

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 2013

## **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	Dan Durkee	Janel Martinez	Toni Roht
Robin Andre	Judy Fortini	Erik Mastrianni	Tia Ruggiero
Jeannette Arends	Nedra Frasier	Kathy McGowin	Laura Saffer
Glenda Armstrong	Cheryl Fuller	Crystal McKinney	Lisa Saville
Shauna Baker	Nancy Getz	Leslie McNulty	Margaret Sawyer
Jackie Barney	Diana Gillis	Angela Meade	Anni Stewart
Cheryl Belcher	Mary Lee Godfrey	Kate Meath	Sharon Schaldone
Patricia Belden	Jennifer Granato	Jackie Merritt	Pamela Silva
Cheryl Bellizzi-Sharon	Dana Hall	Barbara Moehringer	Melody Smith
Craig Briggs	Meg Haskell	Lisa Morton	Helen Stern
Debbie Burke	Alissa Hay	Dorothy Muessig	Gillian Tingley
Linda Bush	Shannon Houlihan	Jackie Mulcahy	Debbie Toolan
Gwen Cameron	Ginelle Jones	Mary Murphy	Victoria Viacava
Georgene Carpenter	Elaine Kane	Patty Myhrberg	Linda Walker
Kerri Carpenter	Barbara Karge	Bethany Paquette	Sandy Watson
Jamie Clute	Michelle Keller-Allison	Nancy Parsons	Valerie Whisenant
Donna Cooke	Sue Kerr	Patricia Pennington	Diedre Winslow
April Cosey	Emily LaLone	Diane Pfeil	Stacy Woodcock
Tara Cote	Mary Lamkins	Kristen Phinney	
Vanessa Dacey	Rebecca LeClaire	Nancy Pieper	
Diane Decesare	Maureen Linehan	Stella Racicot	
Tammie DeLorenzo	Mary Lamkins	Jennifer Rainville	
Tawn Driscoll	Danielle Martin	Cassandra Rausch	
Cathy Dufour	Sarah Martin	Lynne Rodriguez	

**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

Ronald Conover, Bolton

Edna Frasier, Hague

Peter McDevitt, Glens Falls

Harold Taylor, Glens Falls

## WARREN COUNTY HEALTH SERVICES

### 2013 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 2013: 130**

63 Full Time  
11 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 Senior EI/Preschool Service Coordinator (Grade 19)  
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)  
2 Full Time WIC Assistant (Grade 5)  
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)  
1 Full Time Principal Clerk (Grade 7)

#### **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, Certified Home Health Agency, 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 50% by each county. 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.

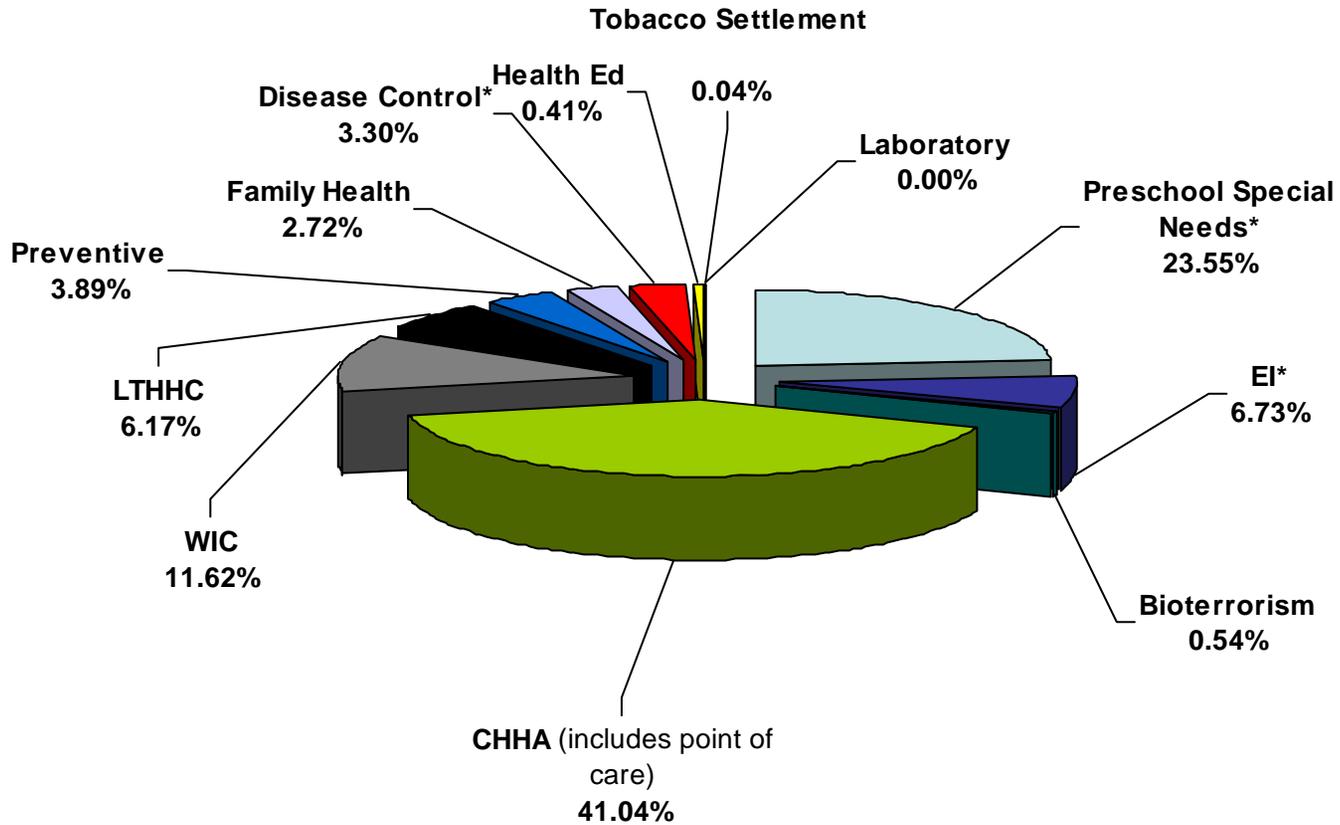
## **BUSINESS ASSOCIATES CONTRACTED IN 2013 FOR THERAPY SERVICES**

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!

### 2013 Actual Expenditures by Program



Total Expenditures: \$11,321,593.66

\*Mandated programs account for 33.58% of total actual expenditures. (They are the Preschool, Early Intervention, and Disease Programs)

Source: Budget Performance Report as of 12/31/2013

**WARREN COUNTY POPULATION**

Source: NYSDOH Statistical Data

**BIRTHS AND DEATHS IN WARREN COUNTY**

**STATISTICAL INFORMATION  
COMPARISON TRENDS**

	2009	2010	2011	2012	2013
<b>Births</b>	<b>643</b>	<b>600</b>	<b>598</b>	<b>577</b>	<b>602</b>
<b>Deaths</b>	<b>527</b>	<b>578</b>	<b>572</b>	<b>596</b>	<b>631</b>

## **Warren County Public Health 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.

### **2013 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**

Warren County's current Emergency Preparedness Grant goes from July 1, 2012 through June 30, 2017 and will provide the program with \$53,500/year. This funding will be utilized to cover staffing to complete the required deliverables. In 2014, staffing will be decreased to one part time Public Health Liaison and a Senior Health Educator (20 hours) due to limited funding.

### **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

- Public Health Emergency Preparedness and Response (PHEPR) 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 2012-2013 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, planning and participation in 2 full scale exercises, communications systems). Completed 12 mandatory Local Health Department deliverables (chose not to participate in the optional Free Flu Vaccine dispensing deliverable because of the many extra requirements attached to using free vaccine) and 23 maintenance deliverables. For more information about deliverables contact Warren County Health Services EPR Program.

### **Networking/Planning Partnerships**

- Approximately 30 organizations and 70 people 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 EPR program for a complete list of partners
- Warren County Health Services participated in 10 regional BT Coordinators meetings in 2013.
- 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 –**

- 2013 A large number of people retired or left agencies that participated in the Warren County ERP Planning Committee. The goal of Warren County Public Health ERP committee is to maintain contact with organizations that had staff retire or leave and to fill the vacancies on the EPR committee.
- Increase training opportunities for Warren County Public Health staff and incorporate ERP into more Public Health programs.
- Maintain an up-to-date volunteer registry using the NYSDOH ServNY system and continue to recruit new volunteers.

### **Drills/Exercises**

- WCHS participated in 1 full scale mass fatality exercise conducted by Glens Falls Hospital. Scenario tested response capabilities of local law enforcement, fire/EMS, Warren County Emergency Operation Center, Glens Falls Hospital surge capacity, Warren County Health Services communications systems and volunteer registry and several other response agencies. The scenario involved 50 “victims” with a focus on pediatric response. The drill identified several areas of improvement. A complete exercise summary is available by contacting Laura Stebbins, Glens Falls Hospital Emergency Management Director [lstebbins@glensfallshosp.org](mailto:lstebbins@glensfallshosp.org).
- Warren County Health Services participated in monthly tabletop 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 participated in an active shooter drill at a local camp for children with severe medical problems. The camp is located in the Adirondack Mountains and has a sprawling campus. The exercise included 30 “victims”, State and County law enforcement, Warren County Emergency Operation Center Mobile Communication Unit, Camp Staff, and local EMS. Warren County Health Services and

Glens Falls Hospital again tested surge capacity, communication systems and volunteer registry. Camp Staff and other responders utilized Start and Jump-Start triage for quick identification of injuries and medical needs of “victims”. Exercise took place in the afternoon during a work week so there was a shortage of EMS personnel available so the exercise was adjusted mid scenario to account for a lack of responders. A complete exercise summary is available by contacting Laura Stebbins, Glens Falls Hospital Emergency Management Director [lstebbins@glensfallshosp.org](mailto:lstebbins@glensfallshosp.org)

- Held a flu clinic for Warren County employees and tested the CDMS (Clinical Data Management System) data system that would be used at Point of Dispensing for dispensing medications during a large scale biological emergency.

#### Goals/Outlook

- Strengthen and increase training/exercise opportunities for partner agencies and volunteers involved in Emergency Response in Warren County.
- Continue to meet all deliverables as provided by NYSDOH.
- Participate/include local partners in the planning, implementation and review of tabletop and full-scale exercises designed to test different aspects of ERP plans.

#### **Concerns/Strengths/Outlook**

##### Concerns

- Lack of funding
- 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 staff from the Warren County Office of Emergency Services and Glens Falls Hospital Emergency Management

## Outlook

Currently, Warren County Health Services is adequately maintaining its ERP (Emergency Response and Preparedness) program. However, any cuts to funding for the ERP program might make it impossible for Warren County Health Services to meet its obligations. Internally staff from other programs is being utilized to assist EPR staff with required meetings, training/activities and to promote familiarity with planning efforts/ agency partners.

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.



## **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 a multi-disciplinary multi-agency collaboration.

**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/or family in self-care and disease management and to support care transition interventions to minimize avoidable complications. Our Homecare Professionals provide health guidance to all ages so that individuals, families, and the community will be helped to achieve and maintain optimum health.

The agency participates 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 comprehensive, case managed programs for persons who wish to be at home but who would otherwise require nursing home placement to meet their needs for care.

## **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 Home Health Consumer Assessment of Healthcare Provides System (HCAHPS) survey results.

The Steering Committee may develop a new process or enhance processes used to improve an Outcome where indicated. All personnel employed by our Division of Homecare play an integral part in achieving the patient centered outcomes.

Our goal is to continue to improve/enhance our delivery of care programs to our clients. The following reports note our achievements in patient centered outcomes comparing our Certified Home Health Agency (CHHA) to other CHHA's at the State and National levels.

The results of the agency's patient centered outcomes and achievements for patient education in prevention processes for 2013 are as follows:

- **Home Health Compare Results/Process Measure Outcomes**
- **Home Health Consumer Assessment of Healthcare Providers and Systems (HCAHPS):**

This survey is a Federal requirement for all CHHA's. The survey needs to be conducted by an outside independent agency that is certified by Centers for Medicare and Medicaid Services (CMS) to do the standardized survey. We have a contract with Strategic Health Plan (SHP) for this service. The survey has 3 Composite Measures:

1. Care of Patients
2. Communications Between Providers and Patients
3. Specific Care Issues: Home Safety Issues, Medications regarding schedule and side effects, and Pain



# Real-Time Home Health Compare

Warren County Health Services

HHC Publication Date: 04/2014

Report Date: 6/4/2014

<b>Managing Daily Activities</b>		<b>You</b>			<b>State (NY)</b>		<b>National</b>		<b>Your % Rank</b>	
DC/TRF - You/SHP: 1/13 - 12/13 CMS: 1/13 - 12/13		Actual	CMS	Risk Adj	CMS	SHP	CMS	SHP	CMS	SHP
1	Improvement in Ambulation	38.2%	50 %	50.9%	59 %	62.5%	61 %	64.2%	23.5%	14.4%
2	Improvement in Bed Transferring	55.7%	62 %	62.7%	54 %	57.4%	57 %	59.9%	75.3%	72.5%
3	Improvement in Bathing	59.0%	64 %	63.4%	63 %	67.4%	67 %	69.1%	45.0%	33.0%

<b>Managing Pain and Treating Symptoms</b>		<b>You</b>			<b>State (NY)</b>		<b>National</b>		<b>Your % Rank</b>	
DC/TRF - You/SHP: 1/13 - 12/13 CMS: 1/13 - 12/13		Actual	CMS	Risk Adj	CMS	SHP	CMS	SHP	CMS	SHP
4	Pain Assessment Conducted	99.8%	100 %		99 %	98.8%	99 %	99.0%	99.0%	70.2%
5	Pain Interventions in Short Term EOC	99.7%	100 %		99 %	99.2%	98 %	98.9%	99.0%	59.3%
6	Improvement in Pain Interfering with Activity	60.4%	61 %	62.0%	68 %	67.8%	68 %	67.8%	36.0%	34.1%
7	Heart Failure Symp Addressed in Short Term EOC	98.6%	99 %		98 %	98.5%	98 %	98.3%	49.3%	34.9%
8	Improvement in Dyspnea	60.7%	70 %	70.8%	66 %	65.1%	65 %	67.4%	68.6%	65.3%

<b>Treating Wounds/Preventing Pressure Sores</b>		<b>You</b>			<b>State (NY)</b>		<b>National</b>		<b>Your % Rank</b>	
DC/TRF - You/SHP: 1/13 - 12/13 CMS: 1/13 - 12/13		Actual	CMS	Risk Adj	CMS	SHP	CMS	SHP	CMS	SHP
9	Improvement in Status of Surgical Wounds	91.0%	99 %	97.4%	89 %	90.5%	89 %	89.3%	91.4%	84.0%
10	Pres Ulc Risk Assess Conducted	99.7%	100 %		98 %	98.8%	99 %	99.2%	99.0%	61.5%
11	Pres Ulc Prevention in POC	99.8%	100 %		98 %	99.2%	97 %	98.2%	99.0%	58.5%
12	Pres Ulc Prevention in Short Term EOC	99.6%	99 %		97 %	98.3%	96 %	97.6%	64.1%	67.3%

<b>Preventing Harm</b>		<b>You</b>			<b>State (NY)</b>		<b>National</b>		<b>Your % Rank</b>	
DC/TRF - You/SHP: 1/13 - 12/13 CMS: 1/13 - 12/13		Actual	CMS	Risk Adj	CMS	SHP	CMS	SHP	CMS	SHP
13	Timely Initiation of Care	97.8%	98 %		94 %	94.9%	92 %	92.4%	88.9%	82.6%
14	Drug Education All Meds in Short Term EOC	95.8%	93 %		92 %	94.1%	93 %	94.4%	38.3%	41.1%
15	Improvement in Management of Oral Meds	39.6%	49 %	47.6%	50 %	56.7%	51 %	54.3%	52.7%	34.1%
16	Fall Risk Assessment Conducted	99.6%	100 %		96 %	98.4%	98 %	97.8%	99.0%	56.8%
17	Depression Assessment Conducted	99.9%	100 %		98 %	98.6%	98 %	98.3%	99.0%	78.8%
18	Flu Vaccine Received - Current Season	79.2%	79 %		66 %	74.5%	72 %	75.3%	62.5%	53.8%
19	PPV Received - Ever	83.2%	84 %		60 %	73.1%	71 %	75.9%	71.4%	61.3%
20	Diabetic Foot Care & Education in Short Term EOC	98.9%	98 %		96 %	97.1%	94 %	95.7%	63.4%	65.8%

<b>Preventing Unplanned Hospital Care</b>		<b>You</b>			<b>State (NY)</b>		<b>National</b>		<b>Your % Rank</b>	
SOC - You/SHP: 10/12 - 9/13 CMS EC: 10/12 - 9/13 CMS Hosp: 10/12 - 9/13		Actual	CMS	Projected	CMS	SHP	CMS	SHP	CMS	SHP
Note: In this section, lower scores are better.										
21	Emergent Care without Hospitalization (60-Day)		11 %		10 %		12 %		62.7%	
22	Hospitalization (60-Day)	17.4%	17 %	16.7%	17 %	14.9%	16 %	15.3%	39.3%	41.9%

<b>HHCAPHS</b>		<b>You</b>		<b>State (NY)</b>		<b>National</b>		<b>Your % Rank</b>	
Sample Months - You/SHP: 10/12 - 9/13 CMS: 10/12 - 9/13		Actual	CMS	CMS	SHP	CMS	SHP	CMS	SHP
23	Composite 1: Care of Patients	91.3%	91 %	85 %	85.6%	88 %	88.6%	73.7%	77.6%
24	Composite 2: Communications	89.2%	89 %	83 %	83.0%	85 %	85.7%	76.7%	80.7%
25	Composite 3: Specific Care Issues	85.5%	91 %	83 %	84.2%	84 %	85.2%	64.8%	54.0%
26	Universal 1: % who Rated Agency 9 or 10	87.7%	88 %	79 %	78.4%	84 %	82.8%	70.7%	78.1%
27	Universal 2: % who would Recommend Agency	87.2%	88 %	75 %	74.7%	79 %	79.0%	85.5%	86.5%

- Outcome Measure
- Process Measure (not subject to risk adjustment)

Note, hyphens indicate data not available.

Italicized scores are CMS closest match.

Your Percentile Ranking (Click to view reference percentiles)

<10%	10% - 20%	20% - 40%	40% - 60%	60% - 80%	80% - 90%	>90%
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Your % Rank - Ranks your actual (risk adjusted/projected where applicable) against the CMS and SHP populations.

Additional information about this report is available at:

[https://secure.shpdata.com/download/shpuniversity/documents/report\\_user\\_guides/Home-Health-Compare-2013-User-Guide.pdf](https://secure.shpdata.com/download/shpuniversity/documents/report_user_guides/Home-Health-Compare-2013-User-Guide.pdf)

## UTILIZATION REVIEW

### **2013 Overview of the Utilization Review Committee**

The Utilization Review Committee of Warren County Health Services held quarterly meetings during the year 2013. The meetings were held March 14<sup>th</sup>, July 31<sup>st</sup>, October 17<sup>th</sup> and December 19<sup>th</sup>.

The numbers of patient records reviewed were 10, 13, 13, and 12 respectively, giving a total of 48 patient records reviewed during the year 2013.

The number of patients on the active roster on the last working day of 2013 was 489, with a breakdown as follows: CHHA – 410 (SN-236, PT/OT-37, and EI/CPSE-137); LTC – 37 and PCA – 42.

### **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  
Staff Nurses  
Physical Therapy Contractor  
Occupational Therapy Contractor

### **Breakdown of Charts Reviewed:**

Number Active	46	Number CHHA	44
Number Discharged	2	Number LTC	4

**Method of Record Selection:** For all meetings during the year 2013, the records chosen were a random selection of patients admitted 3-4 months prior to each meeting. The random selected patients covered all services provided by the agency : SN, PT, OT, MSW, RD, HHA, PCA- IV Therapy, and Telehealth.

**Summary of Utilization of Services:**

Adequate Utilization	48
Overutilization	0
Underutilization	0
Inadequate Information	0
Unable to Decide	0

All records reviewed indicated all services identified were provided and that all care was appropriate.

**CERTIFIED HEALTH CARE AGENCY and LONG TERM HOME HEALTH CARE PROGRAM**  
**SERVICES BY THE NUMBERS**

**Certified Home Health Agency**

VISITS BY DISCIPLINE

Services	2012	2013	2013/2012 % (+ or -)
Nursing	15,343	16,678	9%
Physical Therapy	6,991	6,958	0%
Occupational Therapy	557	579	4%
Speech Therapy	109	38	-65%
Medical Social Worker	100	73	-27%
Nutrition	37	19	-49%
Home Health Aide	3,108	3,243	4%
<b>TOTALS</b>	<b>26,245</b>	<b>27,588</b>	<b>5%</b>

**Long Term Home Health Care Program**

Visits by Discipline

Services	2012	2013	2013/2012 % (+ or -)
Nursing	2,715	2,166	-20%
Physical Therapy	1,028	904	-12%
Occupational Therapy	143	165	15%
Speech Therapy	0	0	0%
Medical Social Worker	105	45	-57%
Nutrition	3	0	-100%
Home Health Aide	2,149	2,202	2%
Personal Care Aide	7,308	7,056	-3%
Respiratory Therapy	26	31	19%
<b>TOTALS</b>	<b>13,477</b>	<b>12,569</b>	<b>-7%</b>

**EVALUATIONS BY DISCIPLINES  
CHHA and LTHHCP**

	2012	2013
Nursing	1590	1619
IV	92	79
Physical Therapy	1096	1071
Occupational Therapy	67	91
Speech Therapy	18	7
Nutrition	8	8
CDPAP	130	110
PRI	114	123
Telehealth	119	121
<b>TOTALS</b>	<b>3199</b>	<b>3229</b>

**Unduplicated Patient Count:** 1980

**Episodes of Medicare Care:**

- 2013 1096 episodes
- 2012 1116 episodes
- 2011 1000 episode
- 2010 1045 episodes

Traditional Medicare was 53% of our business for 2013. Medicare reimburses the agency not by per visit (Fee for Service) 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. Traditional Medicaid comprised 7% of our revenue.

Commercial insurance comprised 40% of our 2013 revenue. Commercial Insurances also include Managed Medicare and Managed Medicaid contracts that reimburse either by episodic rate or per pre negotiated Fee for Service rate. Managed Medicare was 23%, Managed Medicaid was 3% and all other commercial payers were 14%. It is expected that with the transition of the LTHHCP and with the MRT movement that the Managed Medicare % will increase over the next 2-3 years.

Medicaid was reimbursing per visit up to May 1, 2012. New York State's Medicaid Redesign Team (MRT) changed the previous Fee for Service payment as we knew it to an Episodic Rate System (EPS) similar to the Medicare PPS. In 2013 Medicaid was 7% of our CHHA revenue. With the transition to EPS payment system there was a 40% decrease in revenue per visit when a Medicaid episode of care is less than 5 visits in a 60 day episode.

## **LONG TERM HOME HEALTH CARE PROGRAM (LTHHCP)**

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.

	<b>2012</b>	<b>2013</b>
Number of active patients as of 12/31	38	34
New Admissions	14	9
Number of Discharges	10	13



## **MEDICAID REFORM MOVEMENT**

New York States appointed Medicaid Reform Team movement is impacting the delivery of care for all Medicaid funded programs. One of the many goals for the Medicaid Reform is to transition all Medicaid recipients to a Managed Medicaid environment such a Managed Long Term Care Company (MLTC). One program that will be transitioned to the MLTC arena is the Long Term Home Health Care Program throughout New York State. The transition of this population affected our agency with the transition of all straight Medicaid clients In the LTHHCP. This transition was started in August 2013 and was completed in October 2013. This client is still receiving services from our agency as we have a contract with the MLTC to be the provider for the skilled care that this client requires.

Warren County has 2 MLTC's that are accepting clients in our region. They are Fidelis and United Health Care. WCHS has contracts with both MLTC's to be the provider for the authorized skilled care that the clients will need when all patients are transitioned out of the LTHHCP. It is our goal that we will be chosen as the provider based on our experience in managing the LTHHCP for over the past 20 plus years. The dually eligible client's transition will be mandated in Warren County sometime in 2014.

The Long Term Care Home Health Program as we know it will be phased out by 2015 in our geographic region. All present LTHHCP clients will be transitioned to a MLTC program. In the future all clients needing this type of care will be offered to choose a MLTC to join. The MLTC will either have staff to provide the skilled care needed or they will contract with an agency to be the provider. We have positioned the agency to be able to be the provider for these clients care.

## **UNIFORM ASSESSMENT SYSTEM for NEW YORK STATE**

The Need Assessments and the types and processes that were required for Medicaid funded programs 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 was mandated to begin July 2103. WCHS, being in the Pilot Program, was one of a very few agencies' that continued to implement all of the UAS-NY deadlines on time. At the end of 2013 we had fully integrated the process within our CHHA needs assessment team.

## **REVENUES AND EXPENDITURES for CHHA & LTHHCP**

	2012	2013
Revenues	<b>\$5,070,134</b>	<b>\$4,991,167</b>
Expenditures	\$5,218,142	\$5,345,842
Net (Loss)	<b>(148,008)</b>	<b>(\$354,675)</b>

**REVENUES AND EXPENDITURES for CHHA & LTHHCP continued**

In 2013 expenditures increased due in part to an increase in contract and retirement expenses, per diem nursing staffing to cover temporary vacant nursing positions. There was an increase of 5.97% in fringe benefits. These benefits include Retirement, Social Security, Medicare withholdings, hospitalization (for both employees and retirees) and dental insurances. It should also be noted that the rent charged to CHHA and LTC went up \$21,421 or 44.97% in 2013. Due to the age of our current vehicle fleet our Board approved \$141,594 for the purchase of 10 new vehicles in 2013.

**2013 Report of Visits by Town**

<b>Town</b>	<b>Total Visits</b>	<b>%</b>
Adirondack	144	0.26%
Athol	484	0.88%
Bakers Mills	50	0.09%
Bolton Landing	699	1.27%
Brant Lake	537	0.98%
Chestertown	1,854	3.38%
Cleverdale	62	0.11%
Diamond Point	323	0.58%
Fort Ann	79	0.14%
Glens Falls	14,180	25.83%
Hadley	49	0.09%
Hague	464	0.85%
Hudson Falls	17	0.03%
Johnsburg	846	1.54%
Kattskill Bay	9	0.02%
Lake George	3,876	7.06%
Lake Luzerne	954	1.74%
Minerva	19	0.03%
North Creek	3,221	5.87%
North River	46	0.08%
Olmstedville	125	0.23%
Pottersville	1,066	1.94%
Queensbury	18,107	32.99%
Riparius	91	0.17%
Schroon Lake	2	0.00%
Silver Bay	84	0.15%
Stony Creek	723	1.32%
Warrensburg	6,507	11.85%
Wevertown	260	0.47%
<b>Grand Total</b>	<b>54,892</b>	

## **HOME CARE GOALS FOR 2014**

- ◆ Continue to support the Care Transition Initiatives
- ◆ 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 guiding them in managing their health

*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
2009	642	504 (12 sets of twins)	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
2013	602	482 (9 twins)	471 (104 Primary CS) (54 Repeat CS)	23	333	31	5.1%

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 2013, referrals were received on 16 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 2009	54
2010	32
2011	70
2012	41
2013	47

**LACTATION COUNSELING PROGRAM**

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.

	<b>Postpartum Clients Referred</b>	<b>Referred Clients That Were Breastfeeding</b>	<b>Percentage of Breastfeeding Moms</b>
2009	490	361	74%
2010	479	353	74%
2011	473	374	79%
2012	477	388	81%
2013	471	374	79%

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 prenatal program are received by medical care providers and pregnant women 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. The coordinator of the client's health supportive services (HSS), must work closely with the 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 medical provider in the medical provider's office while the HSS will be provided by maternal child health nurses in the client's home or on-site at the Public Health office.

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.

**Program Goal:** To target smoking in prenatal clients and offered referral to smoking cessation program. Mental health assessment for Depression is also in place. The maternal child health nurses have worked hard to develop assessment plans, care plans, and community plans to address and assist clients that smoke. Warren County's Community Health Improvement plan 2013-2017 will address chronic disease and mental health

PRENATAL PROGRAM DATA

	CLIENTS REFERRED (UNDUPLICATED COUNT)	PRENATAL HOME VISITS MADE	TOTAL BIRTHS	TEEN PREGNANCY TRENDS (ENDING IN LIVE BIRTHS) <18YRS OLD
2009	147	193	643	8
2010	141	170	600	10
2011	175	121	598	11
2012	100	91	577	14
2013	67	61	602	9

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 3 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
2013	8 (4 2-day/4 5-week)	32

## Women, Infant and Children Nutrition Program (WIC)

The Warren County WIC Program is sponsored by the Warren County Health Services (WCHS). Our program maintains eight full-time and one part-time staff. Resignation of a Grade 5 position prompted a promotional opportunity for a Grade 3 position to a Grade 5 position and elimination of the Grade 3 position. This promotion has allowed cross training among three staff who share clerical and programmatic duties more proficiently.

WIC clinics are held at the Municipal Center and nine off-sites located in Glens Falls, Queensbury, Lake Luzerne, Warrensburg, North Creek and Horicon. Hours of operation include early morning, early evening and lunchtime appointments. Enrollment in 2013 was 1,365 participants.

Site	Site Participant Average	% of Total Participant Average
Main Site – Warren County Municipal Center	231	17
First Baptist Church – Glens Falls	268	20
Village Green Apartments – Glens Falls	193	14
VFW Post #6169 – Queensbury	237	17
Montcalm Apartments – Queensbury	83	7
Lake Luzerne Community Center – Lake Luzerne	73	5
Cornell Cooperative Extension – Warrensburg	139	10
North Creek Fire House – North Creek	61	4
Horicon Community Center – Brant Lake	80	6
	1365	100%

WIC supports breastfeeding as the primary source of nourishment for children birth to one year old. A newly hired Infant Feeding Advocate continued with the Breastfeeding Support group offered one time per month at the Main site. WIC mothers who initiated breastfeeding increased slightly to 71%; compared to 66.6% for the Capital Region and 76.2% statewide. Eighteen breastfeeding women were issued WIC funded breast pumps which allowed them to return to work after child birth.

Our office works collaboratively with the WCHS Maternal-Child Health Program, United Health, Fidelis Cares, SNAP, Eat Smart NY, and the Warren-Washington County Head Start Program. All of these agencies attend WIC clinics as supportive community resources. The Maternal-Child Health Program promotes the MOMs Program, Child-Find and childbirth classes. United Health and Fidelis Cares, both Warren County Managed Care Medicaid insurance companies, initiated navigational services for the Affordable Care Act. These services have allowed WIC participants with a seamless application process. A Capital Region Food Bank representative also offers assistance to WIC participants for SNAP applications during scheduled clinics. Access to these essential services allows “one-stop shopping” - saving time, money and transportation for participants with limited resources. WIC also offers a confidential setting to SUNY Adirondack, Empire State College and Russell Sage College nursing students completing their Maternal-Child rotation requirements. Warren County WIC also participated in the 2013 Community Day and the 2013 Village Green Health Fair.

### **Warren County WIC is 100% fully funded by the USDA and New York State. The threat of the government shutdown risked the closure of WIC in October 2013 compelling local agencies to plan for participant waiting lists and staff layoffs.**

The Warren County WIC administrative budget for 2013 totaled \$508,270.41 with actual expenditures totaling \$454,906.67. WIC contributed \$31,001 to Warren County for indirect costs. The redemption value of WIC benefits provided to Warren County participants was \$860,888.88 compared to \$958,476.09 in 2012. The NYS Department of Agriculture and Market did not provide the NYS DOH with the annual Farmers' Market Nutrition Program Local Agency and Redemption 2013 Report; however, did indicate the statewide redemption rate increased from 56.8% in 2012 to 58.7% in 2013. As a local WIC agency, designated staff participated in area Farmer's Markets to promote WIC participation

## 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
2009	126
2010	125
2011	109
2012	88
2013	72

## **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

	2009	2010	2011	2012	2013
Referrals Received	155	154	203	199	194
Children Served	276	262	285	281	260
Dollars Received From NYS	353,661.81	336,770.58	193,997.81	\$200,804.41	\$185,543.79
Dollars Received From Medicaid	404,857.26	268,832.58	404,557.15	353,251.57	\$169,817.40
Dollars Received From Private Insurance	39,519.56	24,769.92	19,148.24	33,708.25	\$29,127.02
Costs Before Reimbursement	1,201,449.71	946,876.91	988,424.39	\$955,941.68	\$761,964.28
Amount Appropriated (In budget, amended numbers)	1,238,362.00	1,307,867.96	1,338,749.92	1,244,999.38	1,176,287.58
Expenditures For County After Reimbursement Received	403,411.08	316,503.83	370,721.19	368,177.45	\$377,476.07
Average Cost to County Per Child Served	1,461.63	1,208.03	1,300.77	1,310.24	\$1,451.83
Births in County	643	600	598	577	602

Note: Effective 4/1/13, the State established an EI Escrow account to directly pay vendors within EI after they are paid first by Medicaid and insurances. Expenses will now reflect only the net amount paid from this Escrow account, therefore less expense to the county. This system has taken over a year to properly work correctly. During this time, Medicaid and insurance payments came in slower than in previous years and State reimbursement is also lower since it correlates with expenses paid.

The cost per child has gone up basically due to the cash flow during 2013 and the drop in children served (by 7.5%). During 2013, there were many children evaluated, however did not qualify for EI services at that time. Cash received was not as high as it should have been due to the new escrow system, therefore skewing the actual cost per child. The cost per child served will vary depending upon the reimbursement potential for each individual. Dollars received are based on actual cash in for the year, not revenues booked.

## **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 2009-2010	SCHOOL YEAR 2010-2011	SCHOOL YEAR 2011-2012	SCHOOL YEAR 2012-2013
All Children Served	370	353	292	226
Evaluations Only	78	89	75	51
Tuition Program/Evaluations Costs Approved	\$2,990,227.47	\$2,441,577.18	\$2,112,857.94	\$2,061,049.72
Tuition Program/Evaluations Costs Paid in 2013	\$2,991,733.97	\$2,539,102.34	\$2,160,955.39	\$1,711,727.01
Transportation Costs Approved	\$773,763.30	\$647,099.55	\$416,672.74	\$406,193.57
Transportation Costs Paid in 2013	\$772,256.80	\$689,913.49	\$420,283.30	\$370,003.74
Average Cost Per Child Before Reimbursement	\$10,172.95	\$9,147.35	\$8,839.85	\$9211.20
Amount of Medicaid Received in 2013	\$0.00	\$11,262.11	\$21,673.58	\$176,073.94
Amount State Aid Received in 2013	\$2,631,959.85	\$1,102,852.25	\$2,135,454.97	\$943,599.30
Administrative Costs to Schools Received in 2013	\$45,638.82	\$105,296.85	\$53,250	\$90,060
Administrative Costs Paid to School Districts in 2013	\$76,703.94	\$125,667	\$60,857	\$146,476
Program Costs After Reimbursement	\$1,132,030.92	\$2,114,901.47	\$424,110.14	\$962,057.50
Average Cost Per Child After Reimbursement	\$3,059.54	\$5,991.22	\$1,452.43	\$4,256.89

**\*Source: General Ledger/Accounts Payable Reports and Budget Performance Report, 1/1/13 - 12/31/13.**

Medicaid reimbursements for 2013 were \$ 176,073.94. This was our first full year in two years that the state has allowed us to again bill Medicaid. As you see, we have diligently worked to bill Medicaid for those children that were eligible. This amount however does reduce the amount that the state will need to reimburse the county, therefore you will notice less State reimbursement was received.

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, and Transportation. The cost per child is somewhat skewed due to the fact that the calculation is based on cash in/cash out for the year. In 2013, program costs per child after reimbursement was \$4,256.89 which is more consistent with previous years, however, in 2012 it was much lower due to the fact cash flow during the year was good and we served more children. In 2013 we served 226 children (decrease of 22.60%). Fewer children have qualified for tuition based programs and more have been working with therapy sessions, therefore reducing costs.

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	School Year 2012-2013
Abe Wing	20	18	17	9	15
Bolton	2	4	4	0	0
GF City	110	83	84	57	58
Hadley Luzerne	18	20	18	12	14
Johnsburg	13	7	7	4	6
Lake George	15	17	15	12	13
No. Warren	18	18	15	13	19
Queensbury	90	98	87	81	80
Warrensburg	43	27	18	27	21

Administrative Costs Paid to School Districts During 2013*		
	09/10 School Year Paid 2011/2012	10/11 School Year Paid 2013
Bolton	\$3,269	\$2,420
GFCity	\$13,139	\$43,116
GF Common	\$6,178	\$9,196
Hadley Luzerne	\$8,406	\$10,164
Johnsburg	\$3,736	\$5,808
Lake George	\$0	\$8,712
Queensbury	\$51,410	\$53,992
Warrensburg	\$0	\$13,068
<b>TOTAL</b>	<b>\$86,138</b>	<b>\$146,476</b>

Rate Reconciliations**	2012	2013
Paid Out to Providers	\$51,056	\$40,188
Received from Providers	\$26,609	\$23,547

Budget Appropriation for Contractual Services (Amended Budget)	
2009	\$4,676,782
2010	\$5,151,575
2011	\$5,159,880
2012	\$4,720,000
2013	\$4,096,008

\*Administrative Costs paid in 2013 to school districts for the 2010-11 school year totaled \$146,476. All were paid January 2013. Not all school districts submit administrative costs to the New York State Education Department for reimbursement approval, however more and more have recently submitted vouchers for reimbursement from the counties. 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 10/11 SY it was \$146,476 which is \$60,338 or 70.05% increase from the previous school year.

\*\*Rate reconciliations recorded in 2013 are reflected above for school years 09/10 to 11/12.

Source: General Ledger and Accounts Payable reports from 1/1/13-12/31/13.

## **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**

Health Education programming in Warren County remains a popular and important resource for local schools, businesses, and community groups. The program continues to provide support to a variety of partners by providing print materials, classroom presentations, information seminars, technical assistance for groups developing health and wellness policies and statistical data for grant writers.

As required by New York State Department of Health, Warren County Health Services in cooperation with community partners completed an updated Community Health Assessment (CHA) and Community Health Improvement Plan (CHIP). The CHA provides data, statistics, and community overview to help Warren County Health Services identify strengths, weaknesses, gaps in services and vulnerable populations in the county. The CHIP provides a framework for addressing the gaps and weakness identified by the CHA. Health education will play an integral role in successful implementation of the CHIP.

### **2013 Activities**

#### **Community Health Assessment**

- Warren County Health Services in partnership with Adirondack Health Institute, Glens Falls Hospital, and the Community Health Assessment Workgroup completed an updated Community Health Assessment for Warren County. This document will be used to help identify health topics that health education can work to improve.
- Along with a Community Health Assessment Warren County Health Services completed a Community Health Improvement Plan that identifies two priority areas that Warren County Health Services including Health Education and community partners will work together to try and improve.
- A Community Health Improvement Plan workgroup has been established to set goals, objectives, evaluation methods and corrective action plans to address the priority areas identified in the CHIP.
- Sixteen meetings were held during the development and completion of the CHIP. For more CHA or CHIP information contact Dan Durkee [durkeed@warrencountyny.gov](mailto:durkeed@warrencountyny.gov) or 761-6584.

#### **Program News**

- Requests for programming from local elementary schools and Head Start programs remain strong. The number of contacts among students was down from the year before, but several factors are contributing to the decline. They include new mandates being forced onto schools and a lack of time for the health educator to provide programming.
- Maternal Child Health nurses have begun the implementation of an education and referral program for new parent that use tobacco. The program educates parents on the dangers of secondhand smoke to children. The program provides tip and resources to help parents reduce their child's exposure to secondhand smoke and also refers parents to the NYS Smokers Quitline.
- Began planning for programs that will help Warren County Health Services meet the goals and objectives set forth in the Community Health Improvement Plan. The priority areas include
  - Access to high quality chronic disease preventive care and management in both clinical and community settings,
  - Promote mental, emotional and behavioral health (MEB).

#### **Community Events**

- Health education provided materials and staff at 10 community events. Topics included fall prevention, ticks and Lyme disease information, the role of Public Health today and several other topics. No formal evaluations were completed.

**Trainings/Conferences**

- Attended a one day conference hosted by the New York State Cancer Consortium. Became a registered member of Consortium in September 2013 after attending the conference.

**Networking**

- Worked with Adirondack Health Institute, and the regional Community Health Assessment workgroup to complete the updated Warren County Community Health Assessment.
- Convened the Warren County CHIP workgroup which was tasked with identifying two priority areas that would be used to focus resources to address needs identified by the workgroup.

**Worksite Wellness**

- Established a formal Warren County Employee worksite wellness committee. The committee was established by resolution by The Warren County Board of Supervisors.
- Committee participants were assigned and the committee developed a document that stated the visions, mission, goals and objectives of the workgroup.
- Partnered with the County insurance carrier Blue Shield of NENY and Capital Financial to gather claims data and provide guidance that could be used for evaluation of the Committee’s impact on Worksite Wellness among County employees.
- Conducted a health fair in October with over 120 employees participating.
- Began planning for a regular Lunch and Learn program for employees where they could gather health information from guest speakers during their lunch break.

**Miscellaneous**

- Provided print materials to target groups during different Health Observances (e.g. fall prevention materials to senior groups, posters, brochures etc. to providers offices). Met with news organizations occasionally to provide information about specific health topics.
- Sent PSA’s/news releases to local print media to promote community events or to raise awareness of specific health topics.

**PRESCHOOL ELEMENTARY and ADOLESCENT PROGRAMS**

Program	Attendance '09	Attendance '10	Attendance '11	Attendance '12	Attendance '13
Dental Health	235	644	320	825	548
Nutrition	714	868	852	464	694
Injury Prevention	182	572	567	949	526
Hand Washing/Hygiene	905	653	826	651	599
Exercise/Heart Health	679	251	391	725	626
Sun Safety	342	542	528	831	391
Poison Prevention	209	169	61	583	485
Tobacco Education	703	705	799	751	915
Ticks & Lyme Disease	50	350	285	65	275

Rabies Awareness	0	0	424	0	0
HIV/AIDS	125	293	248	233	189
Flu/H1N1	426	0	0	285	0
TOTAL	4570	5047	5301	6362	5248

#### ADULTS, PARENTS and SENIORS PROGRAMS

Program	Attendance '09	Attendance '10	Attendance '11	Attendance '12	Attendance '13
CPR/First Aid	141	116	130	102	59
School Nurse Training	30	32	45	48	43
Blood Borne Pathogens Training	112	40	46	40	51
Employee Training/Defensive Driving	0	112	22	126	NA*
Senior Health/Fall Prevention	10	50	36	140	25
Flu/H1N1	45	0	0	0	0
Community Programs	*	336	240	50	86
TOTAL	338	686	519	506	264

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

\*Defensive driving program for employees was assumed by Needham Safety Consultant as part of cost saving measures.

#### 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
Southern Adirondack Tobacco Free Coalition	Warren/Hamilton Counties Office for the Aging	

(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.

Lyme Disease: Conducted tick and Lyme disease education for the Upstate Search and Rescuer Volunteers. Provided materials and education at two community health fairs. Gave away over 100 tick removers and provided information to several pediatric offices and worksites in Warren County.

Hypothermia: Conducted a health and safety program about hypothermia to 250 elementary school children (5<sup>th</sup> and 6<sup>th</sup> 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. Provided blood-borne pathogens training to 50 Home Health Aides as part of their yearly required training.

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. Nine hundred fifteen fourth and fifth grade students attended the program. 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.

Conducted a tobacco outreach program at a High School Health Fair. Over one hundred students visited the display and asked questions or took information

Warren County Employee Wellness Program: Conducted the fifth annual Employee Wellness “Biggest Loser” team competition. Thirteen teams and 35 employees participated in the 8 week program. 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 2012 meeting. Attendance was over to forty people (not including county staff). Topics covered during this year’s program included new drugs of abuse, sex education curriculum, and yearly updates. There were several 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](mailto:durkeed@warrencountyny.gov)

## **LEAD POISONING PREVENTION PROGRAM**

Warren County has a Lead Poisoning Prevention Program funded by a NYSDOH \$21,906 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	2009	2010	2011	2012	2013
<10mcg/dl	964	934	1039	964	827
10-14mcd/gl	4	5	3	2	3
15-19mcg/dl	0	1	1	0	0
20-25mcg/dl	0	0	3	0	0
>25mcg/dl	1	1	0	0	0
TOTAL ELEVATED RESULTS	5	7	7	2	3

(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	2009	2010	2011	2012	2013		DISEASE ENTITY	2009	2010	2011	2012	2013
Amebiasis	0	0	0	0	0		Influenza, B	15	0	13	5	39
Anaplasmosis	0	0	0	3	0		Influenza, unspecified	0	0	0	0	1
Babesiosis	0	0	1	0	0		Influenza (Haemophilus) Invasive B	0	0	0	1	0
Brucellosis	1	0	0	0	0		Influenzae (Haemophilus) Invasive not Type B	0	0	2	0	1
Campylobacteriosis	5	6	8	9	9		Legionellosis	1	1	2	0	1
Chlamydia	139	160	188	176	195		Listeriosis	1	0	0	0	0
Cryptosporidiosis	1	0	0	0	1		Lyme Disease	103	45	25	45	100
Dengue Fever	0	0	0	1	0		Ticks Tested/Confirmed Deer Ticks	142/135	81/77	39/38	0	0
E. Coli	2	0	0	0	3		Meningitis (bacterial)	0	0	1	0	0

DISEASE ENTITY	2009	2010	2011	2012	2013	DISEASE ENTITY	2009	2010	2011	2012	2013
EHEC (not serogrouped)	0	0	0	0	0	Meningitis (viral)	0	0	0	0	0
Giardiasis	11	4	9	9	3	Mumps	0	0	0	0	0
Gonorrhoea	3	13	10	6	14	Pertussis	1	11	3	6	1
Haemophilus Influenzae Inv No	1	0	2	0	0	Salmonellosis	7	8	8	5	4
Hemolytic Uremic Syndrome	1	0	0	0	0	Shigellosis	0	0	1	0	1
Hepatitis C (acute)	0	0	0	0	0	Strep Pneumo Invasive Sensitive	0	9	0	5	3
Hepatitis C (chronic)	31	26	30	37	28	Strep Pneumo Invasive Drug Resistant	0	1	0	0	0
Hepatitis B (acute)	0	0	0	0	0	Syphilis, primary	0	0	0	0	0
Hepatitis B (chronic)	3	4	1	0	2	Syphilis, secondary	0	0	1	0	0
Hepatitis B (infant prenatal)	0	0	0	0	1	Syphilis, early latent	0	0	0	1	0
Influenza A	83	0	11	105	54	Syphilis, late latent	0	0	0	4	0
Strep Pneumo Invasive Intermed	4	0	1	0	0	Syphilis, unknown latent	0	0	0	0	0
Strep Pneumo Invasive, unknown	1	0	2	1	1	Swine - Origin Influenza	15	1	0	2	0
Strep Pneumo Invasive, sensitive	4	0	5	0	3	Toxic Shock Syndrome	0	0	1	0	0
Streptococcus Pneumoniae (Unknown)	0	0	0	0	1	Tuberculosis	0	1	0	0	0
Strep Group A Invasive	0	8	1	1	2	Yersiniosis	1	0	1	0	
Strep Group B Invasive	5	6	7	7	6						
Strep Group B Invasive, early	0	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 2013

Town	Not Vaccinated			Vaccinated			Out of Town			Stray		
	Cats	Dogs	Ferrets	Cats	Dogs	Ferrets	Cats	Dogs	Ferrets	Cats	Dogs	Ferrets
Bolton	1	2		3	10							
Chester	2	1			6							
Glens Falls	7	13		4	17			5		2	3	
Hague					1					1		
Horicon	1	1			1							
Johnsburg		3		2	1			1				
Lake George	4	2	1 (pig)	1	12			1		1		
Lake Luzerne	1	1		2	2			1				
Queensbury	5	14	1	11	47		6	5		3		
Stony Creek												
Thurman												
Warrensburg	2	3	1 (llama)		8			2		1	2	
TOTALS	23	40	3	24	110	0	6	15	0	8	5	0

### BITES REPORTED BY MONTH

	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Total
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
2013	18	15	15	19	19	25	23	26	18	22	16	18	234

## RABIES STATISTICS

	2009	2010	2011	2012	2013
Confirmed Rabid Animals	2 skunks 1 fox	1 raccoon 1 fox	0	1 cat 1 bat	1 cat 1 fox 2 raccoon
Animal Specimens Submitted for Testing	54	37	28	45	30
Animal Bites	256	218	208	224	234
Patients Receiving <u>Pre-Exp. Vac.</u> (3 Injections) or <u>Booster Vacc.</u> Fee: \$203.00/Dose	3 Titers Drawn: 0	6 Titers Drawn: 0	8	3	4 Titers Drawn 8
Patients Receiving <u>Post-Exp. Vac. Series @ GF Hosp.</u> (All RIG and First Injections are Given at GF Hospital)	30	34	13	28	31
Patients Receiving <u>Post-Exp. Vac. Series @ P. Health</u> (All RIG and First Injections are Given at GF Hospital)	4	4	1	1	5
<b>Animal Clinics</b>	<b>21</b>	<b>22</b>	<b>23</b>	<b>22</b>	<b>22</b>
<b>Animals Receiving Rabies Vaccinations</b>	<b>834</b>	<b>944</b>	<b>787</b>	<b>1130</b>	<b>905</b>

Expenses paid in relation to Rabies Program: \$28,378.99

Amount vouchered to New York State: \$19,705.36

Rabies Clinic Revenue: \$8,386.00

Total program cost to Warren County: \$287.63

Note: Data above reflects actual expenses incurred and both actual cash received at clinics and amounts vouchered to the State during 2013. We were able to offset 82.42% of clinic costs with donations received during those clinics. Unfortunately the grant funding was maximized for both animal testing and human vaccines, therefore the difference of \$287.63 remains a cost to the county. Rabies expenses increased 16% in 2013 however the impact to the county decreased by 92%. We were able to also bill the state for COLA funds of \$1,432 towards offsetting excess Human Vaccine costs for the year. Primarily most of this cost to the county is related to actual Animal testing costs for the year.

## TUBERCULOSIS PROGRAM

PPD testing is offered by appointment to any Warren County resident requesting it on Monday, Tuesday, and Fridays. 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	
2009	\$60.61
2010	\$39.89
2011	\$ 0.00
2012	\$ 0.00
2013	\$ 0.00

YEAR	INDIVIDUALS TESTED	POSITIVE CONVERTERS	ACTIVE TB CLIENTS DURING YEAR
2009	235	8	0
2010	217	1	1
2011	164	1	0
2012	175	0	0
2013	136	2	0

2013: No active cases.

**Warren/Washington County's STD Clinic Report 2013**

The number of people attending the clinic in 2013 indicates a serious decline from previous years. Even though the numbers of persons attending is less, the number of positive cases of chlamydia is basically unchanged and our numbers of syphilis cases reflects the statewide increase.

We attribute the attendance numbers to the fact that STD testing is more readily available at health facilities throughout the area, not that there is less sexually transmitted disease. The numbers of positive cases remains the same, in spite of fewer people tested.

We continue to send our tests for syphilis to NYS Wadsworth lab for no charge. Our chlamydia/gonorrhea tests are done by GF Hospital for the Medicaid rate and our medications are bought through a State contract at a minimal cost to us.

We are moving forward with the State in determining how we can charge for our services without deterring client attendance. It remains to be seen how this can be accomplished and still maintain the confidentiality that our clients have come to expect. The insurance company, EOB, (explanation of benefits) is a serious barrier: however, we are in consultation with the NYSDOH and other counties as we consider this move.

**HIV and STD (SEXUALLY TRANSMITTED DISEASE) CLINIC**

	2009	2010	2011	2012	2013
Clinics Held	52	52	50	51	48
Participants	377	332	327	356	220
Males	249	222	230	239	162
Females	128	110	97	117	58
Age Range	14-69	14-72	15-86	15-86	17-87
HIV Test Only Done	41	40	40	43	14
STD Test Only Done	83	77	51	70	43
STD & HIV Test Done	193	187	204	188	133
HIV Not Tested*	17*	9		22	0
STD Phone Calls for Results	175	164	168	169	103
Warren Co. Participants	216	157	204	196	111
Washington Co. Participants	107	110	76	109	55
Saratoga Co. Participants	44	53	41	39	44
Other County Participants	10	11	6	12	10

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

**DISEASES WITH POSITIVE TEST RESULTS**

DISEASES	2009	2010	2011	2012	2013
Genital Herpes	9	4	0	4	4
Genital Warts	15	9	10	8	9
Chlamydia	20	23	20	24	21
Gonorrhea	1	0	0	1	0
Syphilis	0	0	0	3	2

## HUMAN IMMUNODEFICIENCY VIRUS (HIV)

Warren County Health Services continued to offer free Rapid HIV testing in 2013. Although Warren County Health services continues to work collaboratively with Washington County to provide HIV test counselors and space to provide testing services, both organizations now follow the new protocols regarding the sharing of tests and materials. The organizations now provide their own test kits and conduct the proper quality control procedures for those tests.

In an effort to better understand who utilizes the Rapid HIV testing program, Warren County updated a tracking log that is used by HIV test counselors during testing. The log helps gather basic demographic data such as gender, race, and sexual orientation, along with other risk behaviors that increase a person's chance of contracting HIV. The information is not linked to names, but is provided to NYSDOH and is utilized to improve outreach efforts. This data also allows Warren County to receive free Rapid HIV test kits from NYSDOH. This data will allow us to compare year-to-year trends of the amount and types of clients we are seeing, and to identify gaps of populations that we are not seeing.

### Activities 2013

- Continued to recruit, train and utilize extra staff to cover HIV clinics on Tuesday nights.
- Continued tracking demographic data as part of the HIV testing program to be able to receive free HIV rapid test kits through NYSDOH, to identify trends and patterns among clients to be able to better meet their needs
- Due to federal government sequester, Ryan White funds were not available. The clinic costs were shared by Warren and Washington counties.

### Comments/Concerns:

- Ryan White funding was not available for 2013. Warren and Washington counties shared the costs evenly
- Overall attendance was significantly down, 220 in 2013 compared to 356 from 2012, a nearly 40% drop. Clients coming for STD and/or HIV testing also dropped nearly 30%.
- Multiple Hudson Headwater Health Network offices and Planned Parenthood offices are offering Rapid HIV Testing, and comments from clients indicated HHHN was also offering incentives for testing (\$5 Stewarts Gift Card)
- HIV Rapid Test by Oraquik became available over the counter

### 2013 Goal Progress

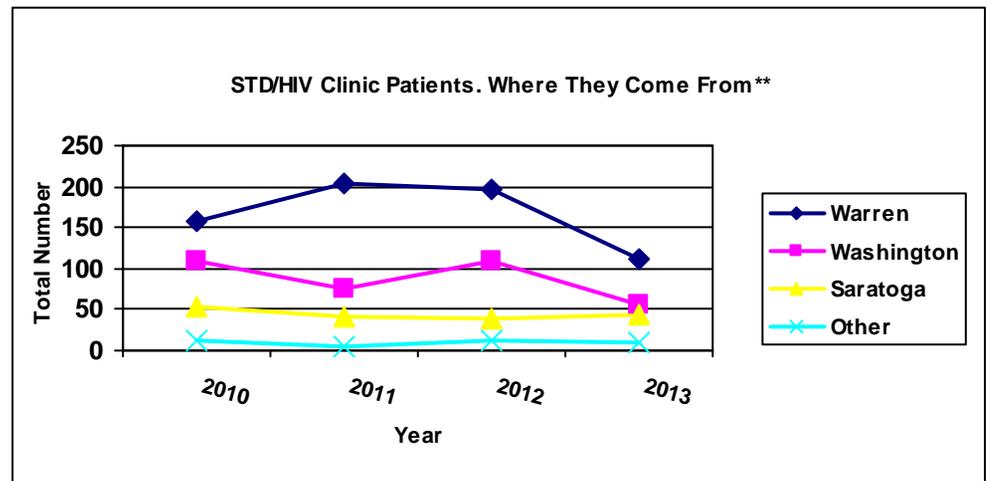
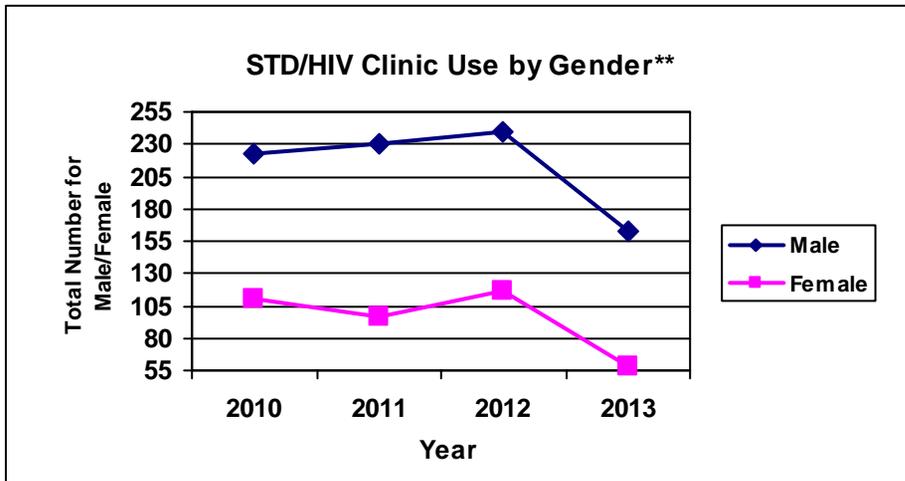
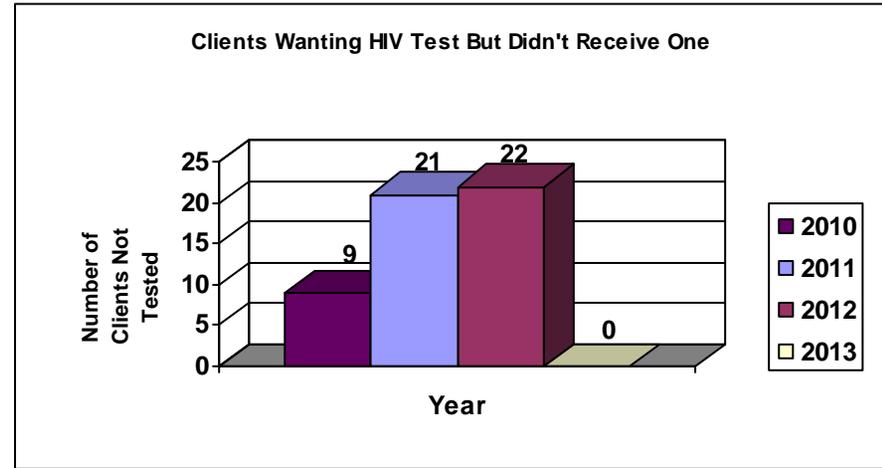
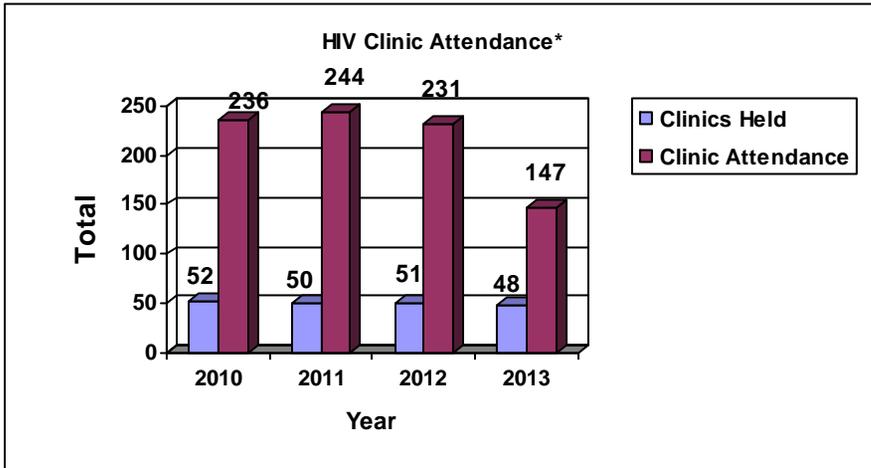
- Lost funding from Ryan White program due to Federal Budget Sequester
- Continued to analyze data about clients, identify target populations and population "gaps"
- The number of people who received STD testing but not HIV testing was 32%, reduced from about 37%, a 13.5% reduction, just shy of our target of 15%. It should be noted that the reason for declining HIV testing is not noted and may be due to the client having received HIV testing elsewhere.

### 2014 Goals/Outlook

- Seek to reestablish funding from the Ryan White Grant, and/or seek additional funding from other sources if possible
- 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](http://www.nyhealth.gov/diseases/aids).

### 2010 - 2013 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 PROGRAM**

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 Immunization Action Plan began a new 5 year plan covering years 2013-2018. NYSDOH, CDC and LHD partner in reaching specific goals. LHD's will have to meet accountability standards each year. Emphasis will be placed on increasing immunization rates in the county.

Specific required standards and activities will need to be carried out. Activities include the assessment of childhood, and teen vaccination rates at all pediatric offices including a follow-up and education meeting, assessment of adult provider vaccination rates, mandated educational programs to providers, health care workers, and to minority groups such as pregnant women and college students. Outreach to all county schools and daycares for assistance with the new amendments to PHL 2164 is also recommended.

Warren County Public Health continues to have ninety minute clinics three times a week. VFC for children under age 19 is available for those children who qualify. Families are encouraged to establish with a provider as soon as possible. Travel clinic is held once a week.

NYSDOH adult hepatitis program provides free vaccines for adults "at risk" of contracting hepatitis A or B, this is offered at the weekly STD/HIV Clinic.

Our goal is to increase vaccination rates across the life span, from infants to seniors, by providing vaccine education to the residents of Warren County. Table top programs, PSA's in newspapers and radio, as well as social media will also be utilized to meet the required NYSDOH activities.

## TRAVEL CLINIC

Travel clinic became operational four years ago in response to requests from the public for yellow fever vaccine. Proof of yellow fever (a WHO certificate) is a requirement for entrance into some countries. WCPH was given permission to begin the clinic with the understanding that it must be self-sufficient. One of our original rules (that clients must have a consultation with our doctor) has caused some unhappiness among prospective clients, but we have adhered to our original guidelines and have been self-sufficient since the inception.

We are able to administer yellow fever vaccine, typhoid fever vaccine and Japanese encephalitis vaccine only with an order from a physician. Some travel clinics do not have a doctor on staff and use a prescription from all clients. We find that the consultation with our doctor is valuable, not only for the order he can issue, but for the wealth of knowledge he possesses.

The clinic is held for two hours each week and is able to handles three appointments. Much of the financial success of the clinic is due to the fact that our physician does not require payment if there are no appointments for a clinic, and the nursing staff is equally flexible.

In order to lessen the problem with “no shows” we have instituted a reminder phone call, which has been successful. We also consider more advertising of the clinic to increase its use and revenue, but we plan to remain with the current structure for the coming year.

Summary of Travel Clinic - 2013

Quarter	COST	CHARGE	PROFIT/LOSS	TOTAL PATIENTS SEEN
1 <sup>st</sup>	\$4,863	\$4,015	<\$848>	18
2nd	\$5,084	\$5,232	\$ 148	25
3rd	\$5,045	\$5,873	\$ 828	21
4 <sup>th</sup>	\$3,825	\$4,261	\$436	16
Totals	\$18,817	\$19,381	\$564	80

## INFLUENZA CLINICS

The role that Public Health plays in administering influenza vaccine continues to be uncertain. In 2013 Warren County ordered 1800 doses of flu vaccine. When the season started we realized how slow the attendance at the flu clinics was going to be, so we reduced our order and accepted only 1000 doses.

This was a wise move, since we administered 900 doses. We held clinics at all of the senior meal sites as well as at all of the town halls. Publicized clinics were held at the Warren County Public Health office throughout the flu season.

The attendance at all of these clinics has declined steadily over the past several years as the medical providers and the pharmacies have become more involved with administering flu vaccine. The challenge to Public Health is to know how much vaccine to have available, how much staff to schedule for clinics and exactly what is the role of public health in the changing world of vaccines.

For the 2014 season, we decided to order the “high-dose” flu vaccine to administer to people over age 65. We read the research that determined that it was more effective than the trivalent flu vaccine for senior citizens.

Our goal for the 2014-2015 is to encourage higher rates of influenza vaccine, regardless of where it is obtained and to promote the use of the Immunization registry (NYSIIS) by all parties involved.

### INFLUENZA VACCINE ADMINISTRATION

	2008	2009	2010	2011	2012	2013
Clinics Offered Throughout the County	51	23	22	24	35	30
Vaccine Doses Administered at Clinics	2952	2311	732	904	875	646
CHHA/Long Term Home Visits For Administration	101	81	33	63	42	47
Homebound Visits For Administration	9	9	7	0	5	7
Miscellaneous Administration i.e. PH Appointments And Other Home Visits	232	311	951	365	967	311
Total Doses Administered	3294	2712	1723	1332	1889	1011

## **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.

<b>BP Clinic Site</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>	<b>2012</b>	<b>2013</b>
<b>Bolton Meal Site</b>	51	62	63	67	46
<b>Chester Meal Site</b>	59	45	87	96	65
<b>Cronin HighRise</b>	104	91	105	92	93
<b>Johnsburg</b>	80	83	113	95	106
<b>L.Luzerne Meal Site</b>	108	105	133	109	135
<b>Presb. Church (GF)</b>	76	77	64	79	63
<b>Queensbury Center</b>	101	78	98	114	134
<b>Solomon Heights</b>	91	82	94	73	74
<b>Stichman Towers</b>	52	60	48	51	67
<b>Warrensburg</b>	88	78	80	84	55
<b>TOTALS:</b>	<b>810</b>	<b>761</b>	<b>885</b>	<b>860</b>	<b>838</b>

## EAST SIDE CENTER OF WARREN WASHINGTON COUNTIES MENTAL HEALTH ASSOCIATION

Warren County Public Health Nurses are an integral part of the schedule of the participants of East Side Center.

Each Friday, a public health nurse from Warren County goes to the Center to meet with clients, to talk with them individually, to take their blood pressures and to weigh them. The professional relationship between the nurses and the clients is beautiful and very rewarding to the nurses. Some of the clients have a weight problem and try very hard to see their weight decrease and thus, to please the nurse. Others have blood pressure concerns and rely on the nurse to advise them and to encourage that they take medication as prescribed. The nurses have been an asset to the staff at the Center on several occasions, when they had a medical event.

The nurses see between 10 – 15 clients each week and are pleased that the Center values their visits so much that they are willing to help contribute to their costs to Warren County.

### 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.

2013 UR Committee members:

Thank you all for your participation and dedication to Public Health

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

QUALITY ASSURANCE

Charts Reviewed in 2013

Meeting Date	MOMS	MCH	Synagis	Child Find	Other Health Supervision
03/13/13	<b>No meeting in March</b>				
06/12/13	4	9	0	0	3
09/11/13	2	9	5	0	3
12/11/13	<b>No meeting in December</b>				
Total	6	18	5	0	6

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. Although no areas were identified. Encourage staff to continue to follow up with concerns from previous visits.
2. Insurance – continue to work on pre-authorization issues.

**Summary of Recommendations** – Continue practice of good documentation.

Additional Activities

1. Consultants – Annual audits by record and pharmacy consultants.
2. Medical Director – Provides overall oversight to QA program and completes peer reviews to medical providers in STD/Travel programs.
3. Satisfaction Questionnaires – Clients and providers complete annual questionnaires. No concerns reported. (EI-19, MCH-21)
4. Logs:
  - General Complaints – none received
  - HIPAA/FERPA Complaints – none received
  - Fire/Disaster Drills – 4 successful drills
  - Accident/Incident Reports 4 (2 staff/2 participants) all reviewed to ensure any hazards are rectified.

### **2014 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 2014**

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 2014 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](mailto:auerp@warrencountyny.gov)  
Website: [www.warrencountyny.gov](http://www.warrencountyny.gov)