

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 2012.

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
Glenda Armstrong
Shauna Baker
Jackie Barney
Mary Beadnell
Cheryl Belcher
Patricia Belden
Craig Briggs
Debbie Burke
Linda Bush
Gwen Cameron
Kerri Carpenter
Jamie Clute
April Cosey
Tara Cote
Kristi Culligan
William Cutler
Diane Decesare
Tammie DeLorenzo
Tawn Driscoll

Cathy Dufour
Dan Durkee
Karen Fidd
Judy Fortini
Nedra Frasier
Cheryl Fuller
Nancy Getz
Diana Gillis
Nichole Gillis
Mary Lee Godfrey
Dana Hall
Meg Haskell
Shannon Houlihan
Ginelle Jones
Elaine Kane
Barbara Karge
Michelle Keller-Allison
Sue Kerr
Emily LaLone
Mary Lamkins
Maureen Linehan

Mary Lamkins
Danielle Martin
Janel Martinez
Erik Mastrianni
Kathy McGowin
Crystal McKinney
Leslie McNulty
Angela Meade
Kate Meath
Jackie Merritt
Barbara Moehringer
Lisa Morton
Dorothy Muessig
Jackie Mulcahy
Mary Murphy
Patty Myhrberg
Barbara Orton
Bethany Paquette
Nancy Parsons
Diane Pfeil
Kristen Phinney
Nancy Pieper

Kristen Phinney
Stella Racicot
Jennifer Rainville
Cassandra Rausch
Lynne Rodriguez
Toni Roth
Tia Ruggiero
Laura Saffer
Margaret Sawyer
Susan Schaefer
Sharon Schaldone
Alissa Seeley
Pamela Silva
Melody Smith
Helen Stern
Debbie Toolan
Victoria Viacava
Linda Walker
Sandy Watson
Valerie Whisenant
Diedre Winslow
Stacy Woodcock

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

Edna Frasier, Hague

Peter McDevitt, Glens Falls

Harold Taylor, Glens Falls

Frank Thomas, Stony Creek

WARREN COUNTY HEALTH SERVICES

2012 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
Tammie DeLorenzo, Clinical Fiscal Informatics Coordinator
Tawn Driscoll, Financial Manager, Health Services
Joseph Dufour, FNP Irongate Family Practice
Dan Durkee, Health Educator, 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
Debra Galatioto, Director of Nursing Practice, Glens Falls Hospital
Mary Lamkins, Supervising Nurse, Health Services
Daniel Larson MD, Public Health Medical Director
Richard Leach MD, Medical Consultant for Infectious Diseases
Richard Mason, Community Member, former Glens Falls City Supervisor
David Mousaw MD, Medical Director for PHCP & Children With Special Health Care Needs Program
Regina Muscatello, Clinical Nurse Supervisor Westmount Health Facility
John Rugge MD, Health Services Medical Director
Christie Sabo, Director Warren Hamilton Counties Office for the Aging
Julie Smith, Director Patient Services, Greater ADK Home Health Aides
Sharon Schaldone, Assistant Director Patient Services
Helen Stern, Immunization Program Coordinator, Health Services

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

HEALTH SERVICES STAFFING

Number of Staff Involved with Health Services in 2012: 130

62 Full Time
12 Part Time
9 Per Diem
47 Contractual

Administrative Staff: 9 (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
4 Supervising Public Health Nurses

Nursing Staff

9 Full Time Public Health Nurses (Grade 21)
4 Part Time Public Health Nurses
21 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)

Per Diem Nurses

2 Public Health Nurses
4 Community Health Nurses
1 Registered Nurses

Other Professional Staff

1 Full Time Senior Public Health Educator/Emergency Preparedness Coordinator (Grade 18)
1 Full Time EI/Preschool Service Coordinator (Grade 18)
1 Part Time EI/Preschool Service Coordinators (Grade 18)
1 Per Diem Early Intervention/Preschool Service Coordinator
1 Part Time Public Health Liaison for Emergency Preparedness
1 Per Diem Health Educator (Grade 14)

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

1 Full Time WIC Program Coordinator (non bargaining)
1 Full Time WIC Nutrition Facilitator (Grade 16)
1 Full Time WIC Dietician (Grade 16)
2 Full Time Nutrition Aides (Grade 6)
1 Full Time WIC Assistant (Grade 5)
1 Part Time WIC Clerk (Grade 4)
1 Full Time WIC Program Aide (Grade 3)
1 Part Time Infant Feeding Advocate (Grade 3)

Clerical Support Staff

1 Part time Administrative Assistant (Grade 8)
1 Full Time Principal Account Clerk (Grade 10)
2 Full Time Senior Account Clerks (Grade 7)
2 Full Time Account Clerks (Grade 4)
1 Full Time Medical Records Clerk (Grade 5)
3 Full Time Senior Clerks (Grade 4)

Contractual Therapists

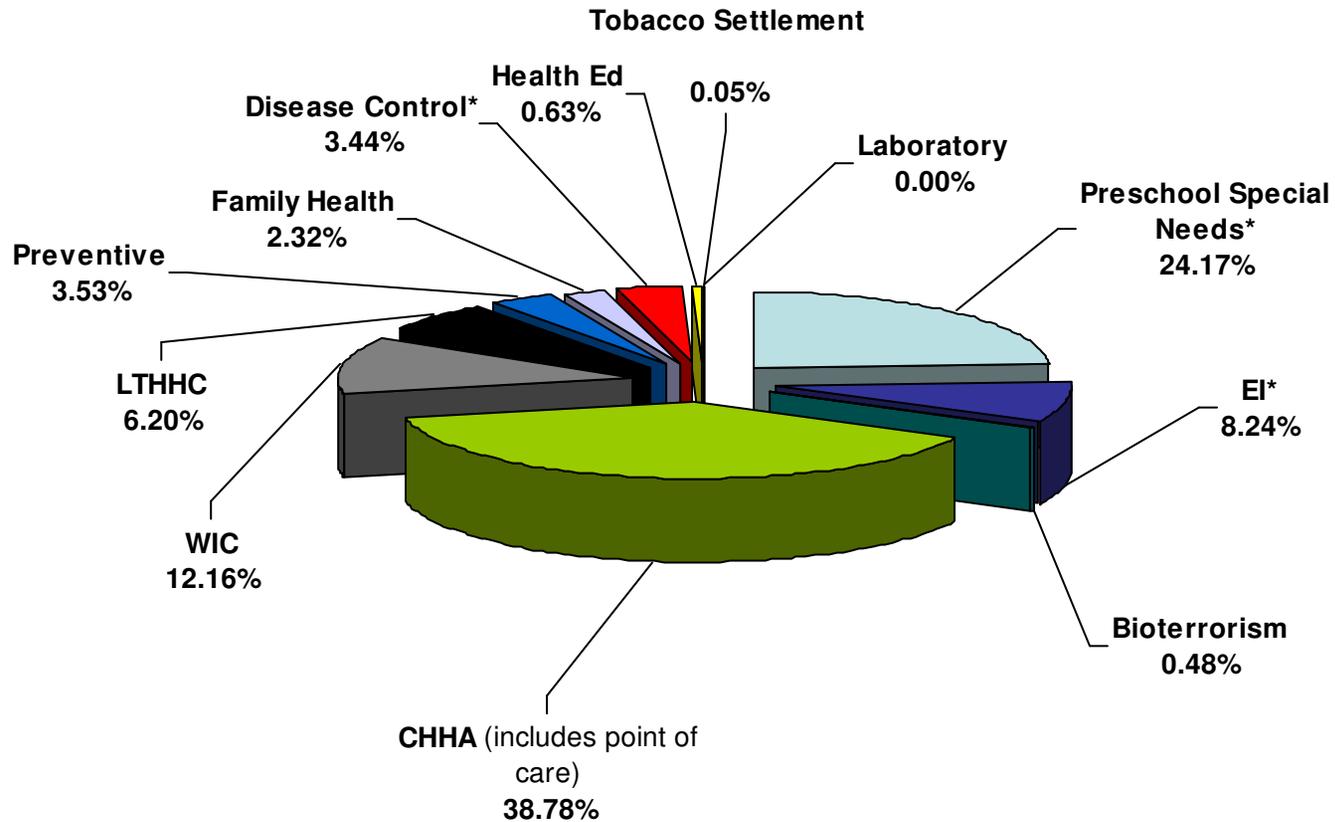
16 Physical Therapists
2 Physical Therapy Assistants
6 Occupational Therapists
15 Speech Therapists
2 Medical Social Workers
1 Respiratory Therapist
1 Dietician

Contractual Medical Directors

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

Medical Consultants are needed per NYSDOH regulations for the operation of our Diagnostic and Treatment Center, Physically Handicapped Children's Program, and the Tuberculosis Program. 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.

2012 Actual Expenditures by Program



Total Expenditures: \$11,601,898.31

*Mandated programs account for 35.85% of total actual expenditures. (They are the Preschool, Early Intervention, and Disease Programs)

Source: Budget Performance Report as of 12/31/2012

WARREN COUNTY POPULATION

Source: NYSDOH Statistical Data

BIRTHS AND DEATHS IN WARREN COUNTY

**STATISTICAL INFORMATION
COMPARISON TRENDS**

	2008	2009	2010	2011	2012
Births	655	643	600	598	577
Deaths	558	527	578	572	596

Warren County Health Services Emergency Response Planning

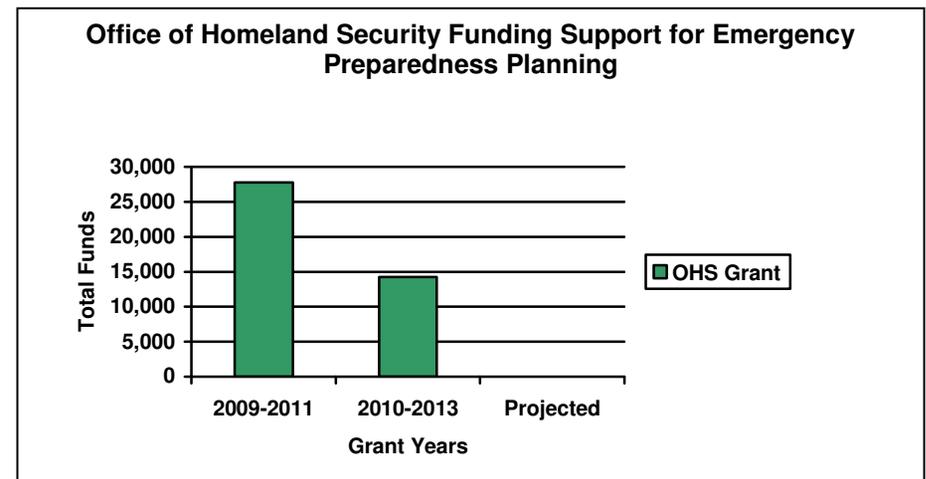
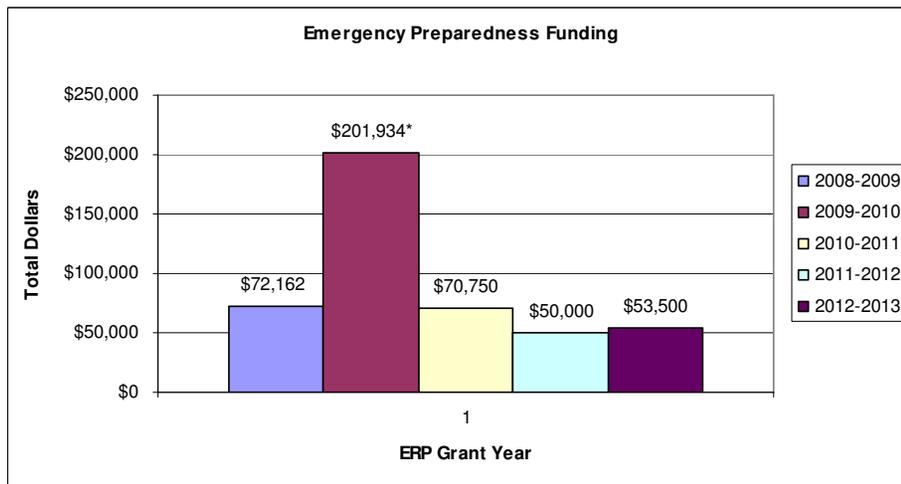
The goal of Warren County Health Services Emergency Response Planning is to develop an Emergency Response Plan that incorporates an all hazards approach that can be quickly adapted and utilized to mitigate the impact and hasten recovery from emergencies regardless of size or cause (natural or man-made). The information included in this annual report is a snapshot of the progress Warren County Health Services has made in Emergency Response planning and some of the strengths, weaknesses and barriers observed through the planning process.

Emergency Response Planning Program Staff

- 1 Senior Health Educator/Emergency Response Coordinator (20 hrs/wk allotted to BT, 20 hrs to Health Education)
- 1 Per diem BT Educator (12 hr/wk)
- 1 Part-time Public Health Liaison (9 hrs/wk)
-

Funding Support

Funding for the Emergency Response Planning (ERP) program continues to be reduced as requirements from New York State Department of Health increase. Warren County Health Services on an annual basis receives money from NYSDOH for Emergency Response Planning (see chart below). Warren County also received funding from the Office of Homeland Security in the form of grants. The grants totaled \$42,028.00 (\$27,778 2009-2011 and \$14,250 2010-2013). Additional OHS funding is not anticipated.



*2009-2010 saw a significant increase in ERP funding in response to the H1N1 Pandemic Flu outbreak. The increase in funding had to be used in the mitigation efforts related to H1N1. Except for 2009-2010, Warren County Health Services has seen funding levels for Emergency Preparedness from NYSDOH fall below the 2008-2009 levels by 19.5% (2010-2011), 30.7% (2011-2012), 25.9% (2012-2013). Office of Homeland Security funds will be completely exhausted in 2013.

Meeting New York State and Federal Mandates

Currently Warren County Health Services in cooperation with local partners has completed and updates annually (or as needed) the following plans as required by State and/or Federal agencies

- Emergency Response and Preparedness (ERP) Plan
 - Pandemic Flu Plan
 - Continuity of Operations Plan (COOP)
 - Mass Fatality Plan
 - ChemPack Plan
 - Isolation and quarantine plan
 - Strategic National Stockpile (SNS) Plan
 - Medical Countermeasures (MCM) Plan
- Met 2011-2012 Grant Year deliverables which included but were not limited to attending regional meetings, participating in webinars and testing ERP capabilities (e.g. volunteer notification drills, Points of Distribution drills, communications systems). There were 10 Local Health Department deliverables and 29 maintenance deliverables. For more information about deliverables contact Warren County Health Services ERP Program.

Networking/Planning Partnerships

- Approximately 70 organizations representing various roles, functions and interests with emergency response planning currently participate in or receive email updates from the Warren County Health Services Emergency Preparedness Planning Group quarterly meetings. Contact WCHS ERP program for a complete list of partners
- Warren County Health Services participated in 10 regional BT Coordinators meetings in 2012.
- Warren County Health Services has approximately 70 volunteers registered with ServNY which allows a secure and direct communication system with our volunteers for trainings/drills/and real-life calls to action.

Goal/Outlook –

- Maintain the current level of participation and communication among WCHS ERP Planning group.
- Maintain an accurate contact list of partners and recruit other partners for the ERP Planning Committee that may provide input/expertise for specific emergency response planning situations.

- Maintain an up-to-date volunteer registry using the NYSDOH ServNY system and continue to recruit new volunteers.

Drills/Exercises

- WCHS conducted 1 full-scale Point of Distribution Exercise to test mass vaccination capabilities. An after action report was conducted to identify strengths, weakness and areas in need of improvement in future drills or real-life events.
- Warren County Health Services participated in monthly table top drills hosted by Glens Falls Hospital Emergency Management Committee. Tabletop drills included topics on weather related events, terrorist/active shooter events, chemical and biological incidents etc.
- Warren County Health Services offered trainings for volunteers, Warren County DPW staff, law enforcement and other entities included in the Warren County ERP plans. Trainings were designed to increase an agency/volunteer's understanding of their role in an emergency and what may be expected in an emergency.

Goals/Outlook

- Strengthen and increase training/exercise opportunities for partner agencies and volunteers involved in Emergency Response in Warren County.
- Continue to conduct all State mandated drills and use the drills to identify strengths/weaknesses and create plans for improvement based on drill results.
- Participate/include local partners in the planning, implementation and review of table-top and full-scale exercises designed to test different aspects of ERP plans.

Concerns/Strengths/Outlook

Concerns

- Lack of funding
- Possible staffing reductions
- Increasing requirements/mandates
- Disconnect between State and Federal expectations and County level realities

Strengths

- Strong and resourceful local partnerships with 70+ EPR committee members
- Excellent communication and support from county agencies and other community partners
- Dedicated staff
- Strong working relationship with Warren County Emergency Operations center staff and Glens Falls Hospital Emergency Management

Outlook

Currently Warren County Health Services is adequately maintaining its ERP program. However, any cuts to funding for the ERP program might make it impossible for Warren County Health Services to meet its obligations.

The network of local partners that participate in planning, drilling and responding to emergencies remains strong. The local ERP planning group allows for effective communication and planning across a broad range of partnering agencies.

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. The Steering Committee is the hub of our agency's QI process. The Steering committee reviews agency Policies and Procedures for all clinical procedures, reviews the findings of the Chart Committee, reviews the Outcome reports for Home Health Compare and the Process Measures (data obtained from OASIS C assessments) and CAHPS survey results.

The Steering committee may develop a new process or enhance the process used to improve an Outcome where indicated. These changes are then instituted to all staff. Monitoring of these changes and their effectiveness is done by reviewing the above noted reports.

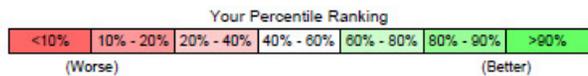
It is our goal to continue to improve our % of achievement to provide the most effective care to our clients. Since the beginning of OASIS C in 2010 the charts below will show how we have continued to be in drive and are moving forward. All personnel employed by our Division of Home Care are involved and committed to our QI Program.

The results of the agency's monitoring processes for 2012 are as follows:

- Home Health Compare Results
- Process Measure Outcomes
- CAHPS Survey (Consumer Assessment of Healthcare Providers and Systems)



Managing Daily Activities			Your Actual	Your Risk Adj	SHP State (NY)	SHP National	Your % Rank	Your Risk Adj % Rank
			HIGHER % ARE BETTER				HIGHER % ARE BETTER	
1	Improvement in Ambulation	Outcome	41.5%	48.6%	61.7%	63.2%	15%	18%
2	Improvement in Bed Transferring	Outcome	58.9%	61.7%	57.5%	59.2%	55%	80%
3	Improvement in Bathing	Outcome	59.9%	62.4%	67.6%	68.7%	31%	37%
Managing Pain and Treating Symptoms			Your Actual	Your Risk Adj	SHP State (NY)	SHP National	Your % Rank	Your Risk Adj % Rank
			HIGHER % ARE BETTER				HIGHER % ARE BETTER	
4	Pain Assessment Conducted	Process	99.8%	n/a*	98.4%	98.9%	77%	n/a*
5	Pain Interventions in Short Term EOC	Process	99.6%	n/a*	98.9%	98.6%	58%	n/a*
6	Improvement in Pain Interfering with Activity	Outcome	57.9%	58.4%	68.3%	67.2%	25%	25%
7	Heart Failure Symp Addressed in Short Term EOC	Process	100.0%	n/a*	98.5%	98.2%	99%	n/a*
8	Improvement in Dyspnea	Outcome	60.8%	67.1%	64.5%	66.7%	38%	60%
Treating Wounds/Preventing Pressure Sores			Your Actual	Your Risk Adj	SHP State (NY)	SHP National	Your % Rank	Your Risk Adj % Rank
			HIGHER % ARE BETTER				HIGHER % ARE BETTER	
9	Improvement in Status of Surgical Wounds	Outcome	86.4%	90.5%	88.5%	87.7%	33%	52%
10	Pres Ulc Risk Assess Conducted	Process	99.9%	n/a*	98.7%	99.0%	78%	n/a*
11	Pres Ulc Prevention in POC	Process	100.0%	n/a*	98.4%	97.0%	99%	n/a*
12	Pres Ulc Prevention in Short Term EOC	Process	99.3%	n/a*	96.8%	96.9%	66%	n/a*
Preventing Harm			Your Actual	Your Risk Adj	SHP State (NY)	SHP National	Your % Rank	Your Risk Adj % Rank
			HIGHER % ARE BETTER				HIGHER % ARE BETTER	
13	Timely Initiation of Care	Process	98.1%	n/a*	95.8%	93.1%	78%	n/a*
14	Drug Education All Meds in Short Term EOC	Process	95.3%	n/a*	93.4%	93.8%	45%	n/a*
15	Improvement in Management of Oral Meds	Outcome	42.4%	42.9%	55.5%	53.3%	34%	31%
16	Fall Risk Assessment Conducted	Process	100.0%	n/a*	94.7%	94.3%	99%	n/a*
17	Depression Assessment Conducted	Process	99.9%	n/a*	98.2%	98.0%	83%	n/a*
18	Flu Vaccine Received - Current Season	Process	75.2%	n/a*	70.4%	70.8%	56%	n/a*
19	PPV Received - Ever	Process	77.2%	n/a*	67.9%	70.1%	60%	n/a*
20	Diabetic Foot Care & Education in Short Term EOC	Process	99.4%	n/a*	95.8%	95.0%	78%	n/a*
Preventing Unplanned Hospital Care			Your Actual	Your Risk Adj	SHP State (NY)	SHP National	Your % Rank	Your Risk Adj % Rank
			LOWER % ARE BETTER				HIGHER % ARE BETTER	
21	Emergent Care without Hospitalization	Outcome	4.4%	n/a*	3.8%	3.8%	38%	n/a*
22	Acute Care Hospitalization	Outcome	26.4%	30.4%	24.4%	23.5%	37%	20%
HHC AHPs			Your Actual	SHP State (NY)	SHP National	Your % Rank		
			HIGHER % ARE BETTER			HIGH %		
23	Composite 1: Care of Patients		92.3%	84.7%	88.6%	84%		
24	Composite 2: Communications Between Providers and Patients		88.9%	81.9%	85.3%	82%		
25	Composite 3: Specific Care Issues		83.8%	82.7%	84.3%	46%		
26	Universal 1: % of Patients who Rated Agency 9 or 10		88.7%	77.7%	82.8%	84%		
27	Universal 2: % of Patients who would Recommend Agency		88.7%	73.6%	79.2%	91%		



*Process Measures are not subject to risk adjustment

For notes and additional information about this report, see the Report User Guide at: https://secure.shpdata.com/download/faq/HHC_Outcomes_2010_FAQ.pdf

Home Health Consumer Assessment of Healthcare Providers and Systems (HHCAHPS)

01/2012 – 12/2012

This survey is a Federal requirement for all CHHA's. The survey needs to be conducted by an agency that is certified by CMS to do the standardized survey. We have a contract with Strategic Health Plan (SHP) for this service.

The survey compares us to other agencies that are contracted with SHP nationally.

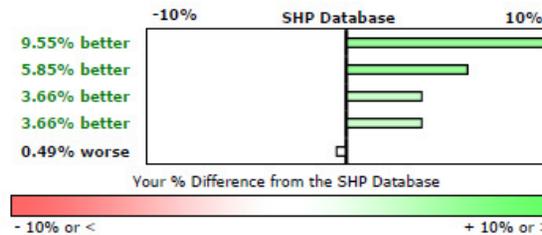
The survey has 3 Composite Measures:

- Care of Patients
- Communications Between Providers and Patients
- Specific Care Issues: Home Safety Issues, Medications regarding schedule and side effects, and Pain

Total completed surveys returned: 233		You	SHP Database
Composite Measures			
C1. Care of Patients	Percent of patients who reported that their Home Health provider "Always" was informed and treated them gently and with respect and that there were "No" problems with the care.	92%	89%
Providers			
C2. Communications Between Providers and Patients	Percent of patients who reported that their Home Health provider "Always" communicated well and promptly.	89%	85%
Providers			
C3. Specific Care Issues	Percent of patients who reported that their Home Health provider handled specific care issues correctly.	84%	84%
Providers			
Universal Measures			
U1.	Percent of patients who gave their HH Agency a rating of 9 or 10 on a scale from 0 (lowest) to 10 (highest).	89%	83%
Providers			
U2.	Percent of patients who reported YES, they would definitely recommend the Home Health Agency	89%	79%
Providers			

Percent Difference from the SHP Database

- U2 % who would recommend the HH Agency **9.55% better**
- U1 % who gave their HH Agency a rating of 9 or 10 **5.85% better**
- C2 Communications Between Providers and Patients **3.66% better**
- C1 Care of Patients **3.66% better**
- C3 Specific Care Issues **0.49% worse**



[View Details Of additional measures not included in composite/universal groups](#)

Strategic Health Plan (SHP)

All of the agencies OASIS C data done at the initial assessment, recertifications and at the transfer or end of care are run through the SHP software. We receive daily reports that edit all OASIS C data for comparison accuracy. These reports provide for us the agency data to measure our patient outcomes and comparing our performance to other agencies within the SHP family. There are over 2500 users of the SHP product. The reports are run daily to monthly and are reviewed by the Steering Committee. It is the Steering Committee that will identify areas needing intervention and or procedure updates that will improve our patient outcomes.

In 2011 we reassigned an RN to do daily review of all client specific data that is run through the SHP program. This process is important to the accuracy of the client data.

The daily review of the OASIS C via the SHP improves the accuracy of data documented and maximizes the revenue received for the episode of care rendered. The Dashboard reports noted above reflex the success of this program.

2012 Overview of the Utilization Review Committee

The Utilization Review Committee of Warren County Health Services held quarterly meetings during the year 2012. The meetings were held March 8th, June 13th, September 20th and December 13th.

The numbers of patient records reviewed were 14, 13, 12, and 9 respectively, giving a total of 48 patient records reviewed during the year 2012.

The number of patients on the active roster on the last working day of 2012 was 385, with a breakdown as follows: CHHA – 231 (SN-117, PT/OT-15, EI/CPSE-99); LTC – 38 and PCA – 116 (Includes CDPAP – 68).

Members of the committee are:

Sharon Schaldone, ADPS
Marietta Anderson, CSN
Mary Lee Godfrey, CSN
Mary Lamkins, LTC Coordinator
Valerie Whisenant, CSN
Cathy DuFour, PHN

Maureen Linehan, RN
Staff Nurses
Physical Therapy Contractor
Occupational Therapy Contractor

Breakdown of Charts Reviewed:

Number Active	37	Number CHHA	42
Number Discharged	11	Number LTC	6

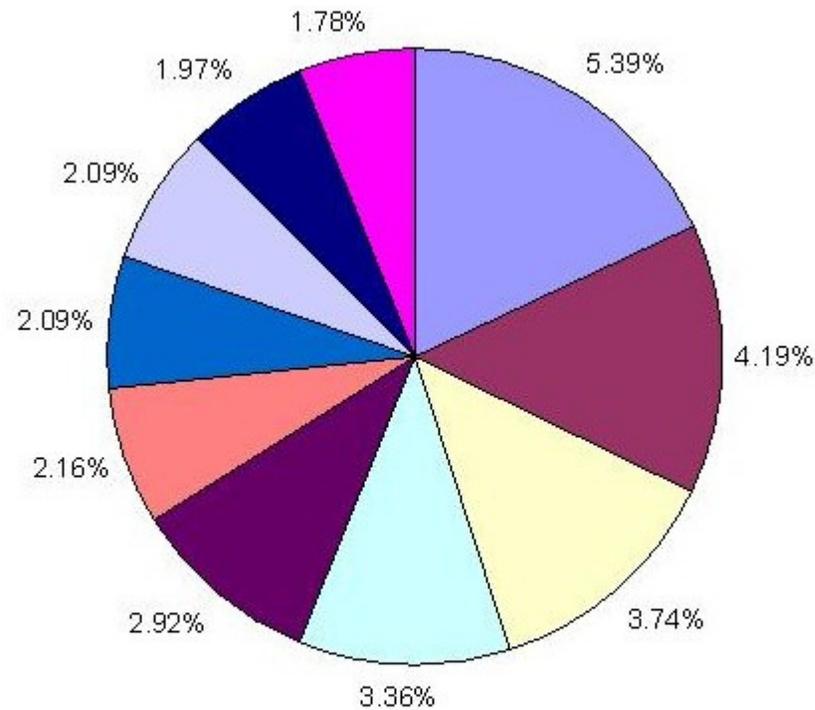
Method of Record Selection: For all meetings during the year 2012, the records chosen were a random selection of patients admitted 3 months prior to each meeting. In addition to these records – in March, 4 long standing patients billed to Medicaid were also chosen and in September, 4 patients with IV line care for Chemotherapy Administration were also chosen.

Summary of Utilization of Services:

Adequate Utilization	45
Overutilization	3
Underutilization	0
Inadequate Information	0
Unable to Decide	0

There were three cases identified with overutilization of services. These involved an excess of PT services in one case, excessive Nutrition visits in the second case and excessive PT, Nutrition and MSW services in the third case. The case where PT was the only involved discipline, the goals had been reached and the patient was at a maintenance level. In the second case with Nutrition, the patient had received 4 months of diet instruction and the patient continued to be non-compliant with the diet restrictions. In the third case, concerning PT – the patient was at a maintenance level only; concerning MSW, the patient had received 6 months of COUNSELING and the reviewer felt that the patient had reached the MSW goals and should be referred for outpatient long term counseling. This patient also received over 6 months of RD instruction and continued to be non-compliant by choice with her diet. In all cases, these findings were discussed with the appropriate disciplines and the services were discharged.

**Top 10 Primary Diagnosis
For Visits between 01/01/2012 and 12/31/2012
For Certified Home Health Agency and Long Term Care Programs**



V57.1	Physical Therapy not elsewhere classified	V54.81	Aftercare following Joint Replacement
491.21	COPD	V58.73	Aftercare of Circulatory Surgery
428	Congestive Heart Failure	V58.78	Aftercare following musculoskeletal Surgery
486	Pneumonia	V58.42	Aftercare of Cardiac Surgery
V58.75	Aftercare of Oral Cavity Digestive System	707.03	Pressure Ulcers

SERVICES BY THE NUMBERS
(Certified Home Health Agency)

VISITS BY SERVICE

Services	2011	2012
Nursing	18,058	18,027
Physical therapy	7620	8,018
Occupational Therapy	618	700
Speech Therapy	173	109
Medical Social Worker	340	156
Nutrition	161	40
Home Health Aide	4746/hours	5257/hours
TOTALS	27,002	27,050

EVALUATIONS BY DISCIPLINES

2011

- Nursing – 1,499
- IV – 98
- Physical therapy – 1,022
- Occupational therapy – 49
- Speech therapy – 11
- Nutrition – 32
- CDPAP – 135
- PRI – 106
- Telehealth - 171

TOTALS = 2,952

2012

- Nursing - 1590
- IV - 92
- Physical Therapy - 1096
- Occupational Therapy - 67
- Speech Therapy - 18
- Nutritional - 9
- CDPAP - 130
- PRI - 114
- Telehealth - 119

TOTALS = 3199

Medicaid was reimbursing per visit up to May 1, 2012. New York States Medicaid Reform Movement (MRT) changed the previous Fee for Service payment as we knew it to a Episodic rate system similar to the Medicare PPS. This is a 40% decrease in revenue per visit when a Medicaid episode of care is less than 5 visits in a 60 day episode. In 2012 it is estimated that this was a \$33,000 loss in revenues for services rendered at the previous Fee fro Service rate.

Total Number of Visits:

- 2012 – 50,683
- 2011 – 52,063
- 2010 – 64,037

Total Evaluations:

- 2012 - 3199
- 2011 - 2980
- 2010 - 3284

Unduplicated Patient Count:

- 2012 – 2313
- 2011 – 2227
- 2010 – 2330

Dec. 31 Census Count

- 2012 - 291
- 2011 - 274
- 2010 - 265

SERVICES BY THE NUMBERS (CHHA)

Episodes of Medicare Care:

- 2012 1116 episodes
- 2011 1000 episode
- 2010 1045 episodes

Traditional Medicare was 41% of our business for 2012. Medicare reimburses the agency not by per visit but by episodes of care. The episode is for a 60 day period and the Medicare payment is calculated by the score determined by the OASIS C assessment.

Commercial Insurances which include Managed Medicare contracts reimburse either by episodic rate or per pre negotiated visit rate. Commercial insurance comprised 41% of our 2012 revenue.

Medicaid was reimbursing per visit up to May 1, 2012. New York States Medicaid Redesign Team (MRT) changed the previous Fee for Service payment as we knew it to a Episodic Rate System (EPS) similar to the Medicare PPS. This is a 40% decrease in revenue per visit when a Medicaid episode of care is less than 5 visits in a 60 day episode. In 2012 it is estimated that this was a \$33,000 loss in revenues for services rendered at the previous Fee for Service rate. There was also a 2% decrease in Medicaid revenue for all services rendered not affected by EPS.

2012 Report of Visits by Town

Town	Total Visits	%
Queensbury	3	0.01%
Adirondack	166	0.30%
Athol	328	0.60%
Bakers Mills	370	0.67%
Bolton Landing	810	1.48%
Brant Lake	646	1.18%
Chestertown	1,311	2.39%
Cleverdale	84	0.15%
Diamond Point	261	0.48%
Fort Ann	161	0.29%
Glens Falls	16,489	30.03%
Hadley	7	0.01%
Hague	355	0.65%
Johnsburg	958	1.74%
Kattskill Bay	2	0.00
Lake George	3,204	5.84%
Lake Luzerne	879	1.60%
North Creek	1,413	2.57%
North River	21	0.04%
Olmstedville	3	0.01%
Pottersville	1,572	2.86%
Queensbury	17,596	32.05%
Riparius	39	0.07%
Schroon Lake	15	0.03%
Silver Bay	20	0.04%
Stony Creek	272	0.50%
Warrensburg	7,660	13.95%
Wevertown	262	0.48%
Grand Total	54,907	

REVENUES AND EXPENDITURES For CHHA \$ LTC

	2011	2012
Revenues	\$5,028,435	\$5,070,134
Expenditures	\$5,041,489	\$5,218,142
Net (Lose)	(\$13,054)	(\$148,008)

Expenditures increased in 2012 due in part to the increase of \$190,712 or 19.74% in fringe benefits. These benefits include Retirement, Social Security, Medicare withholdings, hospitalization (for both employees and retirees) and dental insurances. This was the first year of Retiree hospitalization expense of \$59,624.00.

Medicaid reimbursement in 2012 went from Fee for Service to Episodic Payment System (EPS) in May 2012. This affected our one time skilled nursing visit that is required for a Needs Assessment for all Medicaid funded programs. This Needs Assessment is required to be completed by a nurse proficient in this Needs Assessment and must be done via a Certified Homecare Agency (CHHA). Prior to EPS (05/2012) we received \$157.51/visit. This was decreased to \$95.22/visit. A 41% decrease / a \$33,000 plus lose. **We did however have an over all increase in revenues from 2011 to 2012 of \$41,699.**

BUSINESS ASSOCIATES CONTRACTED IN 2012 FOR THERAPY SERVICES

Juliet Aldrich ST
Amy Anderson ST
Karin Ash PT
Laurie Aurelia ST
Natalie Barber PT
Stephen Bassin PT
Barbara Beaulac PT
Heidi Bohne ST
Diana Burns PT
Sara Bush ST
Beth Callahan PT
Nancy Carroll MSW
Deborah Clynes ST
Rebecca Compson PT
Teresa Costin OT
Theresa Dicroce PTA
Stacie DiMezza ST
Linda Donnaruma OT
Colleen Downing PT
Melissa Dunbar ST
Gary Endal OT
Kathleen Fraser PT

Stacey Frasier OT
Robert Gautreau PT
Debora Gecewicz ST
Stephanie Gulbandsen RD
Dorothy Grover PT
Joseph Hickey RT
Cheryl Hoffis ST
Denise Jackson PT
Cathy Joss ST
Melissa Kenison-Rose OT
Linda LeBlanc ST
Mindy LaVine ST
Rita Lombardo-Navatka MSW
Marie McGowan ST
Catherine Meehan PT
Sara Nelson ST
Anne Paolano PT
Donna Reynolds OT
Jen Whalen PTA
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 is administered by the local DSS. The program provides case management for coordination of services to Medicaid eligible clients who are medically eligible for placement in a nursing home. All individuals in the LTHHCP must receive case management by a nurse 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
- Telehealth

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
- Moving Assistance
- Assistive Technology
- Environmental Modifications

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 and Telehealth are the only direct services 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 coordination between all the services a client receives.

	2011	2012
Number of active patients as of 12/31/12	35	38
New Admissions	17	14
Number of Discharges	19	10

NURSING HOME LEVEL OF CARE

The Long Term Home Health Care Program 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 and this tool is used by the Department of Social Services to determine the individual budget cap (SNF vital signs, 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: 22HRF Patients
 Skilled Nursing Facility (SNF) Level Score: 180 and above: 16SNF 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 in the Long Term Home Health Care Program.

PATIENT REFERRAL SOURCES

SOURCE	2011	2012
Medicaid Unit	2	0
Certified Home Health Agency	9	7
Personal Care Aide Program	3	2
Hospital	0	0
Physicians	0	0
Family	0	0
Self-Referral	1	0
Nursing Home	0	0
CASA	0	1
Rehabilitation	2	2
Other	0	2
TOTAL	17	14

The largest numbers of referrals continue to come from the certified agency. These individuals require 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.

New York States appointed Medicaid Reform Team movement is impacting the delivery of Medicaid funded programs in many ways. The process for applying and the qualifications needed are being impacted. The Need Assessments and the types and processes which we

have been doing will be changed to a formal standardized uniform assessment. Warren County Health Services was chosen to be in the Beta project for 2012, one of a few counties accepted. The Beta project started In Feb. 2012 and we completed it sometime in August of 2012. The Needs Assessment chosen is the Uniform Assessment System for New York State (UAS-NY). This assessment tool will be used to determine the type of program and the amount of service needed to meet the needs of the client in all of the Medicaid funded programs in New York State. This UAS-NY patient specific assessment will be housed in the Health Commerce System (HCS) Department of Health (DOH) site.

The full implementation of the UAS-NY will be mandated to begin sometime in 2013. Warren County Health Services will be trained and have the credentials to be able to move forward with the mandated change.

HOME CARE GOALS FOR 2013

- ◆ Continue to support the Care Transition Initiative
- ◆ Create and Enhance working relationships with referral sources to assure that our residents and existing clients continue to receive the quality of care provided by this agency in support of the changing times in delivering home health care
- ◆ Market our services and accomplishments to our residents and our referral sources
- ◆ Transition our homecare services to accommodate the Medicaid Redesign Team (MRT) in New York State
- ◆ Strengthen and Enhance the existing skilled programs we provide to our clients to guide them in managing their health

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.

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. 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.

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 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	TOTAL BIRTHS	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
2008	657	502 (6 sets of twins, 3 sets of triplets)	496 (365 breastfeeding) (76 Primary CS) (87 Repeat CS)	14	681	10	1.53%
2009	642	504 (12 sets of twins, 1 set of triplets)	490 (361 breastfeeding) (84 Primary CS) (94 Repeat CS)	14	771	17	2.2%
2010	600	485 (12 twins)	479 (55 Primary CS) (101 Repeat CS)	9	661	32	5.5%
2011	598	464 (9 twins)	473 (374 breastfeeding) (123 Primary CS) (50 Repeat CS)	17	544	31	5.2%
2012	577	482 (6 Twins)	477 (388 breastfeeding) (118 Primary CS) (45 Repeat CS)	13	398	17	2.9%

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 2012, referrals were received on 14 young women under age 18 who delivered infants which is .03% 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 2008	79
2009	54
2010	32
2011	70
2012	41

LACTATION COUNSELING 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 two certified Lactation Counselors on staff. Public Health Nurses work in conjunction with a Lactation Consultant at Glens Falls Hospital to assure that nursing mothers are provided with consistent information.

	Postpartum Clients Referred	Referred Clients That Were Breastfeeding	Percentage of Breastfeeding Moms
2008	496	365	74%
2009	490	361	74%
2010	479	353	74%
2011	473	374	79%
2012	477	388	81%

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.

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

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)	PRENATAL HOME VISITS MADE	TOTAL BIRTHS	TEEN PREGNANCY TRENDS (ENDING IN LIVE BIRTHS) <18YRS OLD
2008	119	176	655	7
2009	147	193	643	8
2010	141	170	600	10
2011	175	121	598	11
2012	100	91	577	14

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

- "Clients Refusing Services/Unable To Be Contacted After Referral" 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. Programs are offered either as a 5-week session with 2½ hour classes one evening a week or a 2-day class which is All day Saturday and 3 hours the following Thursday. 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.
2009	8 (4 weekends/4 6-week)	40
2010	8 (4 weekends/4 5-week)	45
2011	8 (5 weekends/3 5-week)	39
2012	8 (5 2-day/3 5-week)	44

WOMEN, INFANTS AND CHILDREN NUTRITION PROGRAM
(WIC)

In March 2012, the Warren County WIC Program recruited a new Coordinator. Seven staff has remained constant with two staff appointed as permanent civil service employees. A Nutrition Aide retired due to disability.

The move from Gurney Lane has proved to be popular and accessible for participants to take care of their personal business held at the Municipal Center and the Human Services Building. WIC clinics are offered at nine sites including the Municipal Center and also in Glens Falls, Queensbury, Lake Luzerne, Warrensburg, North Creek and Horicon. Hours of operation are suited for early morning and early evening appointments. In 2011, the total number of participants enrolled was 1317. Enrolment increased to 1559, in 2012, indicating an 18% increase. The increase is attributed to staffing change to accommodate walk-in appointment and our knowledgeable and attentive Staff who make every effort to support and advocate WIC policy.

Site	Site Participant Average	% of Total Participant Average
Main Site – Warren County Municipal Center	318	20.4
First Baptist Church – Glens Falls	303	19.4
Village Green Apartments – Glens Falls	199	12.8
VFW Post - Queensbury	285	18.3
Montcalm Apartments-Queensbury	76	4.9
Lake Luzerne Town Hall – Lake Luzerne	83	5.3
Cornell Cooperative Extension Education Center - Warrensburg	143	9.2
North Creek Fire House – North Creek	69	4.4
Horicon Community Center - Horicon	83	5.3
	1,559	100%

WIC supports breastfeeding as the primary source of nourishment from birth to one year old. The hire of the Infant Feeding Advocate in late 2011 allowed for the creation of a Breast Feeding Support group offered one time per month at the Main Site located in the Warren County Municipal Center. WIC mothers who initiated breast feeding mothers increased from 67.9% in 2011 to 70.6% in 2012. The Infant Feeding Advocate’s utilization of a cell phone, during business hours, created an avenue of communication with breast feeding mothers.

In addition, participant-centered nutrition education promotes a healthy lifestyle and is emphasized with each participant’s clinic visit. Warren County WIC incorporates the USDA endorsement of My Plate, a food icon that teaches portion and healthy food choices. WIC partners with Eat Smart New York, sponsored by the Warren County Cornell Cooperative Extension at each clinic. In support of Warren County’s adoption of Medicaid Managed Care, WIC partners with United Health Care and Fidelis insurance representatives during most of our clinics.

The Warren County WIC administrative budget totaled \$456,304.00, with actual expenditures totaling \$436,544.00. The redemption value of WIC benefits provided to Warren County residents was \$958,476.09 compared to \$905,575.08 in 2011. These monies provided essential food supplements and locally grown fruits and vegetables to WIC participants, as well as revenue to local community food vendors and farmers.

WIC Benefit Check Redemption	Special Formula Food Instruments Redemption	Farmer’s Market Check Redemption	Total Revenue
\$949,643.05	\$85.04	\$8,748.00	\$958,476.09

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 SERVED
2008	128
2009	126
2010	125
2011	109
2012	88

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.

EARLY INTERVENTION STATISTICS

	2008	2009	2010	2011	2012
Referrals Received	130	155	154	203	199
Children Served	260	276	262	285	281
Dollars Received From NYS	370,995.30	353,661.81	336,770.58	193,997.81	\$200,804.41
Dollars Received From Medicaid	481,521.68	404,857.26	268,832.58	404,557.15	353,251.57
Dollars Received From Private Insurance	52,794.26	39,519.56	24,769.92	19,148.24	33,708.25
Costs Before Reimbursement	1,153,028.34	1,201,449.71	946,876.91	988,424.39	\$955,941.68
Amount Appropriated (In budget, amended numbers)	1,133,861.00 (Over budget by 19,167.34)	1,238,362.00	1,307,867.96	1,338,749.92	1,244,999.38
Expenditures For County After Reimbursement Received	247,717.10	403,411.08	316,503.83	370,721.19	368,177.45
Average Cost to County Per Child Served	952.76	1,461.63	1,208.03	1,300.77	1,310.24
Births in County	655	643	600	598	577

Note: The number of children served by the Early Intervention Program dropped slightly from 2011 to 2012, as shown by the available financial tracking information; the cost per child served will vary depending upon the reimbursement potential for each individual. However, the cost per child increased only .007% or \$9.47/per child in 2012.

Dollars received are based on actual cash in for the year, not revenues booked. Private insurance payments are up due to diligent insurance billings and working on contract negotiations. The NYEIS system has been utilized for the Early Intervention billing/services for over 2 years. The prior system known as the KIDS program, will be obsolete by the end of 2013, with the current children aging out of the program.

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 2008-2009	SCHOOL YEAR 2009-2010	SCHOOL YEAR 2010-2011	SCHOOL YEAR 2011-2012
All Children Served	417	370	353	292
Evaluations Only	88	78	89	75
Tuition Program/Evaluations Costs Approved	\$3,912,417.01	\$2,990,227.47	\$2,441,577.18	\$2,112,857.94
Tuition Program/Evaluations Costs Paid in 2012	\$3,980,727.63	\$2,991,733.97	\$2,539,102.34	\$2,160,955.39
Transportation Costs Approved	\$846,790.00	\$773,763.30	\$647,099.55	\$416,672.74
Transportation Costs Paid in 2012	\$839,850.00	\$772,256.80	\$689,913.49	\$420,283.30
Average Cost Per Child Before Reimbursement	\$11,560.14	\$10,172.95	\$9,147.35	\$8,839.85
Amount of Medicaid Received in 2012	\$195,197.58	\$0.00	\$11,262.11	\$21,673.58
Amount State Aid Received in 2012	\$1,770,708.13	\$2,631,959.85	\$1,102,852.25	\$2,135,454.97
Administrative Costs Received in 2012	\$37,915.94	\$45,638.82	\$105,296.85	\$53,250
Administrative Costs Paid to School Districts in 2012	\$44,183.47	\$76,703.94	\$125,667	\$60,857
Program Costs After Reimbursement	\$2,854,671.92	\$1,132,030.92	\$2,114,901.47	\$424,110.14
Average Cost Per Child After Reimbursement	\$6,845.74	\$3,059.54	\$5,991.22	\$1,452.43

***Source: General Ledger/Accounts Payable Reports and Budget Performance Report, 1/1/12 - 12/31/12.**

Medicaid reimbursements for 2012 were \$21,673.58 The state has allowed us to bill for Medicaid and billing was started late fall, therefore going forward continued revenues will be reflected here. This has been on hold for two years.

Cost per child does not include expense or reimbursement related to administrative cost to school districts. It is strictly related to services only, such as Tuition, Evaluations, Transportation, and Rate Reconciliations. If you notice in 2012, program costs after reimbursement are dramatically lower from previous years due to the fact that cash flow received during the year was much higher and costs much lower. We served 292 (decrease of 17.28%) children during 2012. Less children have qualified for tuition based programs and more have been working with therapy sessions, therefore reducing costs. The cost per child is somewhat skewed due to the fact that the calculation is based on cash in/cash out for the year.

PRESCHOOL PROGRAM

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

SCHOOL DISTRICT	School Year 2008-2009	School Year 2009-2010	School Year 2010-2011	School Year 2011-2012
Abe Wing	20	18	17	9
Bolton	2	4	4	0
GF City	110	83	84	57
Hadley Luzerne	18	20	18	12
Johnsburg	13	7	7	4
Lake George	15	17	15	12
No. Warren	18	18	15	13
Queensbury	90	98	87	81
Warrensburg	43	27	18	27

Administrative Costs Paid to School Districts During 2012*		
	09/10 School Year Paid 2011	09/10 School Year Paid 2012
Bolton	\$0	\$3,269
GFCity	\$13,139	\$0
GF Common	\$0	\$6,178
Had Luzerne	\$8,406	\$0
Johnsburg	\$3,736	\$0
Queensbury	\$0	\$51,410
Total	\$25,281	\$60,857

Rate Reconciliations**	2011	2012
Paid Out to Providers	\$57,192.36	\$51,055.62
Received from Providers	\$1,665.11	\$26,608.84

Budget Appropriation for Contractual Services (Amended Budget)	
2008	\$4,600,000
2009	\$4,676,782
2010	\$5,151,575
2011	\$5,159,880
2012	\$4,720,000

*Administrative Costs paid in 2012 to school districts for 2009-10 school year totaled \$60,857 for three school districts. All were paid January 2012. 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 previous school years. Total paid over last the last two years for 09/10 SY is \$86,138 while for 08/09 was \$125,667 which is \$39,529 or a 31.45% decrease from the 08/09 school year.

**Rate reconciliations recorded in 2012 are reflected above for school years 08/09 to 11/12. During 2012 WCHS actually received credits due the county from providers for previous years where the rate was reconciled to have been lower. These were primarily from Boces and all totaled \$26,608.24. However, WCHS also had to pay an additional \$51,055.62 in rate reconciliations. These providers are New Meadow-\$133.82, and UCP (Prospect School)-\$50,921.80.

*** These totals reflect children receiving services during the fiscal year 1/1/12-12/31/12 to better match with fiscal year expenses.

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.

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.

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 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.

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.

In Warren County, children are placed directly into appropriate programs (i.e. ChildFind, Early Intervention, Health Supervision) and managed by applicable staff which better meets individual needs. This appears to be a working system.

HEALTH EDUCATION

The Warren County Health Education program saw a very busy year in 2012. The number of preschool and school aged children that received programming through the health education program was up by almost 1,000 students. In August 2012 the Warren County health educator began to split time between health education and emergency preparedness programming. The time split didn't seem to have any immediate impact on the health education program offered by Warren County Public Health. Continued monitoring of the program will be used to see if there is any substantial impact to the Health Education program in the future.

2012 Activities

Program News

- School based programming remained strong. In light of budget constraints affecting all school districts in Warren County low cost/no cost health programs seem to be a popular alternative to field trips and other outside programming that schools can no longer afford.
- Eight families successfully completed "BodyWorks" a family nutrition and physical activity program. Participants attended at least 7 out of 10 weekly classes. Families demonstrated new skills for incorporating healthy eating habits and increased physical activity in their daily activities during weekly reporting sessions. One family was featured in a news story in the local paper.
- Efforts to increase participation in fall prevention programming paid off. The number of seniors that were part of the fall prevention programs increased from 36 in 2011 to 140 in 2012.

Community Health Assessment

- Adirondack Rural Health Network along with Warren County and other regional partners began the planning, data gathering and other essential steps needed to complete the 2013-2017 Community Health Assessment. For more CHA info contact Dan Durkee durkeed@warrencountyny.gov
- Served on the Community Health Assessment provider survey development committee. The survey was designed to gather feedback from providers in the region about how much they know about New York State DOH prevention agenda and their thoughts on the current health needs of the county/region they serve. Results due in early Spring 2013.
- Began discussions with regional partners about how to complete a Community Health Improvement Plan (CHIP) which must accompany the 2013-2017 CHA.

Community Events

- Attended 5 community events and presented information on a variety of topics including Lyme Disease, fall prevention, general wellness (know your numbers) etc.

Trainings/Conferences

- Completed a one day training called Be Proud! Be Responsible! An adolescent pregnancy, STD and HIV prevention curriculum. Program is intended to be taught as part of the health education curriculum in schools. Warren County would play a supporting role and provide information and education about certain topics to teachers, students or both.
- Completed a train-the-trainer program called BodyWorks which focuses on creating behavior change in the family setting. The program is designed to teach parents the skills needed to implement small meaningful changes to help create a healthy environment for adolescent and teen children.

Networking

- Continued to work with community partners by attend meetings and offering assistance with community events planning and implementation (Cornell Cooperative Extension, Zontas Club of Glens Falls, Warren County Office for the Aging, Queensbury Seniors, Southern Adirondack Child Care Network, Interagency Council etc.)
- Attended approximately 40 networking meetings with community partners.

Worksite Wellness

- Began Discussion w/ Glens Falls hospital about reviving Warren County Worksite Wellness. Met with Warren County administrator, and county self-insurance representative. Began the process for the creation of a resolution recognizing a Wellness Committee. Discussed the structure of the committee and who should be a part of it. Actual progress was delayed until 2013.
- Offered the employee wellness program “Biggest Loser” for the fourth year. Fifty-six employees completed the eight week program.

Miscellaneous

- Disseminated educational materials on a variety of health topics through tabletop displays, display racks and at community events.
- Attended three worksite trainings provided by Warren County Safety Committee.

PRESCHOOL ELEMENTARY and ADOLESCENT PROGRAMS

Program	Attendance '08	Attendance '09	Attendance '10	Attendance '11	Attendance '12
Dental Health	183	235	644	320	825
Nutrition	386	714	868	852	464
Injury Prevention	367	182	572	567	949
Hand Washing/Hygiene	1020	905	653	826	651
Exercise/Heart Health	381	679	251	391	725
Sun Safety	473	342	542	528	831
Poison Prevention	71	209	169	61	583
Tobacco Education	910	703	705	799	751
Ticks & Lyme Disease	382	50	350	285	65
Rabies Awareness	534	0	0	424	0
HIV/AIDS	40	125	293	248	233
Flu/H1N1	*	426	0	0	285
TOTAL	4707	4570	5047	5301	6362

ADULTS, PARENTS and SENIORS PROGRAMS

Program	Attendance '08	Attendance '09	Attendance '10	Attendance '11	Attendance '12
CPR/First Aid	185	141	116	130	102
School Nurse Training	29	30	32	45	48
Blood Borne Pathogens Training	52	112	40	46	40
Employee Training/Defensive Driving	99	0	112	22	126
Senior Health/Fall Prevention	68	10	50	36	140
Flu/H1N1	*	45	0	0	0
Community Programs	*	*	336	240	50
TOTAL	433	338	686	519	506

Above charts are not all-inclusive. Some programs may not have been included because of size and/or nature of the program.

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	Warren Count Head Start	Hudson Headwaters HIV Network
Interagency Council	NYS Department of Injury Prevention	Washington County Public health
Adirondack Rural Health Network	Glens Falls Hospital	American Academy of Family Physicians
Zonta Club of Glens Falls	Youth Coalition	Hudson Headwaters Health Network
Southern Adirondack Childcare Network	Glens Falls YMCA	10 Warren County School Districts

(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

Ryan White Grant: Supports efforts in Warren County to offer outreach and education to the public about HIV/AIDS.

- Supplied funding for more HIV test counselors to be available during Tuesday evening clinics.
- Please see HIV pages for clinic statistics.

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. Distributed educational materials to the public at rabies clinics, vets offices and at the Warren County Health Department. Conducted rabies education with Glens Falls DPW staff regarding roadkill and potential encounters with wild or stray animals while at work.

Lyme Disease: Conducted tick and Lyme disease education for the Upstate Retired Teachers Association and the Glens Falls DPW staff. Gave away over 100 tick removers and provided information to several pediatric offices and worksite ins Warren County.

Influenza/H1N1: Conducted a flu program for 285 elementary school children (5th and 6th grades) at the annual Environmental Field Days program presented by Cornell Cooperative Extension.

Infectious/HIV Disease: Presented HIV education at a high school in Warren County as requested by the health teacher. Two full days were spent at the school one in the fall and one in the spring to reach all of the students taking health during the year.

Lead: Conducted poisoning prevention programs for local preschool and daycare children. The dangers of lead paint were incorporated into the program. Lead poisoning prevention information was distributed to every child to be taken home. Discussed lead poisoning prevention with Glens Falls Head Start at their annual Wellness meeting. Provided informational brochures upon request.

OTHER PROGRAMS

Tar Wars Tobacco Free Education: Program funding has remained steady for the last two years at \$7500. Stewarts Shops helped offset the cost of prizes awarded to students that participate in the poster contest portion of the program. There was voluntary participation by 100% of school districts in Warren County. Seven hundred fifty students in fourth and fifth grade attended the program. Participation is down slightly in terms of raw numbers. Students created tobacco free posters after receiving a one-hour lesson about the dangers of tobacco and the deceptive practiced of the tobacco companies. The posters demonstrate the knowledge that students gain during the one hour lesson.

Warren County Employee Wellness Program: Conducted the fourth annual Employee Wellness “Biggest Loser” team competition. Nineteen teams registered for the program and 16 teams actually completed the 8 week program. The program was shortened by two weeks after analyzing feedback from participant surveys. Also, teams received weekly motivational and informational emails. This was incorporated based on survey feedback as well. Every team that completed the program lost weight and according to surveys had incorporated at least one healthy behavior No long-term follow-up is planned do to a lack of time and resources.

School Nurse Training: The meeting time was held in early October again after the success of the 2011 meeting. Attendance was close to forty people (not including county staff). Topics covered during this year’s program included concussions, poison prevention, communicable diseases, and others. There were also three community agencies present with informational tables.

For More Information about Warren County Health Education
Please Contact
Dan Durkee
Senior Health Educator & Emergency Preparedness Coordinator
Warren County Health Services
Phone: 518-761-6580 or email durkeed@warrencountyny.gov

LEAD POISONING PREVENTION PROGRAM

Warren County has a Lead Poisoning Prevention Program funded by a NYSDOH \$22,405 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: A 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 below 10mcg/dl 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 and an environmental referral to NYSDOH for lead testing of the home.
- Lead level 20mcg/dl or higher: Same as above.

Services offered by Public 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

BLOOD LEAD SCREENING TESTS	2008	2009	2010	2011	2012
<10mcg/dl	753	964	934	1039	983
10-14mcd/gl	5	4	5	3	2
15-19mcg/dl	0	0	1	1	0
20-25mcg/dl	0	0	0	3	0
>25mcg/dl	0	1	1	0	0
TOTAL ELEVATED RESULTS	5	5	7	7	2

(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.

DISEASES REPORTED FROM LABORATORY CONFIRMATION

DISEASE ENTITY	2008	2009	2010	2011	2012	DISEASE ENTITY	2008	2009	2010	2011	2012
Amebiasis	1	0	0	0	0	Influenza, B	19	15	0	13	5
Anaplasmosis	0	0	0	0	3	Influenza, unspecified	2	0	0	0	0
Babesiosis	0	0	0	1	0	Influenza (Haemophilus) Invasive B	0	0	0	0	1
Brucellosis	0	1	0	0	0	Influenzae (Haemophilus) Invasive not Type B	0	0	0	2	0
Campylobacteriosis	4	5	6	8	9	Legionellosis	1	1	1	2	0
Chlamydia	100	139	160	188	176	Listeriosis	---	1	0	0	0
Cryptosporidiosis	5	1	0	0	0	Lyme Disease	23	103	45	25	45
Dengue Fever	0	0	0	0	1	Ticks Tested/Confirmed Deer Ticks	142/118	142/135	81/77	39/38	0
E. Coli	2	2	0	0	0	Meningitis (bacterial)	2	0	0	1	0

DISEASES REPORTED FROM LABORATORY CONFIRMATION

DISEASE ENTITY	2008	2009	2010	2011	2012	DISEASE ENTITY	2008	2009	2010	2011	2012
EHEC (not serogrouped)	0	0	0	0	0	Meningitis (viral)	0	0	0	0	0
Giardiasis	9	11	4	9	9	Mumps	0	0	0	0	0
Gonorrhoea	18	3	13	10	6	Pertussis	2	1	11	3	6
Haemophilus Influenzae Inv No	1	1	0	2	0	Salmonellosis	8	7	8	8	5
Hemolytic Uremic Syndrome	---	1	0	0	0	Shigellosis	1	0	0	1	0
Hepatitis C (acute)	1	0	0	0	0	Strep Pneumo Invasive Sensitive	0	0	9	0	5
Hepatitis C (chronic)	42	31	26	30	37	Strep Pneumo Invasive Drug Resistant	0	0	1	0	0
Hepatitis B (acute)	0	0	0	0	0	Syphilis, primary	1	0	0	0	0
Hepatitis B (chronic)	4	3	4	1	0	Syphilis, secondary	0	0	0	1	0
Influenza A	35	83	0	11	105	Syphilis, early latent	2	0	0	0	1
Strep Pneumo Invasive Intermed	1	4	0	1	0	Syphilis, late latent	1	0	0	0	4
Strep Pneumo Invasive, unknown	1	1	0	2	1	Syphilis, unknown latent	1	0	0	0	0
Strep Pneumo Invasive, sensitive	2	4	0	5	0	Swine - Origin Influenza	---	15	1	0	2
Streptococcus Pneumoniae (Unknown)	0	0	0	0	0	Toxic Shock Syndrome	0	0	0	1	0
Strep Group A Invasive	3	0	8	1	1	Tuberculosis	1	0	1	0	0
Strep Group B Invasive	7	5	6	7	7	Yersiniosis	1	1	0	1	0
Strep Group B Invasive, early	1	0	0	0	0						

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

Anthrax	Hantavirus Disease	Rabies (see rabies data)
Botulism	Hepatitis A	Rocky Mountain Spotted Fever
Chancroid	Hepatitis A in Food Handler	Rubella
Cholera	Hepatitis B (in pregnancy)	Rubeola
Cyclospora	Lymphogranuloma Venereum	Tetanus
Diphtheria	Malaria	Trichinosis
Ehrlichiosis	Measles	Tularemia
Encephalitis	Plague	Vibriosis
Foodborne Illness	Psittacosis	West Nile Virus

RABIES PROGRAM

Warren County has a Rabies Prevention Program that follows up on all animal bites/exposures, provides rabies pre vaccination immunizations, 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.

Note: As of December, 2011 the rabies law was amended to allow unvaccinated animals involved in a bite to stay at home for the 10-day quarantine period under the discretion of Public Health. Also, scratches alone are no longer considered a potential exposure and do not require a 10-day quarantine.

RABIES DATA FOR 2012

Town	Not Vaccinated			Vaccinated			Out of Town			Stray		
	Cats	Dogs	Ferrets	Cats	Dogs	Ferrets	Cats	Dogs	Ferrets	Cats	Dogs	Ferrets
Bolton	2	2		1	2			1				
Chester	2	2			5					1	1	
Glens Falls	14	12		3	26			1		6	1	
Hague		2										
Horicon		3										
Johnsburg	1	3			2			1		1	1	
Lake George	2	2			5			5		1		
Lake Luzerne					3			1		2	1	
Queensbury	8	11		10	43		1	6		8	3	
Stony Creek												
Thurman		1		1	2							
Warrensburg		6			3					1	1	
TOTALS	29	44	0	15	91	0	1	15	0	20	8	0

BITES REPORTED BY MONTH

	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Total
2009	18	11	16	23	18	23	31	30	20	20	23	23	256
2010	16	7	20	24	21	19	15	37	17	18	17	7	218
2011	12	10	20	18	22	15	35	22	24	13	10	7	208
2012	13	20	14	17	24	20	25	21	18	22	18	12	224

RABIES STATISTICS

	2008	2009	2010	2011	2012
Confirmed Rabid Animals	1 fox 2 bats	2 skunks 1 fox	1 raccoon 1 fox	0	1 cat 1 bat
Animal Specimens Submitted for Testing	81	54	37	28	45
Animal Bites	292	256	218	208	224
Patients Receiving <u>Pre-Exp. Vac.</u> (3 Injections) or <u>Booster Vacc.</u> Fee: \$203.00/Dose	(Due to a rabies vaccine shortage, only post exp. vaccine was given.)	3 Titers Drawn: 0	6 Titers Drawn: 0	8	3
Patients Receiving <u>Post-Exp. Vac. Series @ GF Hosp.</u> (All RIG and First Injections are Given at GF Hospital)	29	30	34	13	28
Patients Receiving <u>Post-Exp. Vac. Series @ P. Health</u> (All RIG and First Injections are Given at GF Hospital)	3	4	4	1	1
Animal Clinics	21	21	22	23	22
Animals Receiving Rabies Vaccinations	927	834	944	787	1130

Amount paid in relation to Rabies Program: \$24,462.24
 Amount vouchered to New York State: \$10,922.07
 Rabies Clinic Revenue: \$9,895.00
 Total program cost to Warren County: \$3,645.17

Note: Data above reflects actual expenses incurred and both actual cash received and amounts vouchered to the State during 2012. We were able to offset 40.45% of costs with donations received during clinics (38.31% in 2011). Overall 85% of costs were reimbursable (82.67% in 2011). Unfortunately the State allows certain maximums for both animal testing and human vaccines, therefore the difference of \$3,645.17 remains a cost to the county. Rabies expenses increased 31% in 2012 however the impact to the county only increased by 13%.

TUBERCULOSIS PROGRAM

PPD testing is offered by appointment to any Warren County resident requesting it on Monday, Tuesday, and Fridays. A fee of \$28.00 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	
2008	\$19.75
2009	\$60.61
2010	\$39.89
2011	\$ 0.00
2012	\$ 0.00

YEAR	INDIVIDUALS TESTED	POSITIVE CONVERTERS	ACTIVE TB CLIENTS DURING YEAR
2008	318	3	1
2009	235	8	0
2010	217	1	1
2011	164	1	0
2012	175	0	0

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

2010: Patient was diagnosed in Florida and moved to Warren County during her treatment. DOT was done until patient moved out of area prior to completing treatment.

2012: No active cases.

STD CLINIC

The STD/HIV clinic continues to be held weekly at the Public Health Office in Warren County Municipal Center. The clinic is sponsored jointly by Washington County and Warren County. If a client from Hamilton County attends the clinic, there is billed for services. Almost two thirds of the clients are residents of Warren County and two thirds are males. A large percentage of males have been referred to the clinic from Planned Parenthood.

We have increased our voice in the local community by using the Warren County Public Health Facebook page to publish reminders of the clinic and to offer information from the CDC and other medical websites. We have partnered with Hudson Headwaters to disseminate information of sexual health to teens. <http://www.teenawareness.net/teens/health-services/>.

Information on the STD/HIV clinic is included in the packet of educational material that is given to the Warren County School Nurses at their annual meeting.

HIV testing is done on the premises and is the Rapid Test so the client can know the result in twenty-five minutes. Currently, the HIV counselor staff consists of the six school nurses and four public health employees who work on a rotating schedule. The salary for the school nurses comes from the Ryan White Fund.

We are waiting to see the effect the Affordable Care Act will have on the STD/HIV clinics.

HIV and STD (SEXUALLY TRANSMITTED DISEASE) CLINIC

	2008	2009	2010	2011	2012
Clinics Held	51	52	52	50	51
Participants	325	377	332	327	356
Males	199	249	222	230	239
Females	126	128	110	97	117
Age Range	15-68	14-69	14-72	15-86	15-86
HIV Test Only Done	65	41	40	40	43
STD Test Only Done	55	83	77	51	70
STD & HIV Test Done	151	193	187	204	188
HIV Not Tested*	25*	17*	9		22
STD Phone Calls for Results	116	175	164	168	169
Warren Co. Participants	189	216	157	204	196
Washington Co. Participants	59	107	110	76	109
Saratoga Co. Participants	67	44	53	41	39
Other County Participants	10	10	11	6	12

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

DISEASES WITH POSITIVE TEST RESULTS

DISEASES	2008	2009	2010	2011	2012
Genital Herpes	2	9	4	0	4
Genital Warts	13	15	9	10	8
Chlamydia	9	20	23	20	24
Gonorrhea	1	1	0	0	1
Syphilis	4	0	0	0	3

HUMAN IMMUNODEFICIENCY VIRUS **(HIV)**

2012 was a year of reorganization for the Warren County HIV/STD clinic. Changes to the clinic were made after consulting with New York State Department of Health and Washington County Public Health staff. Prior to 2012 the HIV/STD clinic was seen as a shared clinic with shared resources between Warren County and Washington County. In January 2012 Warren County Public Health became aware of an oversight with its Limited Services Laboratory Registration (LSLR). Rapid HIV Testing had not been included as part of the services offered through Warren County Public Health.

Therefore, Warren County assistant director of Public Health began the process of getting the Rapid HIV Test added to the renewed LSLR. During that time Warren County was made aware of some changes that needed to be made to the policies and procedures regarding the sharing of HIV test kits and resources. All of the changes that were needed to be in compliance with the LSLR were completed by March of 2012. Currently Warren and Washington County continue to work in partnership to staff and promote the HIV Clinic. However the purchase, storage and quality assurance procedures for HIV test kits and other resources fall to each individual county and can no longer be shared between the two entities.

Activities 2012

- Updated policies and procedures to meet the requirements for being able to offer rapid HIV testing as part of our LSLR
- Began tracking demographic data as part of the HIV testing program to be able to receive free HIV rapid test kits through NYSDOH.
- Secured \$6,000 from the Ryan White program to help staff the HIV Clinics.

Comments/Concerns:

- Currently there is no back-up plan if Ryan White funding becomes unavailable in the future to maintain current staffing levels.
- The number of people receiving only STD testing increased from 51 to 70 during 2012. Overall clinic attendance was up.
- During the 2012 year clients were surveyed at random to get a sense of who our clinic was serving with regards to health insurance coverage. One-hundred nine people completed the survey. Fifty-six percent of people surveyed had health insurance; 44% did not have health insurance.

2012 Goal Progress

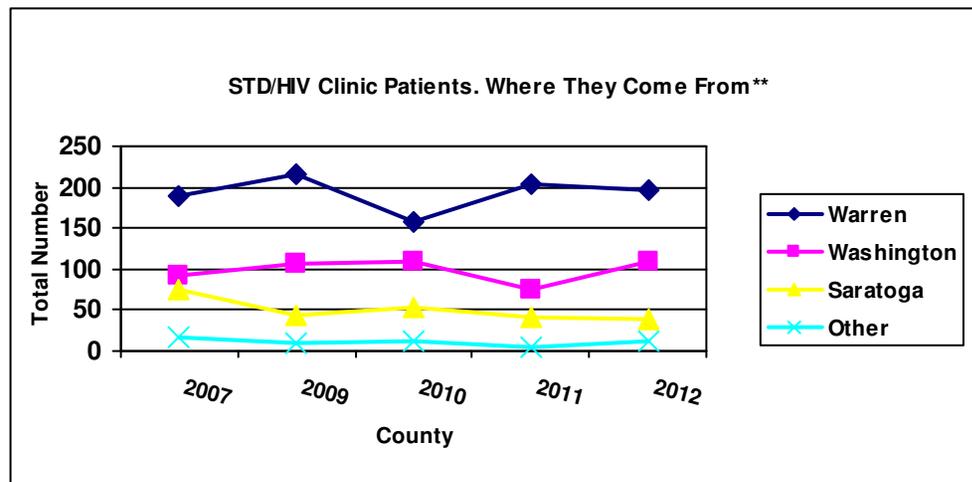
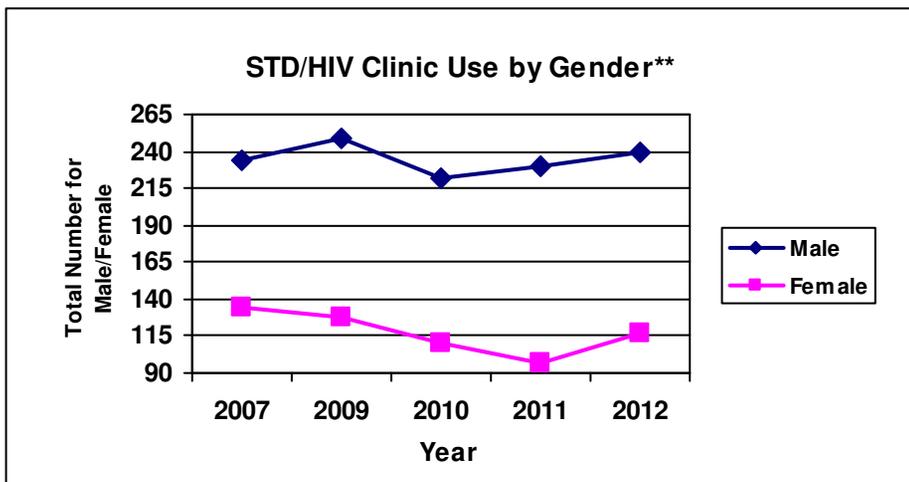
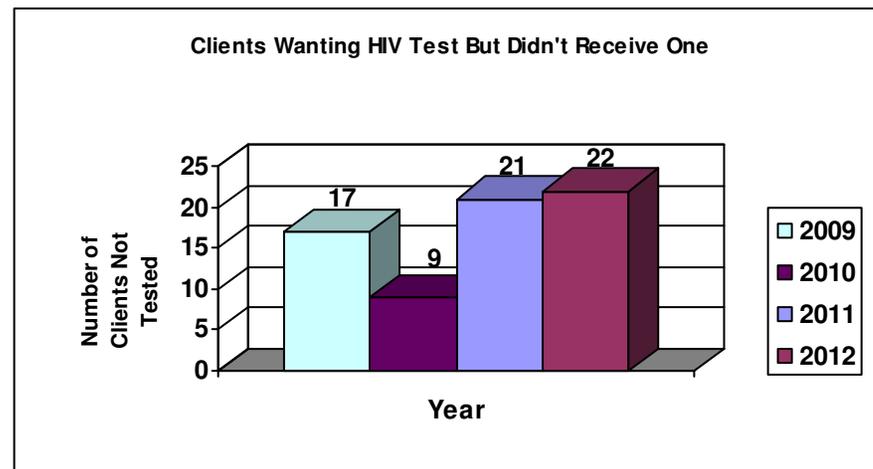
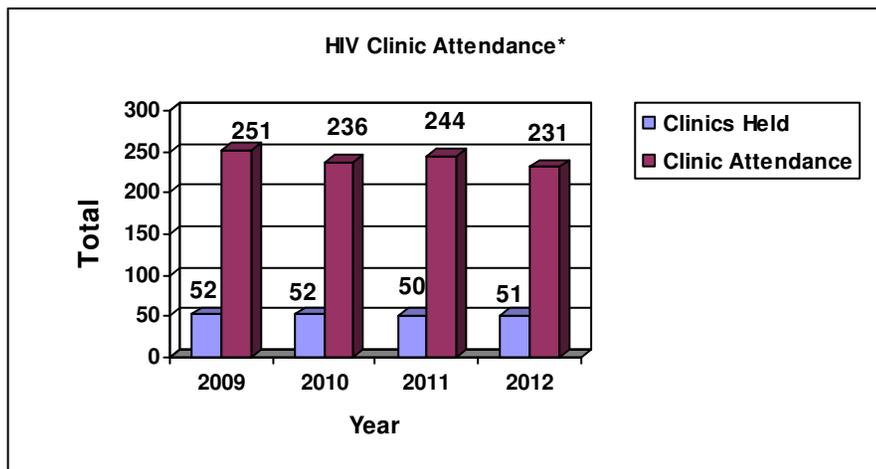
- Hired 5 new staff to perform HIV rapid testing and cover clinics using Ryan White funds.
- Maintained an adequate supply of HIV test kits and successfully performed quality assurance checks on all kits as required by the LSLR.
- During the reorganization process 22 people were unable to receive HIV rapid testing. After the reorganization was completed no one was turned away for Rapid HIV testing. After accounting for the reorganization process the Warren County HIV Clinic staff met the goal of reducing the number of people unable to receive Rapid HIV testing to less than 5 for the year.

2013 Goals/Outlook

- Continue to secure funding from the Ryan White program to maintain current staff levels at all 2013 HIC Clinics
- Use updated data from NYSDOH to help Warren County Public Health target high risk population for HIV testing.
- Continue to try and reduce the number of people receiving STD testing but refusing HIV testing by 15%.

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.

2009 - 2012 HIV RAPID-TEST CLINIC BY THE NUMBERS



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

** 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

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

The delivery of immunizations has changed drastically this past year. More emphasis is being placed on clients receiving vaccines at their “home” medical provider. The providers are realizing this and are much more aware of the vaccine needs of their patients. It is routine now for the doctor’s office to ask the immunization status of the patient during each visit. Because of the increased awareness by providers and their effort to prevent vaccine preventable illness, our immunization clinics have seen a reduction in attendance. In addition to this change, the Vaccine for Children program has also undergone a major overhaul. This is the program that allowed local health departments to use free vaccine for any child under 19 years of age. The vaccine is provided by the US Government and NYS. As health insurances became more available and reimbursed for vaccines, the VFC program was sharply curtailed. The local health departments may not use the VFC vaccine indiscriminately but must encourage the client to go to their home provider. We must first determine the eligibility of the child and if there is truly no insurance, we can vaccinate. This has placed a burden on the clerical staff and the nurses, torn between wanting the child to be protected and also having to question if the child is eligible. We are working to learn to the maze of the health insurance industry.

We continue to take part in the NYSDOH Adult Hepatitis Program. This program provides free vaccine to be used for adults “at risk” of contracting Hepatitis A or B. The vaccine is offered at the STD/HIV clinic.

Health Services continues to offer ninety minute clinics three times each week in the office. The most requested vaccine is Zostavax (prevent shingles), likely because of the Merck sponsored TV ads. We have also seen an increase in numbers of Tdap (tetanus, diphtheria, pertussis) vaccine given due to the increase in Pertussis cases.

Our goal for 2013 is to continue to provide vaccines for Warren County residents and to become proficient at billing.

TRAVEL CLINIC

CLINIC OFFERING VACCINES FOR INTERNATIONAL TRAVEL

Travel Clinic is entering its third full year, and we are satisfied that it has been self-sufficient for its entire existence.

Dr. Richard Leach, Certified in Tropical Medicine, continues to be the consultant.

In order to have clinic coverage by the office clerical staff, the hours of the clinic were changed in the spring of 2013 to 2:00-4:00 p.m. every Wednesday. During 2012, the clinic was held every Wednesday evening from 4-6pm.

Our goals for the future are to be able to bill health insurance companies for the consultation and the vaccines administered. Also, we are aware of the increased interest in travel and realize that we may find it necessary to increase the hours of the clinic. In 2012, 117 clients attended the clinic, traveling to countries that included Madagascar, Zimbabwe, Ethiopia, Rwanda and China. We have managed to keep on hand the various vaccines that are needed for travel to a variety of countries and have the authority to issue Certification of Yellow Fever vaccine.

Summary of Travel Clinic - 2012

Quarter	COST	CHARGE	PROFIT/LOSS
1 st	\$5,053	\$5,130	\$ 77
2nd	\$5,637	\$6,044	\$ 407
3rd	\$6,004	\$6,454	\$ 450
4 th	\$6,452	\$7,792	\$1,340
Totals	\$23,146	\$25,420	\$2,274

INFLUENZA CLINICS

Organization of flu clinics is in a state of flux. The approval by the New York State Department of Health for pharmacists to administer vaccines has made a dramatic difference in attendance at the Public Health flu clinics. In addition, the encouragement for more participation by private providers to administer flu vaccine has led to an increase in the numbers of people being vaccinated at their doctor's office. We, strongly support this action. Our fear is that the increased sites to obtain flu vaccine do not mean that the number of people vaccinated is increased.

We expect that flu season 2013-2014 will be very interesting. Several of the pharmaceutical companies are offering flu vaccine that contains four strains of flu virus instead of the usual three. Also, the news reports of the failure of flu vaccine to prevent the disease in seniors will have a huge impact on the senior population's acceptance of the vaccine.

We ordered 2500 doses of flu vaccine for the 2012 season and held 24 clinics throughout the county. All of the senior meal sites hosted a flu clinic as did seven town halls. Several schools asked that we hold clinics at their facilities for their faculty and ancillary staff. We were able to accommodate Head Start staff and families and several senior facilities, i.e. Adirondack Manor, The Glen and Countryside.

Our goal for the 2013 season is to encourage the vaccination of all of the population of Warren County and to have the nursing staff and vaccine available to meet this goal.

INFLUENZA VACCINE ADMINISTRATION

	2008	2009	2010	2011	2012
Clinics Offered Throughout the County	51	23	22	24	35
Vaccine Doses Administered at Clinics	2952	2311	732	904	875
CHHA/Long Term Home Visits For Administration	101	81	33	63	42
Homebound Visits For Administration	9	9	7	0	5
Miscellaneous Administration i.e. PH Appointments And Other Home Visits	232	311	951	365	967
Total Doses Administered	3294	2712	1723	1332	1889

BLOOD PRESSURE CLINICS

Clinics are held at ten senior sites seven of these are the meal sites and are coordinated with the serving of the meal. Two are held at senior residences, i.e. Stichman, Cronin, and the third at Queensbury Town Center.

Blood pressures are taken by the public health nurse and recorded on the clients chart. Often, the nurse has been seeing the client for many months so that she is able to observe changes in blood pressure, appearance and state of mind. A strong feeling of caring is developed to that the actual blood pressure is a window into a larger picture. Not infrequently, a client is advised to see their doctor immediately because of a dramatically elevated blood pressure or because of a physical complaint that the client is hesitant to take to a doctor. These clinics have been very well received by the participants.

Partial reimbursement is received from Office for the Aging to compensate for the nurses time.

Clinics are offered for free. 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. This picnic has an average of 50 people who get their BP taken. 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	2008	2009	2010	2011	2012
	Bolton Meal Site	60	51	62	63	67
	Chester Meal Site	67	59	45	87	96
	Cronin HighRise	55	104	91	105	92
	Johnsburg	72	80	83	113	95
	L.Luzerne Meal Site	117	108	105	133	109
	Presb. Church (GF)	68	76	77	64	79
	Queensbury Center	97	101	78	98	114
	Solomon Heights	88	91	82	94	73
	Stichman Towers	21	52	60	48	51
	Warrensburg	58	88	78	80	84
	TOTALS:	703	810	761	885	860

COLLABORATIVE INITIATIVE WITH WARREN WASHINGTON COUNTIES MENTAL HEALTH ASSOCIATION

Warren County Public Health has been making hourly, weekly visits to East Side Center for many years. The nurses keep a running log of the clients that they weigh, do blood pressures, and counsel on general health issues. Two years ago, the decision was made for financial reasons to discontinue these visits; however, the administration of East Side Center felt the visits were too valuable to the clients and staff of East Side Center. The weekly visits continue.

During the year of 2012, an average of 15 clients were served each week by Warren County Public Health at East Side Center.

QUALITY ASSURANCE

Public Health has a three level Quality Assurance Program.

- Level 1 utilizes the standard Chart Component List. Staff ensures the charts are complete prior to discharge. The Assistant Director monitors a random sample to ensure charts are complete at discharge
- 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.

2012 UR Committee members:

Thank you all for your participation and dedication to Public Health

Mary Anne Allen PNP, Moreau Family Health	Patty Hunt ADPH, Washington County Public Health
Patty Myhrberg PHN, Child Find Program	Sandy Watson , Registered Dietician, WIC Program
Pat Belden PHN, Communicable Disease	Ginelle Jones RN, MSN FNP Assistant Director Public Health
Janet Cicarelli , Case Manager at GFH	Dr. Dan Larson , Medical Director, Provides Oversight to QA/UR Program
Stacie Dimezza PT, Glens Falls Rehabilitation Center at GFH	Maureen Schmidt CS, Supervisor Preventive Services, DSS
Sandy Noonan , North Country OB/GYN	

QUALITY ASSURANCE

Charts Reviewed in 2012

Meeting Date	MOMS	MCH	Synagis	Child Find	Other Health Supervision
03/14/12	5	15	2		2
06/13/12	5	15	4		4
09/12/12	5	15	4		5
No meeting in December					
Total	15	45	10		11

Summary of Findings: Appropriate

charts were reviewed. All deemed appropriate, however there were a few incidents where there were omissions. None of the findings were thought to impact patient care. The documentation in the charts has significantly improved throughout the years.

Strengths:

- Staff persistence in locating and contacting clients
- Education and coordination with other agencies.
- Good resource to clients

Areas Needing Improvement:

1. MCH: Improve documentation in regard to reinforcement on subsequent visits related to the care plan. The effort is done and documented in the narrative, just not on care plan. Staff education was provided.

Summary of Recommendations

1. Encourage all staff to utilize the Chart Component List prior to discharge ensuring documentation is complete
2. Ensure better flow in Health Supervision Charts by referring to clinical notes in the narrative

Pat Hawley, Records Consultant and Jim Finamore, Pharmacist Consultant, also assist annually with monitoring of the records and quality assurance. Both reviews came back without any significant findings.

2013 GOALS

1. Continue with the current QA Program- It appears to be working.
2. Continue to encourage staff to assist with annual review of policies and procedures
3. Continue to focus on program QA reports of logs, Incident Reports/STD/Travel/CDC/WIC
4. Start to focus and incorporate UR committee in strategic planning process.

CONTINUING CHALLENGES FOR WARREN COUNTY HEALTH SERVICES IN 2013

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 2013 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.

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

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

1-800-755-8102

or

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

Email: auerp@warrencountyny.gov

Website: www.warrencountyny.gov