	---	---	---	---	2	Syphilis, early latent	---	---	1	2	2
Streptococcus Pneumoniae (Unknown)	1	1	2	0	0	Syphilis, late latent	---	---	1	0	1
Strep Group A Invasive	2	3	2	3	3	Syphilis, unknown latent	---	---	2	0	1
Strep Group B Invasive	4	5	3	2	7	Tuberculosis	1	2	1	0	1
Strep Group B Invasive, early	---	---	---	---	1	Yersiniosis	0	0	1	1	1
Totals NYS Reportable (All Diseases)							228	284	261	221	302

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)	Tetanus
Cyclospora	Listeriosis	Toxic Shock Syndrome
Diphtheria	Lymphogranuloma Venereum	Trichinosis
Ehrlichiosis	Malaria	Tularemia
Encephalitis	Measles	Vibriosis
		West Nile Virus

DISEASES REPORTED FROM SCHOOL DISTRICTS

	2003-04	2004-05	2005-06	2006-07	2007-08
Chicken Pox	97	26	41	3	13
Conjunctivitis	440	257	297	146	200
Coxsackie Virus	2	4	0	0	0
Fifth Disease	161	37	35	4	80
Impetigo	30	11	20	10	10
Mononucleosis	41	60	100	42	70
Pediculosis	329	236	320	226	269
Pertussis	4	1	0	0	0
Pneumonia	64	112	51	30	31
Ringworm	28	15	33	18	43
Scabies	5	4	18	6	3
Scarlet Fever	9	8	9	3	15
Shingles	5	11	15	5	9
Strep	518	920	689	386	560

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 548 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	1		0	4					2		
Chester	1	1		1	10							
Glens Falls	3	7	1	10	25		2	2		6	3	
Hague	1				1							
Horicon						1 (horse)		1				
Johnsburg	1	2			7			2			2	
Lake George	5			8	12			4		1		
Lake Luzerne	2			1	5			1		2		
Queensbury	10	10		12	58		1	12		17		
Stony Creek		1			2							
Thurman		2			1					1		
Warrensburg	1	5		2	16					2		
TOTALS	25	29	1	34	141	1	3	22		31	5	

BITES REPORTED BY MONTH

	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Total
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
2008	12	18	14	33	23	26	42	29	24	25	18	28	292

RABIES STATISTICS

	2004	2005	2006	2007	2008
Confirmed Rabid Animals	1 bat/1 fox	0	1 raccoon	1 cat 1 raccoon 1 skunk	1 fox 2 bats
Animal Specimens Submitted for Testing	73	65	89	69	81
Animal Bites	219	179	244	270	292
Patients Receiving <u>Pre-Exp. Vacc.</u> (3 Injections) or <u>Booster Vacc.</u> Private Pay: \$188.00/Dose	5 Titers Drawn: 5	7 Titers Drawn: 10	8 Titers Drawn: 16	13 Titers Drawn: 20	(Due to a rabies vaccine shortage, only post exp. vaccine was given.)
Patients Receiving <u>Post-Exp. Vacc. Series @ GF Hosp.</u> (All RIG and First Injections are Given at GF Hospital)	36	49	32	49	29
Patients Receiving <u>Post-Exp. Vacc. Series @ P. Health</u> (All RIG and First Injections are Given at GF Hospital)	3	2	10	2	3
Animal Clinics	22	25	23	20	21
Animals Receiving Rabies Vaccinations	976	884	1150	850	927

Amount paid in relation to Rabies Program:	29,021.40
Amount of reimbursement from New York State:	16,546.81
Rabies Clinic Revenue	8961.00
Total program cost to Warren County:	3513.59

Note: in past years we have been able to submit the amount over the maximum allowed and have been reimbursed. Over the last years, this has not been the case, therefore more cost to county for a mandated program.

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	
2004	\$366.78
2005	\$7,846.73
2006	\$566.84
2007	\$31.60
2008	\$19.75

YEAR	INDIVIDUALS TESTED	POSITIVE CONVERTERS	ACTIVE TB CLIENTS DURING YEAR
2004	185	2	2
2005	203	10	2
2006	237	7	1
2007	268	0	0
2008	318	3	1

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.

2008: The individual was diagnosed with extra pulmonary TB and completed treatment.

HIV and STD (SEXUALLY TRANSMITTED DISEASE) CLINIC

	2004	2005	2006	2007	2008
Clinics Held	50	52	51	51	51
Participants	197	376	357	368	325
Males	135	233	240	234	199
Females	62	143	111	134	126
Age Range	16-66	13-58	15-70	14-71	15-68
HIV Test Only Done	n/a	n/a	n/a	76	65
STD Test Only Done	n/a	n/a	n/a	73	55
STD HIV Test Done	n/a	n/a	n/a	151	151
HIV Not Tested*	n/a	n/a	n/a	16*	25*
STD Phone Calls for Results	71	152	146	135	116
Warren Co. Participants	106	240	210	181	189
Washington Co. Participants	50	74	74	92	59
Saratoga Co. Participants	30	57	61	76	67
Other County Participants	6	6	5	18	10

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

DISEASES WITH POSITIVE TEST RESULTS

DISEASES	2004	2005	2006	2007	2008
Genital Herpes	3	1	6	0	2
Genital Warts	3	9	11	20	13
Chlamydia	5	14	9	7	9
Gonorrhea	0	3	0	4	1
Syphilis	0	0	3	2	4

VACCINATIONS ADMINISTERED

	Dose #1	Dose #2	Dose #3
Receiving Hepatitis B Series	1	0	0
Receiving Hepatitis A Series	4	5	
Receiving Twinrix (Hep A & B)	16	17	13

The numbers make it clear that all of the STD/HIV clinic numbers are holding steady. Surprisingly, numbers of Syphilis cases increased, reflecting a statewide increase. Cooperation with the Glens Falls Hospital Lab has been excellent. Patient names are never used by the lab, only codes provided by the clinic to identify specimens. This puts an added burden on the lab but works well to maintain confidentiality of our clients. Simultaneous testing for HIV and sexually transmitted diseases has resulted in improved education of clients and quicker diagnosis of disease. NYSDOH has provided information on obtaining medications for treatment of sexually transmitted diseases at much reduced rates so we are able to provide medications as needed. Since the STD Clinic receives free hepatitis vaccine from the NYSDOH Free Hepatitis Program, we are able to offer the vaccine to all clients. Cooperation has been established with Planned Parenthood to help educate teenagers regarding birth control and prevention of pregnancy, using their funding for this population. The HIV Clinic is staffed by Health Educators from Washington County and the STD Clinic is staffed with Public Health Nurses and clerical staff from Warren County. Dr. Peter Hughes is the clinic physician.

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 2008

- Partnered with Washington County Public Health to offer free rapid HIV testing at 51 clinics and testing of 216 people.
- Continued to provide clinic coverage for Washington County Health Educators as needed.
- Developed a more comprehensive way to record HIV/STD testing statistics.

Concerns:

- The current testing site is owned by the City of Glens Falls who is looking to sell the property. If it is sold a location will have to be found which could affect clinic attendance. Current clinic site is located near the Greater Glens Falls Transit bus stop.
- Continued with 1 test counselor per clinic and saw the number of people not tested increase by 56% from 2007. However this increase could be do to the time at which those seeking testing arrived at the clinic. The rapid test takes at least 20 minutes to complete.

2008 Goal Progress

- Continued to offer free HIV/STD testing to the Public Health
- Did not research getting HIV testing into the jail.
- Looked into setting up HIV testing at the Public Health Office. Do to budget constraints and lack of other needed resources a decision to table this discussion for a future date was made.

2009 Goals/Outlook

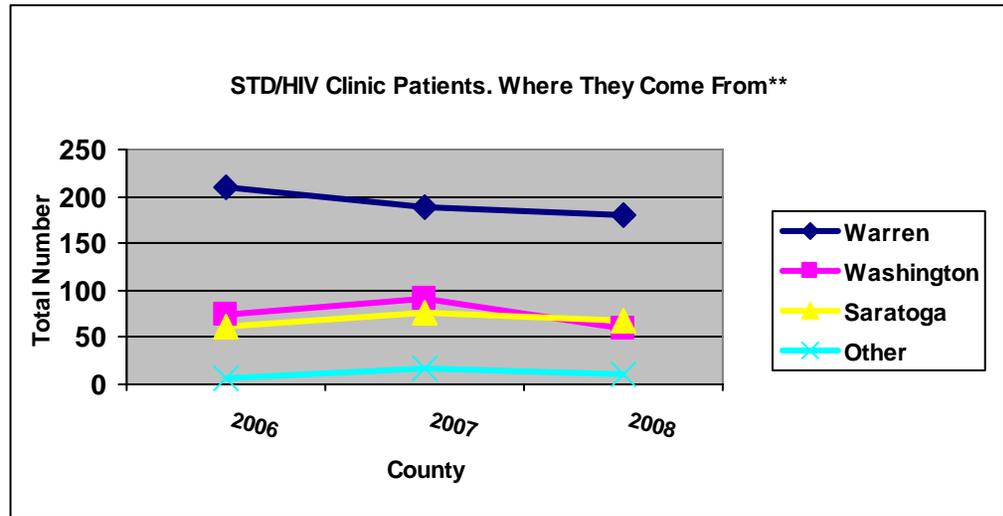
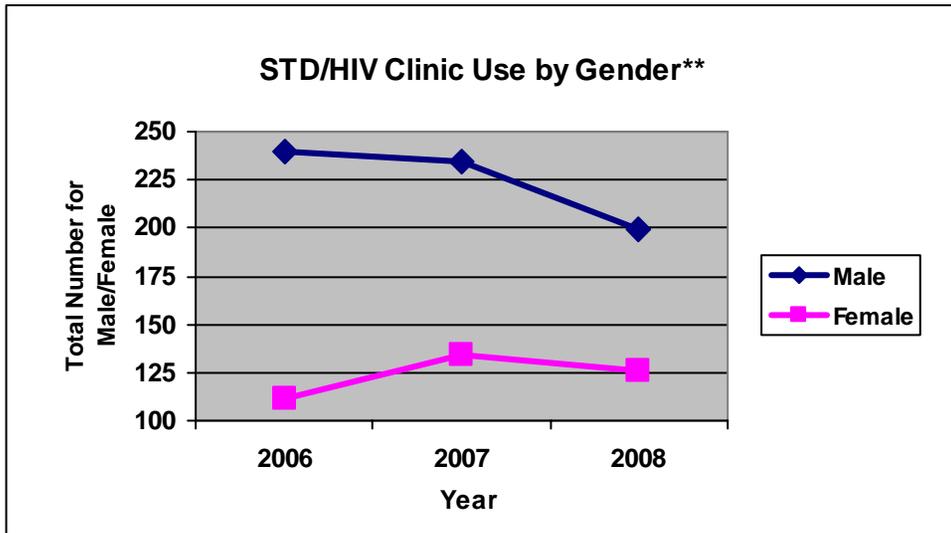
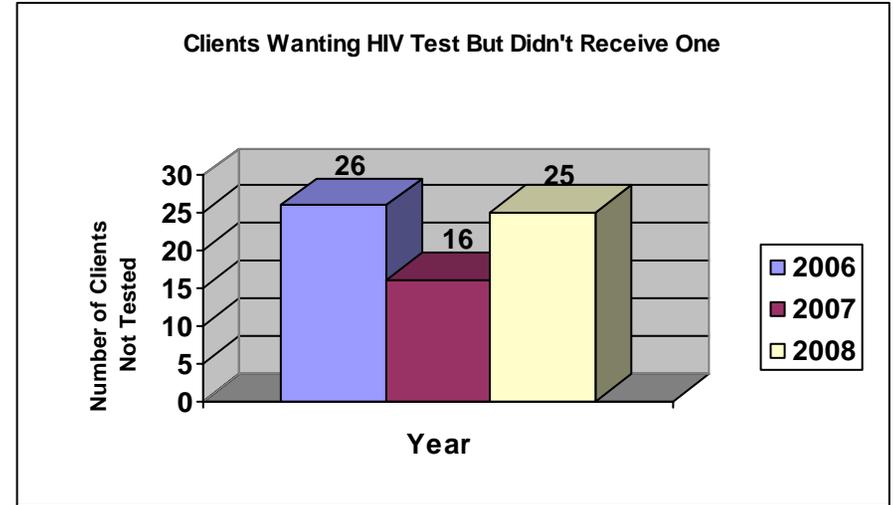
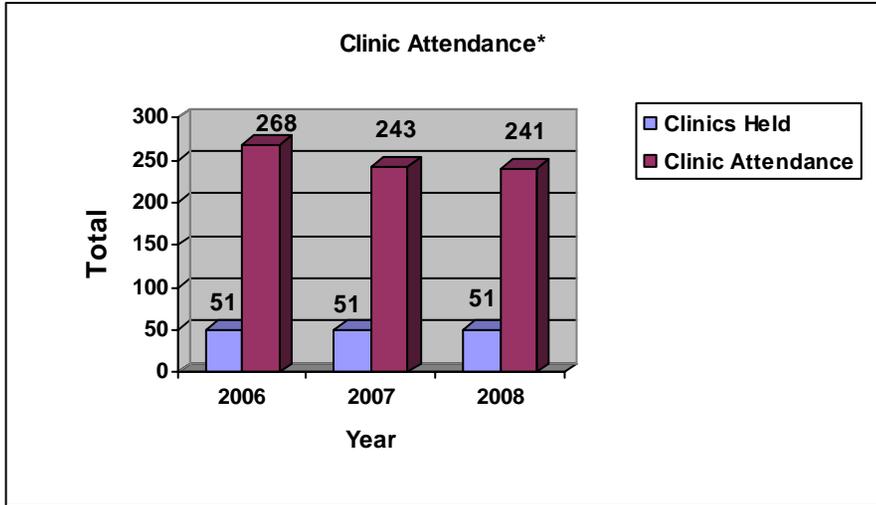
- Increase the number of people receiving free rapid HIV testing at the clinic by 5%.
- Make sure that the people who are unable to receive a rapid test at a particular clinic are given alternatives.
- Find alternatives to the current testing site in the event the site is sold. Have a plan in place to alert the public about any changes.
- Find out how most people are hearing about the clinic to make better use of advertising dollars.

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.

2008 HIV CLINIC BY THE NUMBERS



* The clinic attendance graph includes only those people who came seeking an HIV test.

** 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 a member of the seven-county consortium whose mission is to address immunization status of our children. The Upper Hudson Primary Care Consortium (UHPCC) serves as the contractor for this endeavor and works with the New York State Bureau of Immunization (NYSBI). County health department officials meet regularly with UHPCC staff to review progress of the objectives and to identify changes and concerns as they occur. The NYSBI, in conjunction with Healthy People Year 2010 goals, seeks to meet or exceed a 90% statewide immunization coverage level for two year old children with 4 DTaP, 1 MMR, 3 Hib, and 3 Hep B and increase awareness and numbers for adult immunization as well.

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

1. In coordination with the Immunization Bureau, Assessment Feedback Incentives (E)Xchange (AFIX) site visits will be conducted to raise immunization coverage levels and improve standards of practice at the provider level.
2. Will use the NYSIIS Program to assess immunization coverage levels of providers receiving an AFIX site visit.
3. Conduct vaccine education during each AFIX site visit.
4. Assess county public clinic immunization rates annually and report results.
5. Increase awareness of benefits of adult immunization against influenza, pneumococcal, HPV, hepatitis A and B, tetanus, diphtheria, pertussis, varicella, measles, mumps, and rubella disease.
6. In coordination with various local coalitions, promote/conduct educational and outreach activities to inform health care providers and the public about the benefits of adult immunization.
7. Increase awareness of benefits of vaccination for adult migrant and seasonal farm workers (MSFW) through participation in the "MSFW Immunization Project".
8. Provide or facilitate the provision of free hepatitis A and B vaccination services for high-risk adults in the community through participation in the "Adult Hepatitis Vaccination Program". These settings include STD Clinics, adult immunization clinics, HIV Testing and Counseling sites, county jails, substance abuse services, special public health outreach settings such as homeless shelter, soup kitchens, etc.
9. Increase the proportion of children less than 6 years old with two or more shots in an immunization program.
10. Provide access to up-to-date education and training for local health department Bureau of Immunization staff members, health care providers, and the general public.
11. By September 2009, work with regional office staff to review and update submitted vaccine management education plan to train VFC and State Childrens Health Insurance Plan providers in Warren County.
12. By March 3, 2010 Local health unit immunization staff will be provided access to immunization education and training.
13. Ensure providers abide by their responsibility under the National Childhood Vaccine Injury Act.
14. Liaison with local and regional hepatitis B program managers to reduce perinatal hep B transmission in accordance with NYS Public Health Law.

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

VISIT TYPE	FEE	2004	2005	2006	2007	2008
Hepatitis A	33.00 (adult)	71	69	104	46	50
Hepatitis B	40.00 (adult)	158	153	167	89	51
HPV	15.00 (under 18)	---	---	4	46	20
Influenza	20.00 or Medicare	169	321	201	170	189
IPV	15.00	0	5	4	5	3
Menomune/Menactra	110.00	107	84	76	29	23
MMR	15.00	55	62	47	38	64
Pneumonia	36.00	9	24	3	4	2
Post-Rabies	No charge	11	5	33	8	9
PPD	18.00	155	203	237	185	220
Pre-Rabies	188.00	8	13	21	11	9
Tdap (Tetanus w/Pertussis)	48.00	---	---	16	48	69
Tetanus (Td)	25.00	40	38	23	6	3
Twinrix	52.00	25	293	429	58	45
Varicella	15.00	12	12	39	19	13
Zostavax (Shingles Vaccine)	169.00	---	---	---	120	135
TOTALS	---	820	1282	1404	882	905

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
VFW Post 6196 Queensbury	Monthly: 3rd Friday 9:00-11:00am
Public Health Office By Appointment	Tuesdays, Wednesdays, and Fridays

The CDC halted the Vaccine For Children (VFC) distribution program requiring private providers to order from the NYS VFC Program themselves. This has resulted in reduced contact with providers consequently less exchange of information. The Immunization Coordinator continues to be a resource for information and some vaccines for these providers. VFC vaccine is provided without cost by NYSDOH and the Federal Government and is used exclusively for children’s immunizations. A \$15.00 administration fee is requested per child although this is waived in cases of financial hardship. Since all pediatricians in the area subscribe to the VFC Program, attendance at Public Health Clinics has dwindled. Public Health does continue to hold clinics more than 6 hours per week to offer vaccinations by appointment. This service has been well utilized by the public. NYSDOH instituted an immunization registry, NYSIIS, in early 2008. Since it is now mandatory that all physicians record in the registry this program has become a helpful tool for providers and schools. NYSIIS staff have been very aggressive in teaching health departments and private practices how to utilize the registry. Warren County has been active in promoting the use of NYSIIS.

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	
2004	15
2005	135
2006	136
2007	111
2008	101

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. The sheriff's office offered a jail safety program as an in-service for Public Health Nurses which was a review of issues to make staff aware of changes.

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 2008

MONTH	Hep B	Hep A	Twinrix
January		2	18
February		2	17
March		2	26
April		3	13
May		1	13
June		2	22
July	2	3	16
August		1	15
September		4	19
October		2	11
November		2	14
December	3	4	16

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-insurance 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

	2004	2005	2006	2007	2008
Clinics Offered Throughout the County	11	37	44	46	51
Vaccine Doses Administered at Clinics	2346	3614	3477	2550	2952
CHHA/Long Term Home Visits For Administration	147	175	210	122	101
Homebound Visits For Administration	20	20	14	26	9
Miscellaneous Administration i.e. PH Appointments And Other Home Visits	(not broken out for these years)			199	232

BLOOD PRESSURE CLINICS

Clinics are offered for free. Physicians about elevated blood pressures to assure appropriate medical follow up. General health education materials are available at clinics and the Health Educator works in conjunction with Office for the Aging to develop and implement education programs at various sites. A Public Health Nurse 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 also available. Reimbursement is received from Office For The Aging to cover a portion of the services provided to the senior population.	BP Clinic Site	2004	2005	2006	2007	2008
	Bolton Meal Site	77	88	92	86	60
	Chester Meal Site	70	106	91	77	67
	Cronin HighRise	90	92	125	75	55
	Johnsburg	173	166	183	114	72
	L.Luzerne Meal Site	116	122	134	116	117
	Presb. Church (GF)	---	---	84	89	68
	Queensbury Center	157	144	156	110	97
	Solomon Heights	155	137	169	134	88
	Stichman Towers	43	45	34	30	21
	Warrensburg	79	71	67	59	58
	TOTALS:	960	971	1135	890	703

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 East Side Center and Genesis.

Clinic Site	Blood Pressure and Weights are Taken
East Side Center	About 15 - 20 people are seen weekly
Genesis House	About 5 people are seen weekly

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.

2008 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
 Janet Cicarelli, Case Manager at GFH
 Stacie Dimezza PT, Warren County
 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
 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 2008

Meeting Date	MOMS	MCH	Synagis	Child Find
3/12/08	6	16	0	0
6/11/08	6	8	2	2
9/10/08	4	13	1	0
12/10/08	(No meeting in December)			

Summary of Findings: Appropriate

58 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 March 13, 2009.

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.

1. MOM'S
 - a. Recommendation that documentation should include involvement with different agencies. One chart demonstrated on the Family Information Form other agencies were involved. The recommendation was intended to encourage the nurse to write in narrative any follow up made with agencies. This was an apparent oversight on behalf of the nurse, as typically this is documented in detail.
 - b. Recommendation that when nurse signs a document, that she/he ensure client has completed the form as appropriate. One chart did not have the date the client signed the HIPAA form, however it did have the date the nurse signed, which is typically the same date/time. This recommendation would encourage the nurse to ensure the form is complete prior to signing.
2. MCH
 - a. Recommended unscheduled home visits when phones are disconnected. Typically letters are sent, however, this recommendation was to address poor accessibility to phone.
3. Synagis
 - a. Document other agencies involved/plan a discharge.

2009 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.
5. Expand scope of committee to review findings from CSHCN, STD, CDC and WIC programs. Programs will review charts quarterly and present findings to committee.

(Will be Presented to: Dr. Larson 3/10/09, UR Committee 3/11/09, Health Services Committee 3/27/09, PAC 5/13/09)

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

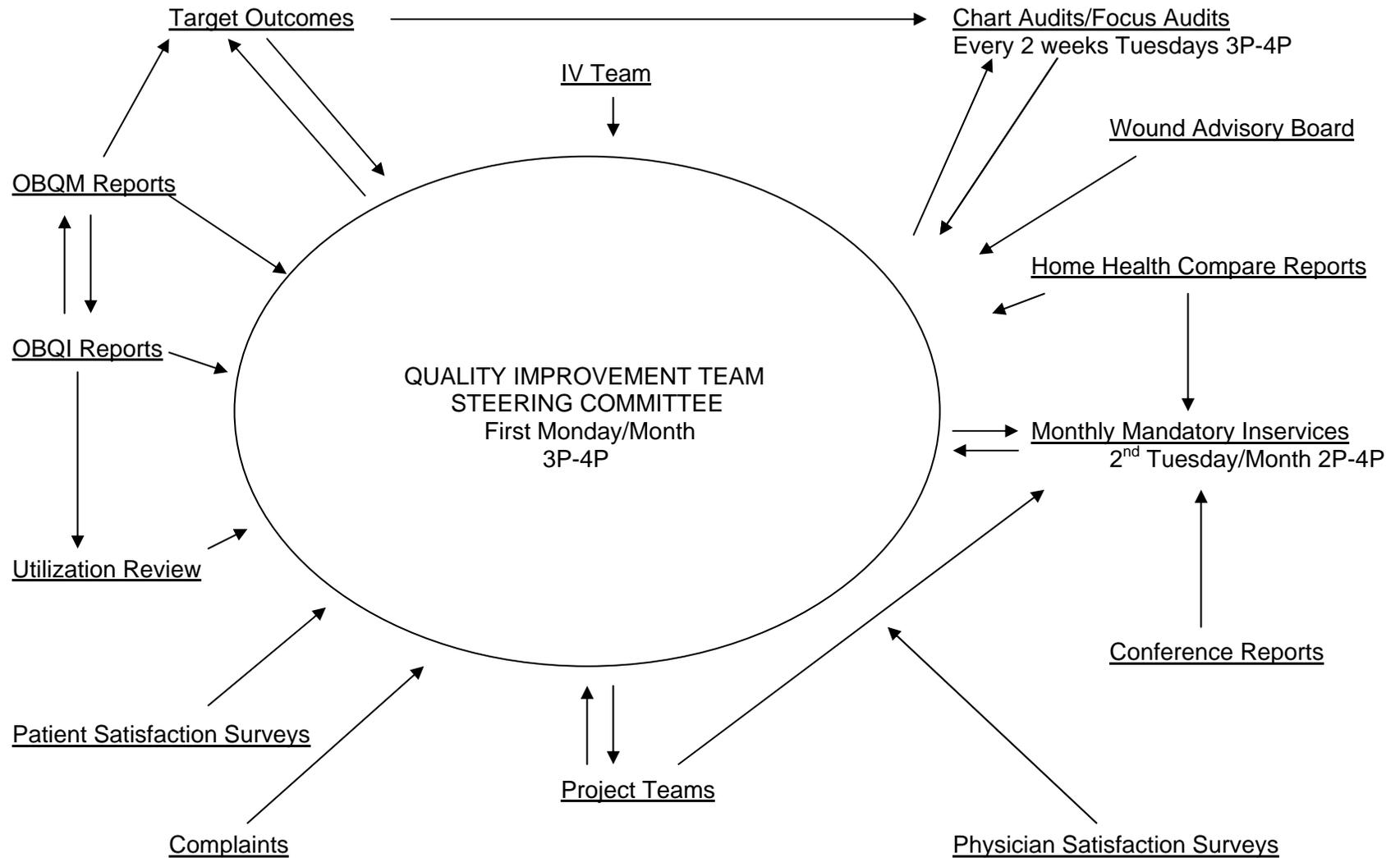
Warren County Health Services Division of Home Care is committed to providing quality health care to all of its clients. The process by which our client outcomes are monitored is through the Quality Improvement Program. This program is comprised of many components that address client outcomes. Two major 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 2008:

1. The Steering Committee continued to work on enhancing our medication reconciliation process. We developed policy and procedure to be done at every admission evaluation. This decreased the medication discrepancies to less than 10%.
2. OASIS training for interpretation of MO 780 oral medication with agency policy and procedure was focus for improving Patient outcome report as noted in OBQI reports and Home Health Compare report.
3. The agency was selected by IPRO to work on the 9th Scope of Work. The focus of this scope is to optimize the patient's transition between hospital and home with the collaborative efforts of the hospital, home care and the physician. The collaborating partners are Washington County Public Health, Glens Falls Hospital and all involved physician's. The target population will be those patients with frequent rehospitalizations within a 30 day period.
4. A liaison RN from our agency was assigned to GFH to work with assisting in the discharge planning for all Warren County Health Services clients that had a rehospitalization within a 30 day period. The liaison also assesses causative factors leading to the hospitalization. This data was analyzed by the Care Team for common factors that could be addressed to prevent avoidable hospital events. Area's identified:
 - a. Medication discrepancies
 - b. No follow up physician office visit
5. The Care Transition Team entered into an agreement with GFH and Hudson Headwater Health Network to work on a grant funded program targeting patients with frequent rehospitalizations in 30 days. The project will be for 18 months. Some of the patients will receive a homecare referral along with a community coach. The goal is to work in collaboration with the home care team to assist the patient in learning to manage their disease process and to enhance there skills in communicating their needs to their physicians.
6. The liaison RN job duties are to assist in the communication and discharge planning of any active home care patient that has a hospitalization to the acute care. This is not limited to 30 day readmits. The communication of any extraneous circumstances in the home that maybe contributing to frequent hospitalizations and the communication of the patients home medication list have been the success of this position. The Outcome of the liaison's duties:
 - Decreased our agencies 30 day readmits by 50% over the past 12 months. This directly impacts our hospitalization rate which is projected to be a revenue producing measurement for the agency in 2011. (P4P)
 - Decreased our patients' medication errors when transitioning from an acute care setting to home and vice versa. Reflective in our patient outcomes for oral medication management which increased by 3.5% in 2008 from 2007.
 - Patient Outcome report for 2008, Jan. thru Dec., our Acute care hospitalization rate decreased 2% from 2007

QUALITY IMPROVEMENT

7. The established Agency Standards of Care continue to be successful in improving our patients' outcomes. This is apparent with the % noted in the 2008 OBQI report:
 - a. Improvement in Management of Oral Meds: An increase of 3.5% from 2007.
 - b. Improvement in Status of Surgical Wounds: An increase of 2.4% from 2007, 11.2 % higher than the National Average.
 - c. Improvement in Transferring: An increase of 1% from 2007, 7.2 % higher than the National Average.
 - d. Improvement in Dyspnea: An increase of 1.2% from 2007, 5.3% higher than the National Average.
 - e. Emergent Care and Acute Care Hospitalization: decreased by about 1% and 2% respectively in 2008 from 2007 due to efforts from the following agency programs:
 - Telemonitoring
 - Front Loading visits for patient that are high risk for Hospitalization
 - Liaison communication to providers during acute care episode
 - Disease Management programs
 - Medication reconciliation procedure

8. The Steering Committee's focus beginning July 2008 was that of positioning the agency for the acquisition of our computerized clinical record. The members of the Steering committee were appointed as the Core Team for the implementation of the Delta Technology System called Encore. Preparation of all staff including professional and support staff were included in the Core Team. Strategic Planning began in late summer with full moving ahead in October of 2008. Transition of all patients began in November of 2008 and was completed by the end of 2008. This involved transitioning 750 patient's data from our old system to Encore. Our plan is to begin live training in Jan. 2009. The Core Tem will be the first live group trained. Training will be one week at a time and 1 week of support. There will be groups not to exceed 12-13 per group. It is expected that training will take 3-4 months continually before the majority of staff are trained.

9. Utilization Review Overview: The review of 68 records for 2008 revealed that less than 3% of the cases had problems. The committee identified only two 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 2008 was 594. (Please note that the numbers for 2007 were calculated to be over 750. This count was inaccurate as it counted all Early Intervention and CPSE cases in Public Health. The cases receiving therapy services in our Homecare Division should have been t he only cases counted in the CHHA census.)

Utilization of Services Summary:

Adequate Utilization	66
Over utilization	0
Underutilization	2
Inadequate Information	0
Unable to Decide	0

TELEMEDICINE PROGRAM

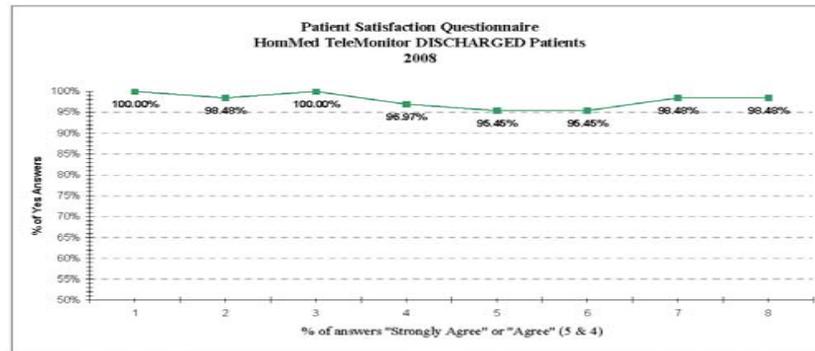
Telemedicine Outcomes:

- 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. This practice continued in 2008 to be enhanced with the addition of most respiratory, cardiac and renal diagnosis. The impact on our patient outcomes is evident by the decrease in our agency’s acute care hospitalizations and emergent care for 2008
- We continue to average 60 to 70 active clients per month with telemonitoring

*WARREN COUNTY PATIENT SATISFACTION SURVEY
TELEMEDICINE 2008*

	Total	4 & 5	Strongly Agree = 5	Agree = 4	No Opinion = 3	Disagree = 2	Strongly Disagree = 1	N/A = 0
Q1	66.67%	100.00%	44	22	0	0	0	0
Q2	62.12%	98.48%	41	24	1	0	0	0
Q3	72.73%	100.00%	48	18	0	0	0	0
Q4	74.24%	96.97%	49	15	2	0	0	0
Q5	71.21%	95.45%	47	16	3	0	0	0
Q6	71.21%	95.45%	47	16	3	0	0	0
Q7	74.24%	98.48%	49	16	0	0	1	0
Q8	77.27%	98.48%	51	14	1	0	0	0

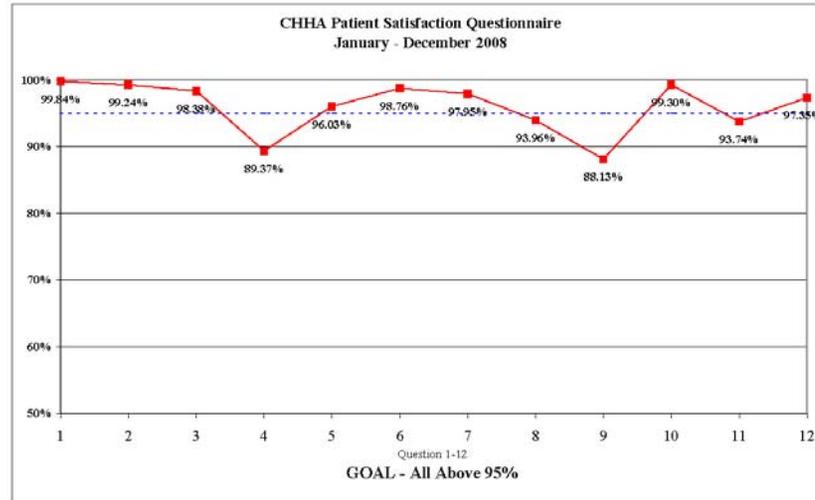
46.01% Returned



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.

WARREN COUNTY PATIENT SATISFACTION SURVEY



49.34% = Percent of Questionnaires Returned

Question Legend

- Q1 When the nurse / therapist visited your home, did they explain why they were there?
- Q2 Was the time of the nursing / therapist visit convenient for you?
- Q3 Did the nurse / therapist review your medications with you?
- Q4 Did the nurse / therapist explain to you any medication side effects and what to watch for?
- Q5 Did the nurse / therapist help you return to your pre-illness state?
- Q6 Did you understand when it was important to call your nurse / therapist or physician?
- Q7 Did the nurse / therapist help you understand how to manage your health condition?
- Q8 Were you aware that the nurse / therapist was going to discharge you prior to the discharge date?
- Q9 Were you involved in the discharge planning?
- Q10 If you contacted our office, were you assisted in a friendly and timely manner?
- Q11 If you needed help after our services, did we advise you where to obtain those services?
- Q12 If you need skilled nursing or therapy in your home in the future, would you contact this agency?

* The medication assessment in the computer system is a required field that will need to be addressed by each discipline at every home visit. This includes running drug a interaction report. It is hopeful that this procedure will be more visible to the client thus improving Q4 outcome.

* The Q9 referring to discharge planning will be addressed in 2009 with the Steering Committee

PATIENT PROFILE

The average age of our patients is: 76.40 and are 58.36% female.

Payer Sources:	91.80% Medicare	National Average: 94.10%
	11.07% Medicaid	National Average: 9.80%
	20.08% Managed Medicare	National Average: 14.30%
	59.92% live with family, National Average: 62.73%	

- 70.33% of patients had a hospital admission 14 days prior to our agency admission, National Average: 58.60%
 - Discharged from a rehabilitation facility – 3.76% higher than National Average
 - Discharge from nursing home – 9.75% lower than National Average

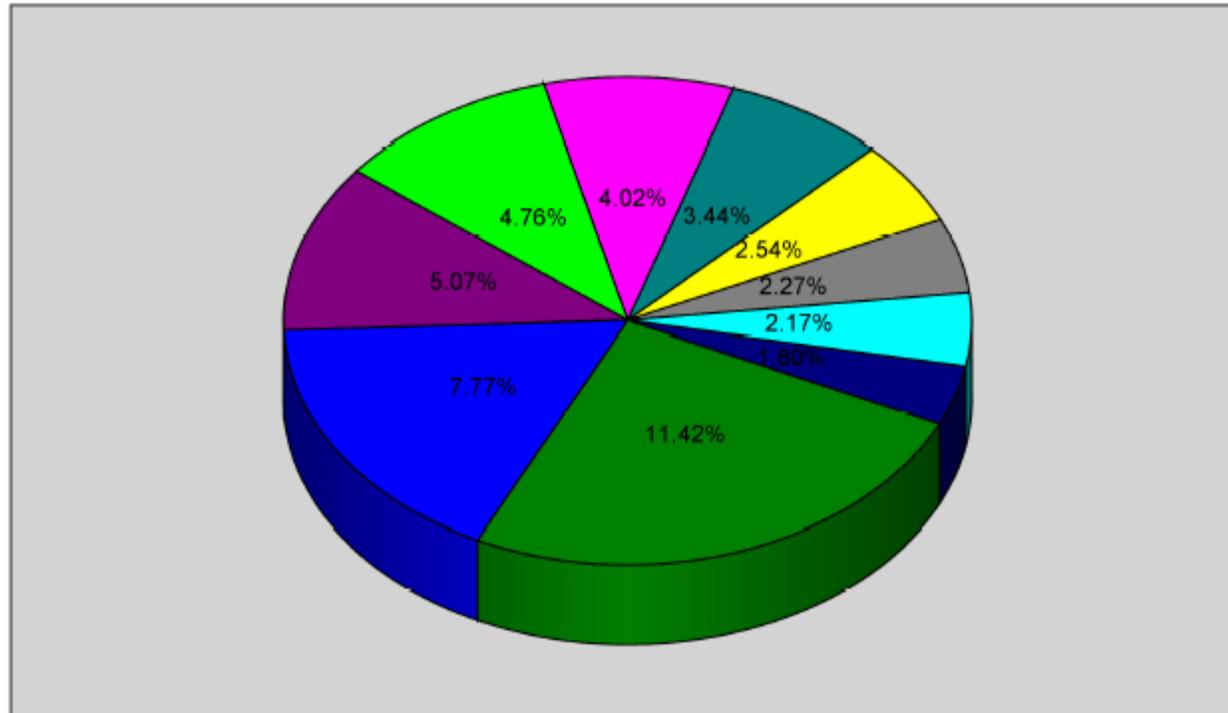
Our patients are more independent in performing their activities of daily living than the national average. Dressing lower body, bathing, and ambulation were the ADLs requiring the most assistance. We see a higher percentage of patients with endocrine, circulatory, respiratory, digestive, and urinary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

Our patients' average length of stay is about 33.36 days, less than the 38.81 National Average.

Top 10 Primary Diagnosis

For Visits Between 1/1/2008 and 12/31/2008

For CHHA & Long Term Care Programs



V57.1	PHYSICAL THERAPY NEC	TOTAL CASES = 216
V54.81	AFTERCARE FOLLOWING JOINT REPLACEMENT	TOTAL CASES = 147
715.90	OSTEOARTHROS NOS-UNSPEC	TOTAL CASES = 96
428.0	CONGESTIVE HEART FAILURE	TOTAL CASES = 90
491.21	OBS CHR BRNC W ACT EXA	TOTAL CASES = 76
V58.73	AFTERCARE OF CIRCULATORY SURGERY	TOTAL CASES = 65
V58.42	AFTER CARE OF CA SURGERY	TOTAL CASES = 48
486	PNEUMONIA, ORGANISM NOS	TOTAL CASES = 43
V58.78	AFTERCARE FOLLOWING MUSCULOSKELETAL SURGERY	TOTAL CAS...
250.00	DMII WO CMP	TOTAL CASES = 34

CERTIFIED HOME HEALTH AGENCY SERVICES BY THE NUMBERS

VISITS BY SERVICE

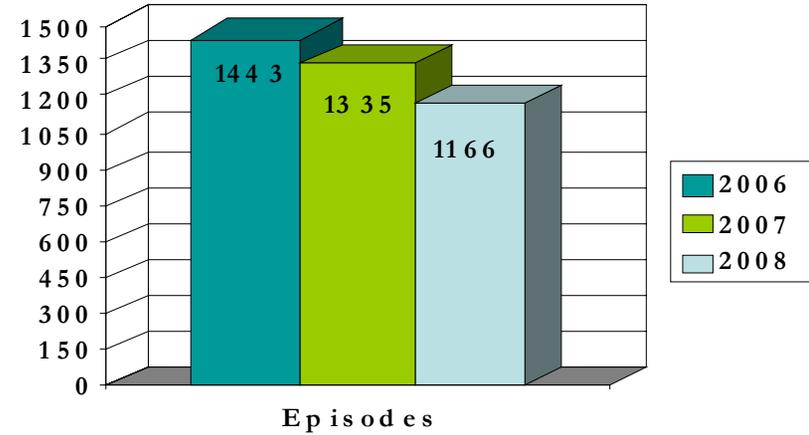
Services	2007	2008	2007/2008 % (+ or -)
Nursing	22,923	24,408	+6%
Physical Therapy	8173	9184	+12%
Occupational Therapy	1420	1029	+44%
Speech Therapy	245	245	0%
Medical Social Worker	166	520	+313%
Nutrition	53	185	+349%
Home Health Aide	4922	6584	+33%
TOTALS	37,511	42,612	+14%

REVENUES AND EXPENDITURES

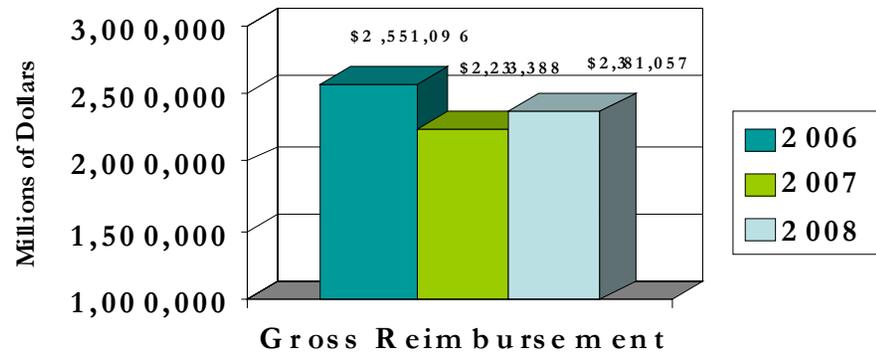
	2007	2008
Revenues	\$5,017,001.00	\$5,515,568.00
Expenditures	\$4,151,644.00	\$4,242,869.00

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

	2007	2008
Business Associates (see list of associates on page 30)	51	51
Therapy Referrals for EI/CPSE	333	248
<i>Referrals for Therapy</i>		
Physical Therapy	999	1099
Occupational Therapy	156	184
Speech Therapy	33	28
Registered Dietician	38	54
Medical Social Worker	66	56

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 2008 the addition of new PT/OTs servicing our critical long term cases was beneficial. ST, MSW and RD services are still difficult to find for coverage of northern regions .

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.

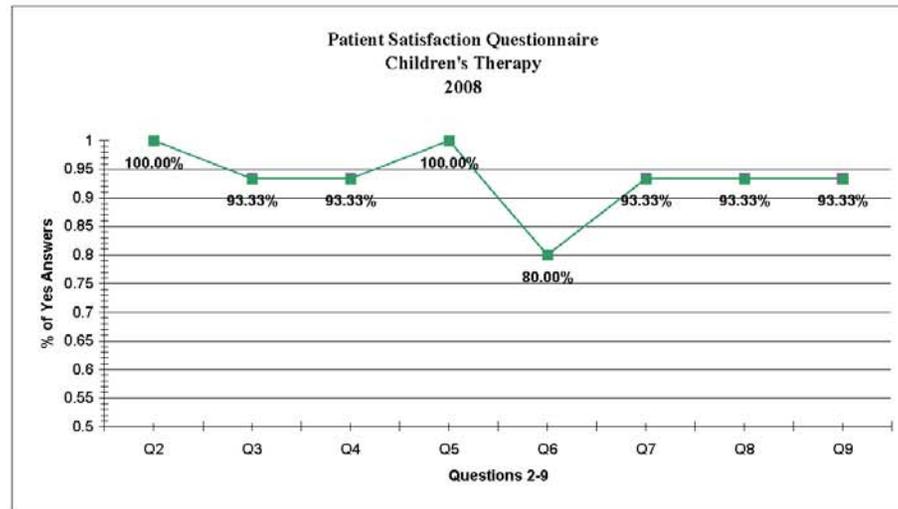
Policies and procedures to standardize the format of therapy reports provided to the Early Intervention and Pre School programs were developed and implemented in 2008.

We have seen an increase of referrals for Physical, Occupational and Nutritional services in our CHHA and LTC programs. Therapists providing services to CHHA and LTC programs must closely prioritize clinical needs of each individual once an evaluation is complete. Servicing the northern communities in our county continues to be an ongoing challenge.

**WARREN COUNTY ANNUAL PATIENT SATISFACTION SURVEY
CHILDREN'S THERAPY'S**

% of Surveys Returned

	Total	
Distributed	36	41.67% Returned
Returned	15	



Question Legend

- * Q1 Please identify what dicipline(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 2008 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
Linda Donnasuma OT
Colleen Downing PT
Melissa Dunbar ST
Gary Endal OT
Kathleen Fraser PT
Stacey Frasier OT

Robert Gautreau PT
Deborah Gecewicz ST
Dorothy Grover PT
Joseph Hickey RT
Cheryl Hoffis ST
Kelly Huntley PT
Denise Jackson PT
Cathy Joss ST
Karen Kowalczyk PT
Linda LeBlanc ST
Mindy LaVine ST
Jeanine Lawler OT
Rita Lombardo-Navatka MSW
Marie McGowan ST
Catherine Meehan PT
Holly O'Meara ST
Anne Paolano PT
Edward Reed PT
Donna Reynolds OT
Kathleen Ryan PT
Donna Sauer-Jones MSW
Teresa Scotch ST
Sara Sellig ST
Marti Tucker PT
Jaimi Lynn Tudor RD
Sandra Watson RD
Adam Willis PT
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. All individuals in the LTHHCP must receive case management and may receive the following services based on assessment and plan of care.

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.

	2007	2008
Number of active patients as of 12/31/07	41	48
New Admissions	33	22
Number of Discharges	26	24

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:	25 HRF Patients
	Skilled Nursing Facility (SNF) Level Score: 180 and above:	23 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.

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

PATIENT REFERRAL SOURCES

SOURCE	2007	2008
Medicaid Unit	1	5
Certified Home Health Agency	17	11
Personal Care Aide Program	3	1
Hospital	0	0
Physicians	1	0
Family	0	0
Self-Referral	0	0
Nursing Home	1	0
Central Intake	5	1
Rehabilitation	4	4
Other	1	0
TOTAL	33	22

The largest number of referrals was 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 Care program for medical eligibility and are then referred for service if deemed appropriate.

REVENUES & EXPENDITURES

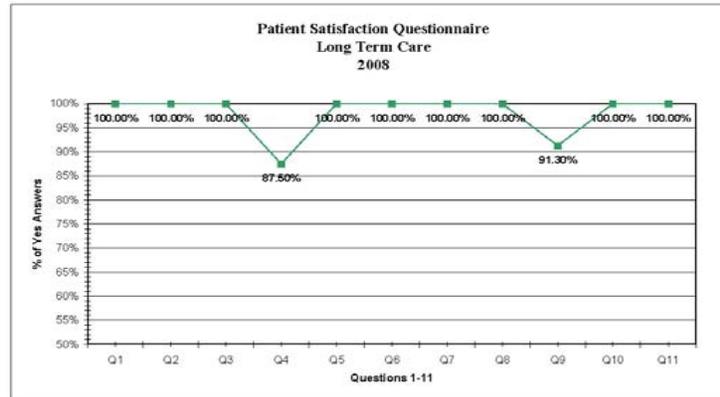
	2007	2008
Revenues	658,138.00	740,047.00
Expenditures	589,774.00	630,629.00

*WARREN COUNTY ANNUAL PATIENT SATISFACTION SURVEY
LONG TERM CARE - 2008*

Question #	Yes	No	N/A	
Q1	100.00%	27	0	0
Q2	100.00%	27	0	0
Q3	100.00%	26	0	1
Q4	87.50%	21	3	3
Q5	100.00%	27	0	0
Q6	100.00%	26	0	1
Q7	100.00%	27	0	0
Q8	100.00%	26	0	1
Q9	91.30%	21	2	4
Q10	100.00%	26	0	1
Q11	100.00%	27	0	0

% of Surveys Returned

Distributed	49
Returned	27



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 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?

HOME CARE ACCOMPLISHMENTS AND GOALS

ACCOMPLISHMENTS FOR 2008:

- The Telemedicine Program continues to be a vital part of our agency's standard of care. We serviced 215 unduplicated patients in 2008. This program continues to decrease the % of hospitalizations for our CHF patients to 12 – 14 % down for 38 – 40 % due to the early detection of symptoms and home treatment options. We service about 70 to 90 patients per month on the monitors.
- Medicaid will pay for telemonitoring if the patient is screened and meets certain criteria. We also have negotiated with Senior Blue for a monthly fee for telemonitoring. We collected revenue of \$115,160 2008 for services dating back to October 2007. The revenue for Telemonitoring will be annual for both payers.
- 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.
- The Hospitalization risk tool is now required assessment for all patient admissions. Telemonitoring or front loading visits for the first three weeks of care is standard practice.
- 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 have entered phase 3 of the project. We plan to ask for Board approval to hire a coordinator for 2009 as the project requires full time attention to grow to its fullest potential.
- 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 have decreased our 30 day readmits by 50% in 2008 largely due to these efforts
- We collaborated with Glens Falls Hospital to connect electronically to allow access to our patients' treatment data therefore enhancing our referral process. Power Chart is now an accepted means of communication between GFH and our agency for patient specific data related to the patient's hospital treatment.
- We were successful in positioning the agency for full implementation of the Encore system (ELECTRONIC MEDICAL RECORD AND BILLING SYSTEM) with the transitioning of all active patients by the end of Dec. 2008
- Entered into an agreement with IPRO to work on the collaboration efforts for 2008-2009 with Glens Falls Hospital and neighboring Washington County Public Health.
- Warren County Health Services Homecare Division proudly continues to be revenue producing. This is quite an accomplishment in today's health care arena with all of the Federal and State cuts to health care. Our total profits for Homecare from CHHA and LTHHC was \$1,382,117.00. This is an increase of \$448,396.00 from 2007.

GOALS FOR 2009:

- Collaborate with IPRO on the 9 Scope of Work Care Transition Project along with the Glens Falls Hospital and Washington County Public Health.
- Hire a coordinator for NYConnects to continue to develop the county's Single Point of Entry (POE) / New York Connects: Choices for Long Term Care.
- To fully implement the Encore system point of care electronic medical record. This will involve the training of over 100 employees. The acquisition involves all clinical and billing aspects for the agency. This transition 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

40

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 2008. These clients are seen every six months to review the plan of care and the client's condition. The RN and LPN staffs come from licensed agencies that are responsible for training, scheduling, and employment issues.

CONTINUING CHALLENGES FOR WARREN COUNTY HEALTH SERVICES IN 2009

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 2009 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 2009, the agency will complete the transition 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

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