

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 2011.

VISION:

Healthy People in Healthy Communities

MISSION:

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

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

GOALS:

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

WARREN COUNTY HEALTH SERVICES TEAM

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

Marietta Anderson
Robin Andre
Jeannette Arends
Shauna Baker
Jackie Barney
Mary Beadnell
Cheryl Belcher
Patricia Belden
Kimberly Botto
Craig Briggs
Debbie Burke
Linda Bush
Gwen Cameron
Kerri Carpenter
Jamie Clute
April Cosey
Tara Cote
Beth Coughlin
Kristi Culligan
William Cutler
Diane Decesare
Tammie DeLorenzo
Tawn Driscoll

Cathy Dufour
Dan Durkee
Samantha Eggers
Karen Fidd
Judy Fortini
Nedra Frasier
Cheryl Fuller
Nancy Getz
Diana Gillis
Nichole Gillis
Mary Lee Godfrey
Renee Hala
Dana Hall
Kathy Harriss
Meg Haskell
Anne Horwitz
Shannon Houlihan
Heidi Iuliucci
Glenda Johnson
Ginelle Jones
Elaine Kane
Barbara Karge

Cathy Keenan
Michelle Keller-Allison
Sue Kerr
Mary Lamkins
Roxana Lewis
Maureen Linehan
Jo Marie
Danielle Martin
Erik Mastrianni
Kathy McGowin
Crystal McKinney
Angela Meade
Kate Meath
Jackie Merritt
Barbara Moehringer
Lisa Morton
Dorothy Muessig
Patty Myhrberg
Barbara Orton
Bethany Paquette
Diane Pfeil

Kristen Phinney
Nancy Pieper
Stella Racicot
Jennifer Rainville
Lynne Rodriguez
Nancy Rozelle
Tia Ruggiero
Leslie Russell
Laura Saffer
Susan Schaefer
Sharon Schaldone
Pamela Silva
Melody Smith
Helen Stern
Patricia Tedesco
Debbie Toolan
Victoria Viacava
Linda Walker
Sandy Watson
Valerie Whisenant
Diedre Winslow
Jeanne Wood
Marilynn Wood

I am honored to be their colleague ~ *Pat Auer*

HEALTH SERVICES COMMITTEE

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

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

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

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

Warren County Board of Supervisors
Health Services Committee Members

Matthew Sokol, Chairman, Queensbury

Fred Champagne, Queensbury

Peter McDevitt, Glens Falls

Harold Taylor, Glens Falls

Frank Thomas, Stony Creek

WARREN COUNTY HEALTH SERVICES

2011 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
Donna Kirker, Vice President Patient Services and Chief Nursing Officer
Mary Lamkins, Supervising Nurse, Health Services
Daniel Larson MD, Public Health Medical Director
Richard Leach MD, Medical Consultant for Infectious Diseases
Richard Mason, Former Warren County Board of Supervisors Official
David Mousaw MD, Medical Director for PHCP & Children With Special Health Care Needs Program
Regina Muscatello, Clinical Nurse Supervisor Westmount Health Facility
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
Sara Sellig, Speech Therapist
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 2011: 153

63 Full Time
13 Part Time
9 Per Diem
57 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 Health Educator (Grade 14)
2 Part Time EI/Preschool Service Coordinators (Grade 18)
1 Per Diem Early Intervention/Preschool Service Coordinator
1 Part Time Emergency Preparedness Coordinator (Contractual)
1 Part Time Public Health Liaison for Emergency Preparedness
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 Assistant (Grade 4)
2 Full Time WIC Nutrition Aides (Grade 6)
1 Full Time WIC Dietician (Grade 16)
1 Full Time WIC Nutrition Facilitator (Grade 16)
1 Full Time WIC Program Aide (Grade 3)
1 Part 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)
1 Full Time Office Specialist (Grade 7) (vacant)
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 Word Processing Operator (Grade 4)

Contractual Therapists

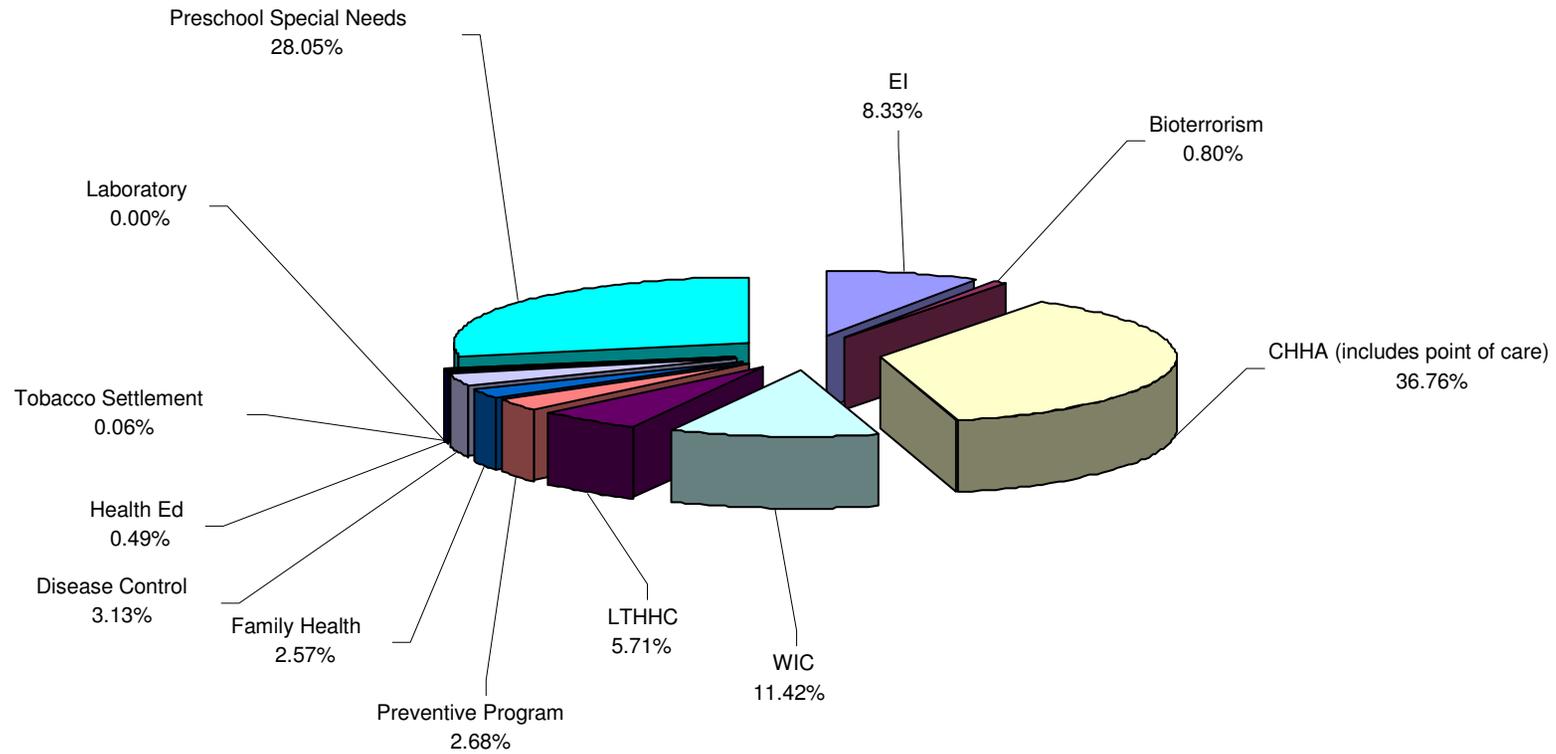
19 Physical Therapists
9 Occupational Therapists
20 Speech Therapists
3 Medical Social Workers
1 Respiratory Therapist
2 Dietician

Contractual Medical Directors

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

Medical Consultants are needed per NYSDOH regulations for the operation of our Diagnostic and Treatment Center, Physically Handicapped Children's Program, and the Tuberculosis Program. In addition, Adirondack Pediatrics P.C. provides physician coverage for monthly Queensbury Well Child clinics. The Town of Queensbury covers the cost (\$100.00 per clinic) for the physicians. Peter Hughes MD provides physician coverage for the weekly Sexually Transmitted Disease clinics. The costs for the clinics are divided between Warren and Washington Counties at \$100.00 per clinic. Glens Falls Animal Hospital veterinarians and animal handlers provide staffing for Rabies clinics and prepare animal specimens for rabies testing as needed. They receive reimbursement per contractual basis.

2011 Actual Expenditures by Program



Total Expenditures: \$11,870,166.60

*Mandated programs account for 39.51% of total actual expenditures. (They are the Preschool, Early Intervention, and Disease Programs)

Source: Budget Performance Report as of 12/31/2011

WARREN COUNTY POPULATION

Source: NYSDOH Statistical Data

BIRTHS AND DEATHS IN WARREN COUNTY

STATISTICAL INFORMATION COMPARISON TRENDS

	2007	2008	2009	2010	2011
Births	625	655	643	600	598
Deaths	613	558	527	578	572

EMERGENCY RESPONSE PLANNING

World wide natural disasters, an escalation of terrorist type events and emerging viral/bacterial illness around the globe have changed our lives forever. These threatening realities remind us of the importance of having county, state, and nationally coordinated and multidisciplinary comprehensive emergency response plans. To this end, Warren County Public Health brought together a team of local partners to identify and coordinate the communications and response duties of these agencies so that during a real (natural or man-made) event, staff and equipment resources will be effectively and efficiently utilized. Routine planning meetings, joint training sessions, webinars and educational programs for the general public, schools, providers and volunteers are part of the preparedness planning process. Ongoing performance goal writing, as mandated by NYSDOH and CDC, includes the completion of the Warren County Pandemic Flu Plan, Continuity of Operations Plan (COOP), Mass Fatality Plan, Chempack Plan, Isolation & Quarantine Plan and the Strategic National Stockpile (SNS) Plan. Participation in several full scale drills, 11 tabletop drills and one real event (Hurricane Irene) has provided us with new experiences that will ultimately facilitate the review, updating and improvement of current plans. Warren County receives a NYSDOH and a Office of Homeland Security (OHS) grant to cover administrative costs of the program. Activities are reported to NYSDOH quarterly as required. A part-time Public Health Liaison, BT Educator and contract BT Coordinator are responsible for meeting grant goals.

PUBLIC HEALTH EMERGENCY RESPONSE AND PREPAREDNESS COMMITTEE – 2011 (from 11/8/11 committee list)

Name	Jurisdiction Represented	Job Title
Dan Albert	NYS Office of Homeland Security	Project Assistant
Patricia Auer	Warren County	Director of Health Services
Harold Barber	NYSDEC	Environmental Conservation Officer
Amy Bartlett	Warren County	Attorney
Patricia Belden	Warren County	PHN for Disease Control
Marie Capezzuti and/or	Washington County	PH-BT Coordinator

Name	Jurisdiction Represented	Job Title
Matt Brown		
Andrew Caruso	Lake George School	Supt. Of Buildings & Grounds
Bob Condon	The Post-Star	City Editor
Joanne Conley	Warren County	Assistant Tourism Coordinator
Dave Dematteo	NYSOEM	
Mark DeSimone	Warren County	Mortician
Amy Drexel	Warren County Office of Emergency Services	Emergency Services Coordinator
Tawn Driscoll	Warren County	Fiscal Manager – Health Services
John Ellingsworth	Glens Falls Fire Department	Assistant Chief
Joyce Flower	Irongate Family Practice	LPN
Anita Gabalski	NYSDOH District Office	Director – Glens Falls Office
John Greening	CR Bard, Inc.	
Bruce Hersey	Adirondack Emergency Community Chaplains	Coordinating Chaplain
Patty Hunt	Washington County	Director – Public Health
Ginelle Jones	Warren County	Assistant Director of Public Health
Bruce Jordan	NYSOEM	Region Coordinator
Marjorie Kelly	ACC	Director, Human Resources Dept.
Geoffrey Kent	FBI	Special Agent, WMD Coordinator
David Kolb	NYS Police	Sergeant
Frank Komoroske	NYS DOT	Resident Engineer
Brian LaFlure	Warren County	Director – Warren County Office of Emergency Services
Daniel Larson MD	Warren County	Medical Director
Richard Leach MD	Warren County	Medical Director for Infectious Disease
Sandy LeBarron	Finch Paper	Environmental Control Manager
Ann Marie Mason	Queensbury School	Safety Compliance/Asset Control Coordinator
Charles McCabe	Ames Goldsmith	Health & Safety Director
David Mousaw MD	Warren County	Medical Director for Pediatrics
Cheryl Murphy	American Red Cross	Regional Response Manager
John Murphy	National Grid	
Chris Norton	Warren County	EMS Coordinator
Sheri Norton	Warren County	GIS Coordinator
John O'Connor DVM	Warren County	Veterinarian
Facilitator; Barbara Orton	Warren County	BT Coordinator
Anthony Palangi	ACC	Facilities Director
Mike Palmer	Queensbury	Fire Marshall
Timothy Place	BOCES	Assistant Superintendent
Stella Racicot	Warren County	RN, Public Health Liaison to Glens Falls Hospital
Monty Robinson	Harrisena Community Church	Pastor
Christie Sabo	Warren County	Director, Office for the Aging
Laura Saffer	Warren County	BT Educator
Sharon Schaldone	Warren County	Assistant Director of Home Care
Keith Scherer		Senator Little's representative

Name	Jurisdiction Represented	Job Title
James Schrammel	Warren Co. Glens Falls Fire Department	HAZMAT Coordinator Chief
Gary Scidmore PA-C	Warren County	EMS Coordinator
Michael Shaw	NYSDOH District Office	Senior Engineer, Supervisor
Thomas Smith	Warren County	Glens Falls Hospital Pharmacist
Warren Snyder	National Weather Service	
Kathleen Sposato	Glens Falls Hospital	Director of Infection Prevention & Control
Laura Stebbins RN MSN	Glens Falls Hospital	Director of Emergency Preparedness
Dan Stec	Warren County	Chairman, Board of Supervisors
Helen Stern	Warren County	Immunization Coordinator
Mark Sullivan	BOCES	Safety Specialist
Sarah Sweeney	Lehigh NE	Environmental Manager
Barbara Taggart	Warren County	Administrator – Westmount Health Facility
Will Valenza	City of Glens Falls	Chief of Police
Suzanne Wheeler	Warren County	Deputy Commissioner – Social Services
Bud York	Warren County	Sheriff
Rob York	Warren County	Director, Office of Community Services
VACANT	HHHN	
VACANT	National Guard	

DIVISION OF HOME CARE

HOME CARE SERVICES

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

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

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

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

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

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

QUALITY IMPROVEMENT PROGRAM

Warren County Health Services Division of Home Care is committed to providing quality health care to all of its clients. The process by which our client outcomes are monitored is through the Quality Improvement Program. The Steering Committee is the hub of our agency's QI process. The Steering committee reviews agency Policies and Procedures for all clinical procedures, reviews the findings of the Chart Committee, reviews the Outcome reports for Home Health Compare and the Process Measures (data obtained from OASIS C assessments) and CAHPS survey results.

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

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

The results of the agency's monitoring processes for 2011 are as follows:

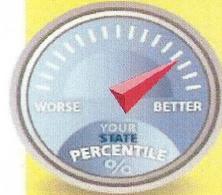
- Home Health Compare Results
- Process Measure Outcomes
- CAHPS Survey

From:

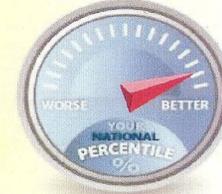


To: WARREN CO HLTH SVS CHHA
1340 STATE ROUTE 9
LAKE GEORGE, NY 12845

Your Percentiles Dashboard: Jan 2011 Thru Dec 2011



Your state percentiles gauge is at 81% with all percentiles weighted equally



Your national percentiles gauge is at 89% with all percentiles weighted equally

Your Percentiles Detail:

Outcomes	Your CMS Outcome	State Percentile	National Percentile	State 80 percentile Goal	National 80 percentile Goal
Started care in timely manner	95	59	64	Up 3% to 98%	Up 2% to 97%
Taught patients about meds	96	72	64	Up 1% to 97%	Up 2% to 98%
Assessed risk of falling	100	81	52	You are there!	You are there!
Assessed for depression	100	85	68	You are there!	You are there!
Checked for flu shot	76	67	61	Up 2% to 78%	Up 7% to 83%
Checked for pneumonia shot	81	79	73	You are there!	Up 3% to 84%
Diabetic foot care	100	92	82	You are there!	You are there!
Checked for pain	100	85	63	You are there!	You are there!
Treated for pain	100	78	61	You are there!	You are there!
Treated heart failure symptoms	100	66	55	You are there!	You are there!
Bed sore prevention (from Dr.)	100	87	74	You are there!	You are there!
Bed sore prevention (in Plan)	99	64	55	You are there!	Up 1% to 100%
Bed sore risk assessment	100	78	72	You are there!	You are there!
Better walking/moving	43	26	15	Up 13% to 56%	Up 20% to 63%
Better to/from bed	58	77	68	Up 1% to 59%	Up 4% to 62%
Less pain moving	56	16	22	Up 14% to 70%	Up 21% to 77%
Better at bathing	61	58	39	Up 4% to 65%	Up 11% to 72%
Better at meds/oral	43	37	41	Up 8% to 51%	Up 12% to 55%
Short of breath less often	66	63	59	Up 3% to 69%	Up 7% to 73%
Improved Wounds	95	93	75	You are there!	You are there!
Admitted to hospital	33	46	24	Down 7% to 26%	Down 12% to 21%
Urgent/unplanned care	n/a	n/a	n/a	n/a	n/a
Increase in pressure sores	n/a	n/a	n/a	n/a	n/a
Overall Percentiles		81	89		

From:



To: WARREN CO HLTH SVS CHHA
1340 STATE ROUTE 9
LAKE GEORGE, NY 12845

Your Outcomes Dashboard: Jan 2011 Thru Dec 2011



Your outcomes gauge is at 75%
15 are above your market, 5 are below

Your outcomes are in Drive
7 went forward, 3 went backward



YOUR ADDRESS

Good Score

Your Outcome Detail:

Outcomes	Your Value	Market Average	State Average	National Average	Last Update Your Value	Change Since Last Update
Started care in timely manner	95	92	94	90	92	3
Taught patients about meds	96	85	88	88	97	-1
Assessed risk of falling	100	82	92	93	100	0
Assessed for depression	100	95	97	97	100	0
Checked for flu shot	76	77	64	68	73	3
Checked for pneumonia shot	81	76	58	66	79	2
Diabetic foot care	100	89	94	89	99	1
Checked for pain	100	98	98	98	100	0
Treated for pain	100	96	98	97	100	0
Treated heart failure symptoms	100	96	97	97	100	0
Bed sore prevention (from Dr.)	100	93	95	93	100	0
Bed sore prevention (in Plan)	99	96	97	94	99	0
Bed sore risk assessment	100	98	97	98	100	0
Better walking/moving	43	53	54	56	43	0
Better to/from bed	58	51	51	54	59	-1
Less pain moving	56	66	67	66	56	0
Better at bathing	61	61	61	64	61	0
Better at meds/oral	43	45	46	47	41	2
Short of breath less often	66	60	64	64	67	-1
Improved Wounds	95	85	87	88	93	2
Admitted to hospital	33	27	31	26	34	-1
Urgent/unplanned care	n/a	n/a	n/a	n/a	n/a	n/a
Increase in pressure sores	n/a	n/a	n/a	n/a	n/a	n/a

Our Percentiles and Outcomes Dashboard Reports

What these reports show:

These reports show the 2011 outcomes as reported by CMS. The PERCENTILE report compares use to State and National percentile outcomes. Our goal is to be in the top 80% or higher. The OUTCOMES report shows our latest outcomes but in a very user friendly manner.

Where the data comes from:

The outcome data was compiled by CMS (Center for Medicare and Medicaid Services) from the OASIS C data submitted for each client that had an episode of care with our agency. This data is published at their Home Health Compare web site, Medicare.gov. The home health outcome data is made available to the public and the percentile data is calculated by HCA specifically for our agency.

How the market is determined:

The Home Health Compare data lists the zip codes in which we have served patients. If any are more than 50 miles from our office they are excluded based upon the likelihood that we entered the patient's home address rather than where they were actually receiving care.

Why the market outcomes are important:

Some outcomes are highly influenced by geographic area within a state. So it makes sense to show how our outcomes compare to the outcomes of other providers who serve the same patients. This eliminates the penalty for serving patients who live in an area with chronically poor outcomes. It also raises the bar for serving patients who live in an area with excellent outcomes.

How the outcome percentiles are determined:

The outcomes of all providers in a state or the nation are put in a list from worst to best. The providers in the first 1 % of the list are given the percentile of 0%, meaning their group is better than 0% of the other providers on the list. The providers in the next 1 % of the list are given the percentile of 1 %, meaning their group is better than 1 % of the other providers on the list. This process continues until 100% of the providers on the list are assigned a percentile.

Sometimes a group of providers on the list with the same outcome score stretches across more than one percentile range. When this happens the whole group of providers is given the higher percentile. This adjustment prevents providers with the same outcome score from being assigned different percentiles.

How the overall percentiles are determined:

Each provider in a state or the nation is put into a list, along with the total sum of all ten of their outcome percentiles. Based on these totals each provider is then assigned an overall percentile. Do not attempt to average your individual outcome percentiles to get this number. The mathematics of percentiles does not work that way.

What the "80 percentile goals" mean in the last two columns:

CMS has discussed providing full positive participation in pay-for-performance to the top 20% of providers. These are the providers at and above 80 percentile. The last two columns show how much improvement our outcomes need in the reporting period to have us in the 80 percentile bracket for each outcome.

Important points about overall percentiles

1. While every bit helps, it is not required to have any of our individual outcome percentiles at 80 to have our overall percentile at 80.
2. If our outcome percentiles are consistently high then our overall percentile will be higher than our average percentile.
3. If our outcome percentiles are consistently low then our overall percentile will be lower than our average percentile.
4. The mathematics of overall percentile calculation can be very counterintuitive.

What the gauges mean:

The needle on the left gauge is a visual indicator of our overall state percentile. The needle on the right gauge is a visual indicator of our overall national percentile.

What the colors mean:

The colors indicate good and bad percentile levels. Lighter yellow to darker orange is progressively worse. Lighter blue to darker blue is progressively better.

-  90% Plus
-  70% Plus
-  50% Plus
-  30% Plus
-  10% Plus
-  Less than 10%

Home Health Consumer Assessment of Healthcare Providers and Systems (HCAHPS)
01/2011 – 12/2011

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

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

The survey has 3 Composite Measures:

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



Real-Time Survey of Patients' Home Health Experiences

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

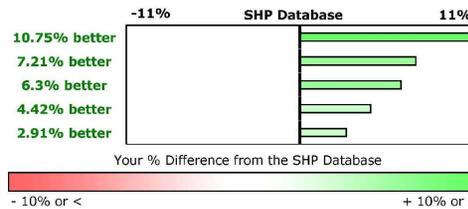
Survey Return Rate

Total mailed surveys for reporting period:	541
Total number of ineligible surveys:	2
Total completed surveys returned:	227
Survey return rate:	42%

		You	SHP Database
Composite Measures			
C1. Care of Patients	Percent of patients who reported that their Home Health provider "Always" was informed and treated them gently and with respect and that there were "No" problems with the care.	93%	88%
Providers			
C2. Communications Between Providers and Patients	Percent of patients who reported that their Home Health provider "Always" communicated well and promptly.	91%	85%
Providers			
C3. Specific Care Issues	Percent of patients who reported that their Home Health provider handled specific care issues correctly.	87%	84%
Providers			
Universal Measures			
U1.	Percent of patients who gave their HH Agency a rating of 9 or 10 on a scale from 0 (lowest) to 10 (highest).	90%	83%
Providers			
U2.	Percent of patients who reported YES, they would definitely recommend the Home Health Agency	90%	79%
Providers			

Percent Difference from the SHP Database

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



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

Strategic Health Plan (SHP)

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

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

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

Utilization Review Overview:

Utilization of Services Summary:

Adequate Utilization	48
Over utilization	2
Underutilization	1
Inadequate Information	2
Unable to Decide	1

- Two cases were identified as over use of services. One case was excessive PT visits and one case was over use of Skilled Nurse. These were isolated cases and they were handled individually with the Primary Case Manager.
- One case was under utilized and along with inadequate information documented. These findings were handled individually and closer supervision of the nurse's documentation was done by the agency supervisors.
- The other inadequate information was due to lack of completion of assessment documentation and the Case Manager was counseled individually.
- The one unable to decide was focusing only on the technical skill and not the client's co-morbidities affecting their overall health status

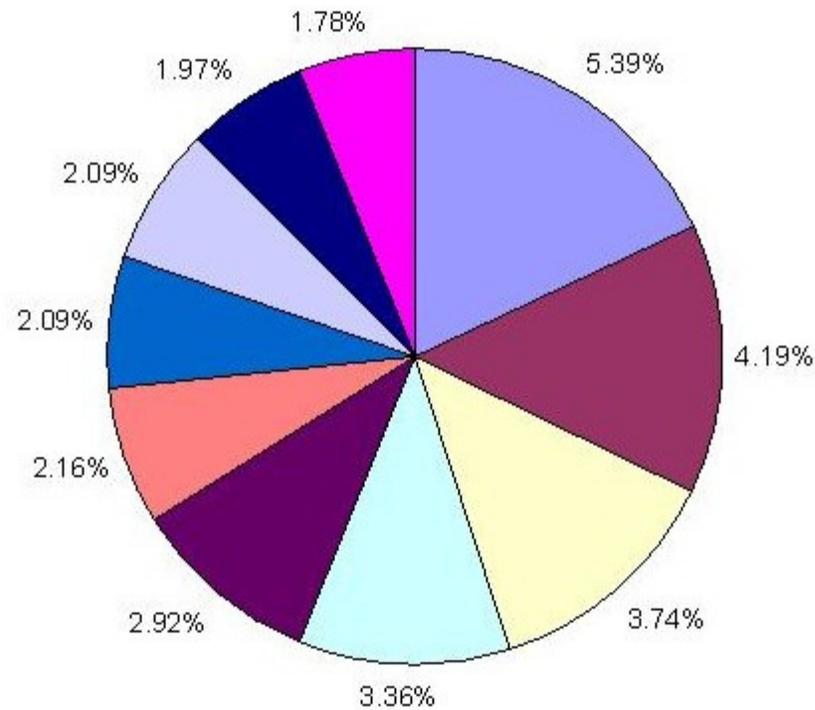
UTILIZATION REVIEW OVERVIEW

2011 patient count on 12/31.2013 was 409:

- CHHA patients: 258 (SN-123, PT/OT/Pediatric : 19, EI/CPSE: 116) LTC :35
- PCA: 115 (includes CDPAP: 68)

The identified areas noted prompted focus audits on IV cases and the Steering committee reviewed and updated the agencies Med Reconciliation procedure. This procedure was inserviced to all skilled providers and the process was audited in Chart review meetings.

**Top 10 Primary Diagnosis
For Visits between 01/01/2011 and 12/31/2011
For Certified Home Health Agency and Long Term Care Programs**



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

SERVICES BY THE NUMBERS
(Certified Home Health Agency)

VISITS BY SERVICE

Services	2010	2011	2010 / 2011 % (+ or -)
Nursing	18,392	16,481	-10%
Physical therapy	7,970	6,702	-16%
Occupational Therapy	700	464	-34%
Speech Therapy	129	164	27%
Medical Social Worker	261	202	-23%
Nutrition	220	131	-40%
Home Health Aide	4,199	2,858	-32%
TOTALS	31,871	27,002	-15%

EVALUATIONS BY DISCIPLINES

<u>2010</u>	<u>2011</u>
▪ Nursing – 1,623	1,499
▪ IV – 110	98
▪ Physical therapy – 1,077	1,022
▪ Occupational therapy – 78	49
▪ Speech therapy – 2	11
▪ Nutrition – 37	32
▪ CDPAP – 143	135
▪ PRI – 79	106
TOTALS = 3,149	TOTALS = 2,952

Medicare comprises more than 50% of our business. Medicare reimburses the agency not by per visit but by episodes of care. The episode is for a 60 day period and the Medicare payment is calculated by the score determined by the OASIS C assessment. Most other payers are following this method. Medicaid is presently reimbursing per visit but will be going to episodic payment in 2012.

Therefore it is good business that we decrease our visit numbers while improving our Outcomes and maintaining patient satisfaction.

Episodes of Care:

- 2011 – 1000 episode
- 2010 1045 episodes
- 2009 – 1228 episodes

As noted there was a significant drop in episodes of care from 2009. This is due to the increase in Managed Medicare's which are not calculated in the episodic numbers. We have had about a 10% increase in Managed Medicare over the past 3 years.

REVENUES AND EXPENDITURES

	2010	2011
Revenues	\$4,666,221.09	\$4,316,929.47
Expenditures	\$3,694,851.52	\$4,363,347.27
Net Gain	\$971,369.57	-\$46,417.80

Expenditures increased in 2011 due to the addition of \$893,178.56 in fringe benefits. These include Retirement, Social Security and Medicare withholdings, hospitalization and dental insurances. These expenses were not reflected in previous years. They are now directly expensed to each county department.

BUSINESS ASSOCIATES CONTRACTED IN 2011 FOR THERAPY SERVICES

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

Deborah Gecewicz ST
Dorothy Grover PT
Joseph Hickey RT
Cheryl Hoffis ST
Kelly Huntley PT
Denise Jackson PT
Cathy Joss ST
Melissa Kenison-Rose OT
Karen Kowalczyk PT
Linda LeBlanc ST
Mindy LaVine ST
Jeanine Lawler OT
Rita Lombardo-Navatka MSW
Marie McGowan ST
Catherine Meehan PT
Holly O'Meara ST
Anne Paolano PT
Edward Reed PT
Donna Reynolds OT
Kathleen Ryan PT
Donna Sauer-Jones MSW
Teresa Scotch ST
Sara Sellig ST
Jaimi Lynn Tudor RD
Sandra Watson RD
Jen Whalen PTA
Adam Willis PT
Nicole Willis PT

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

LONG TERM HOME HEALTH CARE PROGRAM

The LTHHC Program is a NYSDOH Waiver Certified Program that is administered by the local DSS. The program provides case management for coordination of services to Medicaid eligible clients who are medically eligible for placement in a nursing home. All individuals in the LTHHCP must receive case management by a nurse and may receive the following services based on assessment and plan of care:

Non-Waiver Services

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

Waiver Services

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

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.

	2010	2011
Number of active patients as of 12/31/11	37	35
New Admissions	20	17
Number of Discharges	22	19

NURSING HOME LEVEL OF CARE

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

DMS1 Scores: Health Related Facility (HRF) Level Score: 60-180: 21HRF Patients
 Skilled Nursing Facility (SNF) Level Score: 180 and above: 14SNF Patients

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

PATIENT REFERRAL SOURCES

SOURCE	2010	2011
Medicaid Unit	0	2
Certified Home Health Agency	11	9
Personal Care Aide Program	6	3
Hospital	0	0
Physicians	1	0
Family	0	0
Self-Referral	0	1
Nursing Home	1	0
Central Intake	0	0
Rehabilitation	0	2
Other	1	0
TOTAL	20	17

The largest numbers of referrals continue to come from the certified agency. These individuals require ongoing care for their chronic health needs. Referrals from Medicaid are for couples in the community who apply for spousal Medicaid and are looking to participate in either the Long Term program or are seeking nursing home placement. Prospective applicants who wish community services are screened by the Long Term Care program for medical eligibility and are then referred for service if deemed appropriate.

Division of Home Care - SERVICES BY THE NUMBERS

Long Term Home Health Care Program

VISITS BY SERVICE

Services	2010	2011	2011/2010 % (+ or -)
Nursing	1,933	2,238	16%
Physical Therapy	681	919	35%
Occupational Therapy	202	154	-24%
Speech Therapy	0	9	100%
Medical Social Worker	293	138	-53%
Nutrition	29	31	7%
Home Health Aide	1,324	1,888	43%
Personal Care Aide	6,178	6,523	6%
Respiratory Therapy	210	152	-28%
TOTALS	10,850	12,052	11%

REVENUES AND EXPENDITURES

	2010	2011
Revenues	717,612	711,505
Expenditures	589,348	678,142
Net	128,264	33,363

Note: Expenses increased due to the addition of fringe benefits to each department. LTC fringe total - \$72,594.24.

Less than 30% of Long Term Home Health Care Programs in New York State are making a profit. We are proud to be one of them. Our patient population in LTC is decreasing yearly due to the competition of the Nursing Home Diversion Waiver Program. This program has no budget cap which is the limiting factor with the LTC Program. There has been much lobbying by the CHHA's to have the barrier lifted to allow for more needed aide coverage with keeping the nursing case management. During 2011, additional fringe benefits of \$71,410.16 were added to the LTC department that was not reflected in previous years. Even with this additional expense, a profit remains.

The Medicaid Reform Team has set forth movement to assign all Medicaid recipients old and new to a Managed Long Term Care Organization (MLTC). This is expected to begin in 2012. This may eventually phase out the LTC program as we now know it. WCHS is pursuing contracts with all the MLTC'S that will be serving our County with hopes to be able to be the provider for these clients and all future clients.

We hope to be serving you in 2012 and for years to come.

HOME CARE GOALS FOR 2012

- Collaborative efforts will continue with GFH via the liaison involvement.
- Continue collaborative efforts with Hudson Headwaters Healthcare Network (HHN) in their Medical Home Pilot through the Transitions Care Program
- Continue collaborative efforts with Health Home for Northern NY (Adirondack Health Institute + Hudson Headwaters Health Network, Community Partners + Adirondack Health) This is preparation for future changes from Medicaid Reform
- Continue to focus on addressing our 30 day readmits
- Position the agency to be competitive in the changing Home Care arena as imposed by Medicaid Reform mandates

COOPERATIVE EFFORTS WITH OTHER COUNTY DEPARTMENTS

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

A. PCA – Personal Care Aide Program (DSS)

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

B. CDPAP (The Consumer Directed Personal Assistance Program)

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

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

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

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

C. COORDINATED CARE

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

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

CENTRAL INTAKE

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

PRIVATE DUTY NURSING

An assessment of a client's needs is made by CASA and an agency nurse in conjunction with the physician and other interdisciplinary professionals for referral to NYSDOH for authorization of PDN services. Private duty nursing provides care at the RN and LPN level, typically, for skilled care such as ventilator-dependent patients or patients on enteral feedings. There was one case being followed at the end of 2008. These clients are seen every six months to review the plan of care and the client's condition. The RN and LPN staffs come from licensed agencies that are responsible for training, scheduling, and employment issues.

DIVISION OF PUBLIC HEALTH

PUBLIC HEALTH SERVICES

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

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

10 ESSENTIAL PUBLIC HEALTH SERVICES:

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

MATERNAL CHILD HEALTH PROGRAM

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

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

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

SUMMARY OF SERVICES

YEAR	TOTAL BIRTHS	NEWBORNS REFERRED	POSTPARTUM CLIENTS REFERRED	HEALTH SUPERVISION CLIENTS REFERRED	TOTAL HOME VISITS	PREMATURELY BORN INFANTS (less than 35 weeks gestation)	% Births Less Than 35 Weeks Gestation
2007	620	481 (7 sets of twins, 1 sets of triplets)	458 (340 breastfeeding) (54 Primary CS) 95 Repeat CS)	15	773	8	1.7%
2008	657	502 (6 sets of twins, 3 sets of triplets)	496 (365 breastfeeding) (76 Primary CS) (87 Repeat CS)	14	681	10	1.53%
2009	642	504 (12 sets of twins, 1 set of triplets)	490 (361 breastfeeding) (84 Primary CS) (94 Repeat CS)	14	771	17	2.2%
2010	600	485 (12 twins)	479 (55 Primary CS) (101 Repeat CS)	9	661	32	5.5%
2011	598	464 (9 twins)	473 (374 breastfeeding) (123 Primary CS) (50 Repeat CS)	17	544	31	5.2%

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 2011, 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 2007	57
2008	79
2009	54
2010	32
2011	70

LACTATION COUNSELING PROGRAM

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

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

	Postpartum Clients Referred	Referred Clients That Were Breastfeeding	Percentage of Breastfeeding Moms
2007	458	340	74%
2008	496	365	74%
2009	490	361	74%
2010	479	353	74%
2011	473	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 the prenatal program are primarily received from medical care practices on Medicaid eligible women. Physicians may receive an enhanced Medicaid rate if they enroll with New York State Department of Social Services as a "MOMS Provider". Part of this agreement is to refer all Medicaid clients to receive "Health Supportive Services" (HSS). Medicaid Obstetrical and Maternal Services (MOMS) and Health Supportive Services (HSS) are preventive health services that are delivered by designated Article 28 hospitals and diagnostic treatment centers and Article 36 certified home health agency providers. They are monitored by the Office of Public Health of the New York State Department of Health. MOMS and HSS are intended to supplement obstetrical services provided by private medical practitioners, through the provision of health supportive services including nutrition, psychosocial assessment and counseling, health education, and coordination of other services needed by Medicaid eligible women during pregnancy and for a period of up to 60 days after delivery. As coordinator of the client's health supportive services, the Health Supportive Services Provider (HSSP) must work closely with the MOMS medical practitioner to ensure that every opportunity is provided for clients to receive comprehensive and continuous prenatal care. The clinical aspect of obstetrical care will be provided by a MOMS medical provider in the medical provider's office while the HSS will be provided by the MOMS HSSP in the client's home or on-site at an Article 28 facility.

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

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

In late 2007, the MOMS Program was transferred to an electronic record, thanks to the efforts of Jeremy Scime, IT Department. Information charting is done on-site making this information up-to-date which will facilitate communication with clients and network collaborating agencies. Reports and data are accessible and useful for the QA process and client-targeted education

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

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

PRENATAL PROGRAM DATA

	CLIENTS REFERRED (UNDUPLICATED COUNT)	PRENATAL HOME VISITS MADE	TOTAL BIRTHS	TEEN PREGNANCY TRENDS (ENDING IN LIVE BIRTHS) <18YRS OLD
2007	182	259	625	13
2008	119	176	655	7
2009	147	193	643	8
2010	141	170	600	10
2011	175	121	598	11

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

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

CHILDBIRTH EDUCATION CLASSES

Warren County Health Services has 4 certified Childbirth Educators who alternate teaching the Childbirth Education Classes. The classes are held at the Municipal Center in Lake George. Programs are offered either as a 5-week session with 2½ hour classes one evening a week or a weekend class Friday evening, all day Saturday, and 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.
2008	10 (5 weekends/5 6-week)	44
2009	8 (4 weekends/4 6-week)	40
2010	8 (4 weekends/4 5-week)	45
2011	8 (5 weekends/3 5-week)	39

WOMEN, INFANTS AND CHILDREN NUTRITION PROGRAM
(WIC)

During 2011, the Warren County WIC Program experienced several staff changes resulting in the hire of a new Coordinator, an Infant Feeding Advocate and a temporary Program Aide. The hire of the Infant Feeding Advocate allowed for the creation of a Breast Feeding Support group, offered one time per month at the Main Site located in the Warren County Municipal Center. WIC mothers who initiated breastfeeding increased to 64% in 2011 from 61% in 2010.

WIC continues to support breastfeeding as the primary source of nourishment from birth to one year old. In addition, participant-centered nutrition education promotes a healthy lifestyle and is emphasized with each participant's clinic visit. Warren County WIC incorporates the USDA endorsement of My Plate, a food icon that teaches portion and healthy food choices. WIC partners with Eat Smart New York, sponsored by the Warren County Cornell Cooperative Extension at each clinic.

WIC clinics are offered at eight sites including the Municipal Center and also in Glens Falls, Queensbury, Lake Luzerne, Warrensburg, North Creek and Horicon. Hours of operation are suited for early morning and early evening appointments. The Warrensburg site was moved from the Warrensburg Town Hall to the Cornell Cooperative Extension during the summer of 2011. In 2010, the total number of participants equaled 1,334. In 2011, the total number of participants decreased to 1,317. Staff attendance at the Annual WIC Conference confirmed a decline in overall statewide participation. WIC intends to increase collaboration with other community organizations designed to support the nutritional status of families, with the intention of increasing participant enrollment.

Site	Site Participant Average	% of Total Participant Average
Main Site – Warren County Municipal Center	265	20
First Baptist Church – Glens Falls	271	21
Village Green Apartments – Glens Falls	182	14
VFW Post - Queensbury	232	18
Lake Luzerne Town Hall – Lake Luzerne	67	5
Cornell Cooperative Extension Education Center - Warrensburg	149	11
North Creek Fire House – North Creek	60	5
Horicon Community Center - Horicon	67	6
	1,317	100%

The Warren County WIC administrative budget totaled \$486,545.14 with actual expenditures totaling \$449,980.99. The redemption value of WIC benefits provided to Warren County residents was \$905,575.08. These monies provided essential food supplements to WIC participants and revenue to local community food vendors.

During the summer season, WIC households were encouraged to participate in the Farmer's Market Nutrition Program (FMNP), as a tool to increase consumption of fruits and vegetables and promote the Eat Well Play Hard initiative. The NYS Department of Agriculture and Markets issued farmer's market check allocations for \$4,200. These monies are intended to be spent at local farmer's markets. Warren County WIC participants produced a 41.3% redemption rate, compared to 56.7% statewide. Increased participation in the FMNP is a projected goal for 2012.

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
2007	146
2008	128
2009	126
2010	125
2011	109

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

	2007	2008	2009	2010	2011
Referrals Received	153	130	155	154	203
Children Served	281	260	276	262	285
Dollars Received From NYS	307,792.25	370,995.30	353,661.81	336,770.58	193,997.81
Dollars Received From Medicaid	403,277.54	481,521.68	404,857.26	268,832.58	404,557.15
Dollars Received From Private Insurance	74,972.70	52,794.26	39,519.56	24,769.92	19,148.24
Costs Before Reimbursement	1,200,556.86	1,153,028.34	1,201,449.71	946,876.91	988,424.39
Amount Appropriated (In budget, amended numbers)	1,003,153.00 (Over budget by 197,403.86)	1,133,861.00 (Over budget by 19,167.34)	1,238,362.00	1,307,867.96	1,338,749.92
Expenditures For County After Reimbursement Received	414,514.37	247,717.10	403,411.08	316,503.83	370,721.19
Average Cost to County Per Child Served	1,475.14	952.76	1,461.63	1,208.03	1,300.77
Births in County	625	655	643	600	598

Note: The number of children served by the Early Intervention Program seems to have increased slightly from 2010 to 2011, as shown by the available financial tracking information; the cost per child served will vary depending upon the reimbursement potential for each individual. Referrals were up from previous years, however many children did not qualify for the program.

Dollars received are based on actual cash in for the year, not revenues booked. Private insurance payments are down due to insurance policies changing their benefit requirements; therefore many are no longer paying for EI services rendered. In 2011, the state implemented a new Early Intervention billing/services system called NYEIS. The accuracy of this system has not been totally proven by the state. They continue to work on these issues daily.

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 2007-2008	SCHOOL YEAR 2008-2009	SCHOOL YEAR 2009-2010	SCHOOL YEAR 2010-2011
All Children Served	365	417****	370	353
Evaluations Only	110	88	78	89
Tuition Program/Evaluations Costs Approved	\$3,737,728.73	\$3,912,417.01	\$2,990,227.47	\$2,441,577.18
Tuition Program/Evaluations Costs Paid	\$3,723,342.40	\$3,980,727.63	\$2,991,733.97	\$2,539,102.34
Transportation Costs Approved	\$824,325.43	\$846,790.00	\$773,763.30	\$647,099.55
Transportation Costs Paid	\$827,346.47	\$839,850.00	\$772,256.80	\$689,913.49
Average Cost Per Child Before Reimbursement	\$12,467.64	\$11,560.14	\$10,172.95	\$9,218.97
Amount of Medicaid Received	\$212,925.33	\$195,197.58	\$0.00	\$11,262.11**
Amount State Aid Received	\$2,461,154.14	\$1,770,708.13	\$2,631,959.85	\$1,102,852.25
Administrative Costs Received in 2011	\$54,600.00	\$37,915.94	\$45,638.82	\$105,296.85
Administrative Costs Paid to School Districts in 2011	0	\$44,183.47	\$76,703.94	\$125,667
Program Costs After Reimbursement	\$1,876,609.40	\$2,854,671.92	\$1,132,030.92	\$2,114,901.47
Average Cost Per Child After Reimbursement	\$5,141.40	\$6,845.74	\$3,059.54	\$5,991.22

*Source: General Ledger/Accounts Payable Reports and Budget Performance Report, 1/1/11 - 12/31/11.

**There were no Medicaid reimbursements for 2010 due to the fact that the state had not allowed billing since 6/30/09. However by 3rd quarter in 2011, the state notified us we could begin billing for Medicaid within the Preschool Program.

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 Tuitions, Evaluations, Transportation, and Rate Reconciliations.

PRESCHOOL PROGRAM

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

SCHOOL DISTRICT	School Year 2007-2008	School Year 2008-2009	School Year 2009-2010***	School Year 2010-2011***
Abe Wing	14	20	18	17
Bolton	6	2	4	4
GF City	73	110	83	84
Hadley Luzerne	18	18	20	18
Johnsburg	7	13	7	7
Lake George	18	15	17	15
No. Warren	17	18	18	15
Queensbury	99	90	98	87
Warrensburg	45	43	27	18

Administrative Costs Paid to School Districts During 2011*		
	08/09 School Year	09/10 School Year
Bolton	\$1,401	\$0
GFCity	\$44,929	\$13,139
GF Common	\$7,092	\$0
Had Luzerne	\$11,208	\$8,406
Johnsburg	\$7,868	\$3,736
Queensbury	\$53,169	\$0
Total	\$125,667	\$25,281

Rate Reconciliations**	2010	2011
Paid Out to Providers	\$94,874.67	\$57,192.36
Received from Providers	\$152,806.62	\$1,665.11

Budget Appropriation for Contractual Services (Amended Budget)	
Year	Amount
2007	\$3,420,910.00
2008	\$4,600,000.00
2009	\$4,676,782.00
2010	\$5,151,575.00
2011	\$5,159,880.00

*Administrative Costs paid to school districts for 2008-09 school year totaled \$125,667. All were paid February 2011. In December 2011, a few schools were also paid for 2009/2010 administrative costs of \$25,281. Not all school districts submit administrative costs to the New York State Education Department for reimbursement approval. Without state education approval school districts cannot bill the county. Often by the time they are approved by the State Education Department, the numbers actually reflect previous school years. Previous year was \$76,703.94, therefore a 64% increase over 08/09 school year.

**Rate reconciliations recorded in 2011 are reflected above for school years 08/09 to 09/10. During 2011 WCHS actually received credits due the county from providers for previous years where the rate was reconciled to have been lower. These totaled \$1,665.11. However, WCHS also had to pay an additional \$57,192.36 in rate reconciliations. These providers are New Meadow-(\$4,937.26), Boces-(\$30.50) and UCP (Prospect School)-(\$52,224.60).

*** These totals reflect children receiving services during the fiscal year 1/1/11-12/31/11 to better match with fiscal year expenses.

CHILDREN WITH SPECIAL HEALTH CARE NEEDS PROGRAM (CSHCN)

A Historical Perspective

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

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

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

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

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

The work group adopted the following definition of children with special health care needs: Children with special health care needs are those children 0-21 years of age who have or are expected to have a serious or chronic physical, developmental, behavioral or emotional condition and who also require health and related services of a type or amount beyond that required by children generally.

New York State has a long history of concern for the health of all children including those with special health care needs. The health department's involvement with children with disabilities dates back to polio clinics held in the beginning of the century.

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

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

New York State Department of Health continues to provide funding to counties to facilitate the Children With Special Health Care Needs (CSHCN). Counties are responsible for submitting quarterly data to the NYS Department of Health that identify the types of children's health problems involved with children participating in the PHCP. The goal is to identify "gaps" with insurance coverage for children's services i.e. what types of things are not covered by insurance plans and what is the resultant impact on the involved child's health.

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

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

HEALTH EDUCATION

2011 Activities

Program News

- Continued with school based health programs focusing on pre-k thru third grade students (see chart below)
- Created and presented a Lead Poisoning prevention conference for daycare providers in Warren County.
- Improved outreach to senior centers and supplied fall prevention materials to all senior centers in Warren County. Fall prevention programs were presented at Senior Centers in Warren County as part of the NYSDOH fall prevention initiative. Thirty-six people attended. All participants received nightlights and eye glass cleaners as part of the initiative.

Community Health Assessment

- Continued to work with the Community Health Assessment steering committee. Reviewed and approved a two year update on progress towards addressing physical activity and nutrition in the Adirondack Rural Health Network region. For more information please contact Dan Durkee at 761-6580 or email durkeed@warrencountyny.gov
- Continued to serve as the Warren County Public Health representative at the Adirondack Rural Health Network meetings. The meetings are used to develop a plan for addressing the mandated community health assessment due in 2014, to the New York State Department of Health.

Community Events

- Attended 10 community events. Distributed educational materials to over 250 participants on a variety of topics.

Trainings/Conferences

- Completed 1 online course designed to enhance the skills of health educators both were focused on physical activity and nutrition in the community. Also, attended the New York State Public Health Association annual conference in Syracuse
- Attended the last DELTA training program designed to give participants the skills needed to interpret outcome evaluations and apply the information to current and future efforts.
- Completed a train-the trainer program called BodyWorks which focuses on creating behavior change in the family setting. The program is designed to teach parents the skills needed to implement small meaningful changes to help create a healthy environment for adolescent and teen children.

Networking

- Continued to work with community partners by attend meetings and offering assistance with community events planning and implementation (Cornell Cooperative Extension, Zontas Club of Glens Falls, Warren County Office for the Aging, Queensbury Seniors, Southern Adirondack Child Care Network, Interagency Council etc.)
- Attended over 30 networking meetings with remaining partners.

Worksite Wellness

- Continued to produce an employee Newsletter, but have reduce the frequency to once very two months due to a lack of time
- Had approximately 60 employees participate in Biggest Loser contest where they competed against each other and teams from Washington County. Warren County teams lost more weight than Washington County teams.

Miscellaneous

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

PRESCHOOL ELEMENTARY and ADOLESCENT PROGRAMS

Program	Attendance '07	Attendance '08	Attendance '09	Attendance '10	Attendance '11
Dental Health	173	183	235	644	320
Nutrition	1039	386	714	868	852
Injury Prevention	523	367	182	572	567
Hand Washing/Hygiene	1427	1020	905	653	826
Exercise/Heart Health	520	381	679	251	391
Sun Safety	620	473	342	542	528
Poison Prevention	18	71	209	169	61
Tobacco Education	609	910	703	705	799
Ticks & Lyme Disease	*	382	50	350	285
Rabies Awareness	*	534	0	0	424
HIV/AIDS	*	40	125	293	248
Flu/H1N1	*	*	426	0	0
TOTAL	4929	4707	4570	5047	5301

ADULTS, PARENTS and SENIORS PROGRAMS

Program	Attendance '07	Attendance '08	Attendance '09	Attendance '10	Attendance '11
CPR/First Aid	205	185	141	116	130
School Nurse Training	28	29	30	32	45
Blood Borne Pathogens Training	65	52	112	40	46
Employee Training/Defensive Driving	54	99	0	112	22
Senior Health/Fall Prevention	*	68	10	50	36
Flu/H1N1	*	*	45	0	0
Community Programs	*	*	*	336	240
TOTAL	761	433	338	686	519

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

NETWORKING WITH THE COMMUNITY

American Red Cross	Adirondack Community College	Capital Region BOCES Health Services
Communities That Care	Cornell Cooperative Ext. of Warren County	Council for Prevention
Domestic Violence Committee	Warren Count Head Start	Hudson Headwaters HIV Network
Interagency Council	NYS Department of Injury Prevention	Washington County Public health
Rural Health Network	Glens Falls Hospital	American Academy of Family Physicians
Zonta Club of Glens Falls	Upper Hudson Prenatal Network	Youth Coalition
Southern Adirondack Childcare Network	Glens Falls YMCA	

(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 equipment for free walk-in HIV clinic held every Tuesday in 2011.
- Please see HIV pages for clinic statistics.

MATERIAL DISTRIBUTION

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

Rabies: Sent out yearly mailings to all the health care providers, vets and relevant professional with information about reporting to the county. Distributed educational materials to the public at rabies clinics, vets offices and at the Warren County Health Department. Conducted rabies education with elementary students.

Lyme Disease: Conducted tick and Lyme disease education for elementary students. Distributed educational materials to all of the participants as well as made materials available at doctor's offices, Warren County Health department and other relevant locations. Sat in on several community meetings regarding the impact of Lyme in Warren County and what is being done to address it.

Influenza/H1N1: Conducted community outreach using schools, daycares, Headstart programs, healthcare provider offices and mailings. Pamphlet, posters, brochures and facts sheets were distributed to everyone that requested them. Also, materials were sent to any workplaces, healthcare offices and other location deemed appropriate even if they were not requested.

Infectious 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. Also conducted a program for foster children about HIV/STDs

Lead: Conducted two lead poisoning prevention programs for local preschool and daycare. Thirty people were in attendance. A brief survey was used to assess knowledge gained about the role of daycare and preschool providers in preventing lead poisoning. Also presented information at the Southern Adirondack Child Care Network monthly meeting about lead and other poisoning hazards. Continued to provide lead information too new moms enrolled in the Warren County prenatal/postnatal program.

OTHER PROGRAMS

Tar Wars Tobacco Free Education: The program has seen significant cuts in funding over the last two years. Therefore out reach to Stewarts Shops was needed to help offset the cost of prizes awarded to students that participate in the poster contest portion of the program. There was voluntary participation by 90% of school districts in Warren County. Almost eight-hundred students in fourth and fifth grade attended the program. Participation is the same as the year before. Students created tobacco free posters after receiving a one-hour lesson about the dangers of tobacco and the deceptive practiced of the tobacco companies. The posters demonstrate the knowledge that students gain during the one hour lesson.

Warren County Employee Wellness Program: Conducted the third annual Employee Wellness “Biggest Loser” team competition. Nineteen teams registered for the program and 16 teams actually completed the 10 week program. The program offered lunch and learn sessions for participants which were poorly attend. Most participants were unwilling to give up their lunch hour. However, every team that completed the program lost weight and according to surveys had incorporated at least one healthy behavior change (cutting back on soda, being more active etc) into their daily lives. No long-term follow-up is planned do to a lack of time and resources.

School Nurse Training: This annual meeting went through a major overhaul. The meeting time was scheduled for early October instead of late August after a survey submitted by nurses indicated timing of the meeting made it difficult to attend. Nurses also submitted ideas for topics of interest which were used to bring three guest speakers to the program. Nurses also indicated that having the meeting after work hours was ideal. Finally extensive email, save the date notices and other forms of communication were used to try and help boost attendance. The overhaul was successful with over 45 school nurses and community outreach people attending the program. The nurses gathered information about fecal-incontinence, suicide prevention and teen health wit ha focus on teen pregnancy and sexual education.

Community Outreach: Health Educator was able to increase community outreach. Warren County’s Health Educator attended a dozen community events. The events covered all age groups and a myriad of health topics including injury prevention, fall prevention, heart health, cancer, and more.

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

LEAD POISONING PREVENTION PROGRAM

Warren County has a Lead Poisoning Prevention Program funded by a NYSDOH \$23,732 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	2007	2008	2009	2010	2011
<10mcg/dl	675	753	964	934	1039
10-14mcd/gl	3	5	4	5	3
15-19mcg/dl	1	0	0	1	1
20-25mcg/dl	0	0	0	0	3
>25mcg/dl	0	0	1	1	0
TOTAL ELEVATED RESULTS	4	5	5	7	7

(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	2007	2008	2009	2010	2011	DISEASE ENTITY	2007	2008	2009	2010	2011
Amebiasis	0	1	0	0	0	Influenza, B	1	19	15	0	13
Babesiosis	0	0	0	0	1	Influenza, unspecified	1	2	0	0	0
Brucellosis	0	0	1	0	0	Influenzae (Haemophilus) Invasive not Type B	0	0	0	0	2
Campylobacteriosis	6	4	5	6	8	Legionellosis	2	1	1	1	2
Chlamydia	96	100	139	160	188	Listeriosis	---	---	1	0	0
Cryptosporidiosis	3	5	1	0	0	Lyme Disease	26	23	103	45	25
E. Coli	0	2	2	0	0	Ticks Tested/Confirmed Deer Ticks	117/97	142/118	142/135	81/77	39/38
EHEC (not serogrouped)	0	0	0	0	0	Meningitis (bacterial)	0	2	0	0	1
Giardiasis	3	9	11	4	9	Meningitis (viral)	3	0	0	0	0
Gonorrhea	6	18	3	13	10	Mumps	0	0	0	0	0

DISEASE ENTITY	2007	2008	2009	2010	2011	DISEASE ENTITY	2007	2008	2009	2010	2011
Haemophilus Influenzae Inv No	0	1	1	0	2	Pertussis	0	2	1	11	3
Hemolytic Uremic Syndrome	---	---	1	0	0	Salmonellosis	3	8	7	8	8
Hepatitis C (acute)	---	1	0	0	0	Shigellosis	---	1	0	0	1
Hepatitis C (chronic)	46	42	31	26	30	Strep Pneumo Invasive Sensitive	5	0	0	9	0
Hepatitis B (acute)	0	0	0	0	0	Strep Pneumo Invasive Drug Resistant	1	0	0	1	0
Hepatitis B (chronic)	5	4	3	4	1	Syphilis, primary	1	1	0	0	0
Influenza A	2	35	83	0	11	Syphilis, secondary	0	0	0	0	1
Strep Pneumo Invasive Intermed	1	1	4	0	1	Syphilis, early latent	2	2	0	0	0
Strep Pneumo Invasive, unknown	---	1	1	0	2	Syphilis, late latent	0	1	0	0	0
Strep Pneumo Invasive, sensitive	---	2	4	0	5	Syphilis, unknown latent	0	1	0	0	0
Streptococcus Pneumoniae (Unknown)	0	0	0	0	0	Swine - Origin Influenza	---	---	15	1	0
Strep Group A Invasive	3	3	0	8	1	Toxic Shock Syndrome	0	0	0	0	1
Strep Group B Invasive	2	7	5	6	7	Tuberculosis	0	1	0	1	0
Strep Group B Invasive, early	---	1	0	0	0	Yersiniosis	1	1	1	0	1

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 2011

Town	Not Vaccinated			Vaccinated			Out of Town			Stray		
	Cats	Dogs	Ferrets	Cats	Dogs	Ferrets	Cats	Dogs	Ferrets	Cats	Dogs	Ferrets
Bolton		1		3	3							
Chester		2			7					1		
Glens Falls	5	7		8	18			4		3	4	
Hague	1				1			1				
Horicon					2			1				
Johnsburg	2	3		1	3							
Lake George		4		3	8			2				
Lake Luzerne		1	1 (horse)		4					1		
Queensbury	3	3		6	55		2	3		8	2	
Stony Creek												
Thurman					3					1		
Warrensburg		3		1	9			3		1		
TOTALS	11	24	1	22	113	0	2	14		15	6	

BITES REPORTED BY MONTH

	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Total
2008	12	18	14	33	23	26	42	29	24	25	18	28	292
2009	18	11	16	23	18	23	31	30	20	20	23	23	256
2010	16	7	20	24	21	19	15	37	17	18	17	7	218
2011	12	10	20	18	22	15	35	22	24	13	10	7	208

RABIES STATISTICS

	2007	2008	2009	2010	2011
Confirmed Rabid Animals	1 cat 1 raccoon 1 skunk	1 fox 2 bats	2 skunks 1 fox	1 raccoon 1 fox	0
Animal Specimens Submitted for Testing	69	81	54	37	28
Animal Bites	270	292	256	218	208
Patients Receiving <u>Pre-Exp. Vac.</u> (3 Injections) or <u>Booster Vacc.</u> Fee: \$203.00/Dose	13 Titers Drawn: 20	(Due to a rabies vaccine shortage, only post exp. vaccine was given.)	3 Titers Drawn: 0	6 Titers Drawn: 0	8
Patients Receiving <u>Post-Exp. Vac. Series @ GF Hosp.</u> (All RIG and First Injections are Given at GF Hospital)	49	29	30	34	13
Patients Receiving <u>Post-Exp. Vac. Series @ P. Health</u> (All RIG and First Injections are Given at GF Hospital)	2	3	4	4	1
Animal Clinics	20	21	21	22	23
Animals Receiving Rabies Vaccinations	850	927	834	944	787

Amount paid in relation to Rabies Program:
 \$18,574.94
 Amount of reimbursement from New York State:
 \$8,239.48
 Rabies Clinic Revenue: \$7,116.50
 Total program cost to Warren County: \$3,218.96

Note: Data above reflects actual expenses incurred and actual cash received during 2011. In previous years we have been able to submit the amount over the maximum allowed and have been reimbursed. However, over the last few years, this has not been the case.

TUBERCULOSIS PROGRAM

PPD testing is offered by appointment to any Warren County resident requesting it on Tuesdays, Wednesdays, and Fridays. A fee of \$28.00 per test is requested, but is waived if it is a financial hardship. Agencies whose personnel must be screened for tuberculosis also may request screening by Warren County Public Health.

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

Amount Paid for Tuberculosis Medications	
2007	\$31.60
2008	\$19.75
2009	\$60.61
2010	\$39.89
2011	\$ 0.00

YEAR	INDIVIDUALS TESTED	POSITIVE CONVERTERS	ACTIVE TB CLIENTS DURING YEAR
2007	268	0	0
2008	318	3	1
2009	235	8	0
2010	217	1	1
2011	164	1	0

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

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

STD CLINIC

The STD clinic is held in conjunction with the HIV clinic, which is very convenient for the clients. Since the origin of the STD clinic it has been held in cooperation with Washington County. The costs of the clinic are shared.

The first STD clinic, or VD clinic as it was known then, was held in the MacEachron House in 1974. It was staffed by Warren County Public Health nurses and a list of rotating physicians. In the late 1980's, Henry Long, PA began as a permanent medical consultant and continued for several years. He was succeeded by Peter Hughes, M.D, a local urologist, who has been with the clinic for more than twenty years.

The collection of specimen to identify the STD present has changed drastically over the years of the clinic. We are now able to collect a urine specimen for the testing of gonorrhea and chlamydia while a blood sample is necessary for the test for syphilis. The urine specimen is sent to Glens Falls Hospital Lab and the blood sample is sent to Wadsworth Lab. (NYS Lab). The results of the tests at both labs are accessible via the computer.

New York State Department of Health contracts with a medical supply company in order for STD clinics to obtain treatment medications at a reasonable cost. Warren County Public Health takes advantage of this contract and obtains medication that can be provided without charge.

The most important aspect of the STD clinic is the confidentiality of the client is safeguarded. The tests that are sent to the Glens Falls Hospital are coded so they cannot be identified except in the public health office. This is extremely important to many of the patrons of the STD/HIV clinic.

The age of the clients range from 15-86 years. The gender of the clients is predominately male. Most of the participants are from Warren County although Washington County is well represented as is Saratoga County.

We speculate that as Health Care becomes more universally available, the need for an STD/HIV clinic will diminish. Is this fact or fiction?

HIV and STD (SEXUALLY TRANSMITTED DISEASE) CLINIC

	2007	2008	2009	2010	2011
Clinics Held	51	51	52	52	50
Participants	368	325	377	332	327
Males	234	199	249	222	230
Females	134	126	128	110	97
Age Range	14-71	15-68	14-69	14-72	15-86
HIV Test Only Done	76	65	41	40	40
STD Test Only Done	73	55	83	77	51
STD & HIV Test Done	151	151	193	187	204
HIV Not Tested*	16*	25*	17*	9	
STD Phone Calls for Results	135	116	175	164	168
Warren Co. Participants	181	189	216	157	204
Washington Co. Participants	92	59	107	110	76
Saratoga Co. Participants	76	67	44	53	41
Other County Participants	18	10	10	11	6

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

DISEASES WITH POSITIVE TEST RESULTS

DISEASES	2007	2008	2009	2010	2011
Genital Herpes	0	2	9	4	0
Genital Warts	20	13	15	9	10
Chlamydia	7	9	20	23	20
Gonorrhea	4	1	1	0	0
Syphilis	2	4	0	0	0

HUMAN IMMUNODEFICIENCY VIRUS **(HIV)**

Warren County Public Health completed its first full year of HIV testing at its new Warren County Municipal Center location in 2011. Even with the difficult winter and spring weather conditions which forced the cancellation of two clinics, demand for rapid HIV testing remained high. Warren and Washington Counties continued to work together to make sure enough staff was available to cover the 50 free walk-in clinics offered in 2011.

Activities 2011

- Continued to promote the new location of the HIV testing site at the Warren County Municipal Center
- Promoted World AIDS day by issuing a press-release and offering free HIV testing at the Warren County Public Health office during regular office hours. Unfortunately no one attended.
- Worked with local high school nurses to promote testing opportunities for high-risk high school students.

Comments/Concerns:

- Transition to the new clinic location exceeded expectations. Even with limited access to public transportation to and from the clinic site attendance remained strong.
- Twenty-one people had to be turned away for HIV testing in 2011. This is the largest number of people turned away since 2008. However, it must be noted that during one clinic the tester ran out of testing kits. To make sure this doesn't happen in the future new procedures have been adopted to ensure adequate inventory at all future clinics.

2011 Goal Progress

- Reduced the number of people who received and STD test but refused and HIV test by 34%.
- Failed to meet the goal of no more than 5 people turned away from HIV testing during clinic hours. The number actually increased significantly. However this is most likely due to two fewer clinics and a lack of testing resources being available which put increased pressure on the remaining clinics.

2012 Goals/Outlook

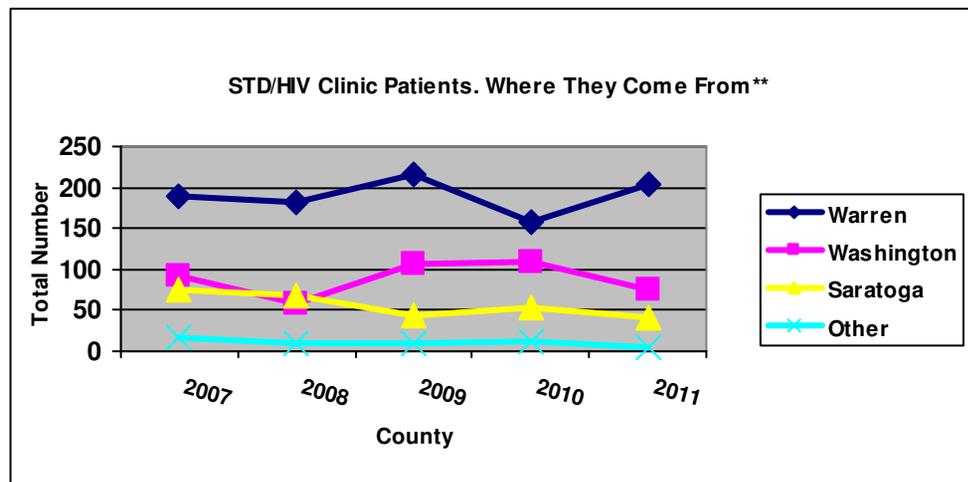
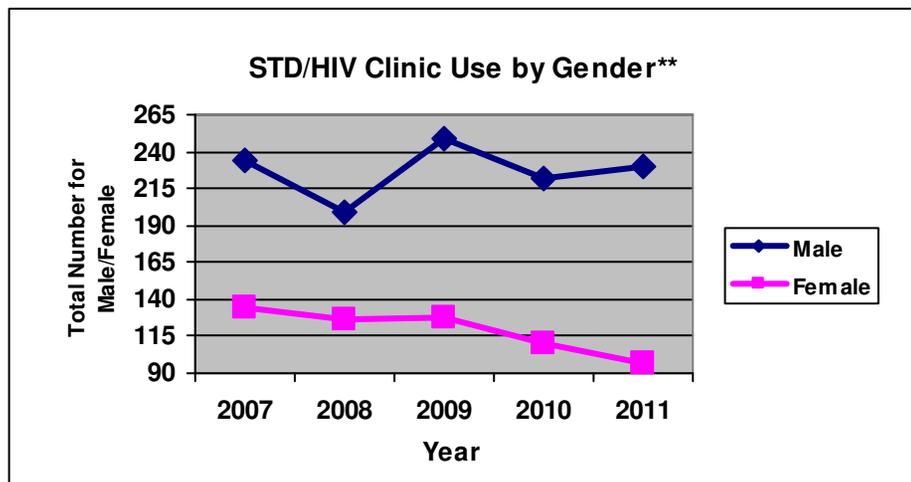
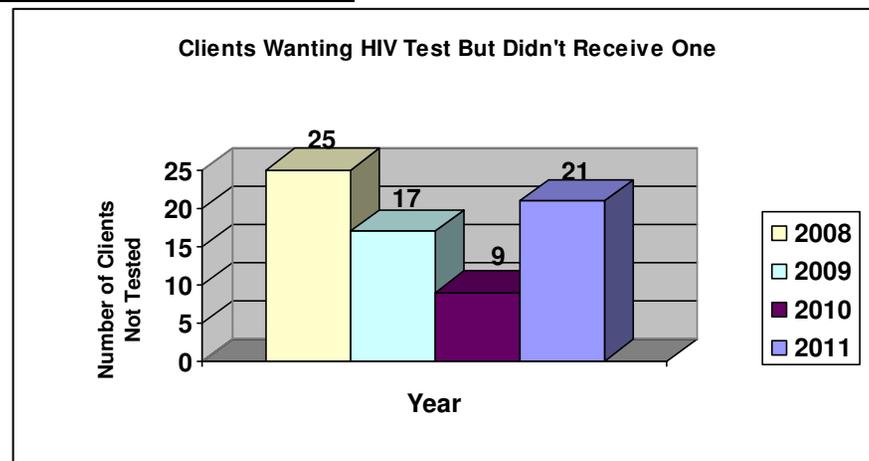
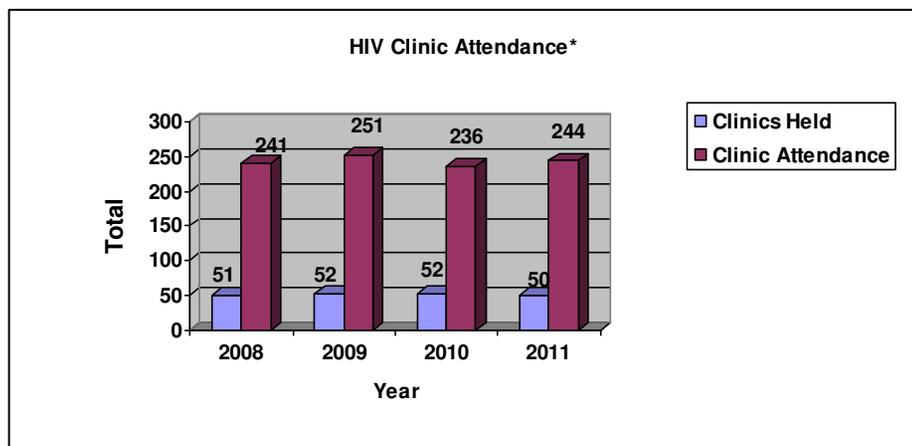
- Ensure that there are an adequate number of testing kits/resources to conduct testing at all future clinics (since HIV test kits are ordered through the New York State Department of Health some circumstances may be beyond the control of Warren County Public Health)
- Continue to try and reduce the number of people unable to receive an HIV test during clinic hours to no more than 5 a year. Most people that don't receive a test show up at the end of clinic when there isn't enough time to complete the HIV rapid test.
- Look at the feasibility of hiring a new HIV tester to cover some future clinics and to relieve pressure on current testers.

Warren County Public Health will continue to work with Washington County Public Health to ensure free rapid HIV testing for anyone wishing to get tested. Warren County will continue to offer a site for rapid HIV testing to be administered.

Warren County Public Health will continue to raise awareness about the rapid HIV testing by disseminating educational materials and referring anyone looking for HIV testing to the weekly clinics held at the Warren County Municipal Center.

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

2008 - 2011 HIV RAPID-TEST CLINIC BY THE NUMBERS



* The HIV clinic attendance graph includes 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 testing/information. Anyone attending the clinic for HIV or STD or a combination of HIV/STD testing/information is included in these numbers.

PERINATAL HEPATITIS B

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

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

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

IMMUNIZATION ACTION PLAN

The Immunization program is a viable, critical component of Warren County Health Services. In 2010 the CDC named the “top ten public health achievements of the last decade” and the number one achievement was “The substantial decline in vaccine preventable diseases”.

Warren County Public Health’s Immunization Program, strives to increase our county’s awareness of the value of vaccines and endeavors to make vaccines available and convenient for everyone. For this reason we hold clinics three times each week in our office.

In 2009 The American Recovery and Reinvestment Act (ARRA) appropriated \$300 million to the national immunization program with the goal of providing vaccines to people who were unable to afford them. We have been participating in the ARRA Vaccine program since it’s inception. We had huge success dispensing our original allotment and have requested additional (Zostavax) shingles and Tdap vaccine from NYSDOH and have been able to dispense all of the extra vaccine. The original order of pneumococcal vaccine was dispensed but the demand was slow. There was little interest in the HPV vaccine but the recommendations that males receive it as well as females had not been published.

We have enrolled in the Merck Vaccine Patient Assistance Program that enables us to offer Merck vaccines to clients without insurance. The vaccine we use is replaced to us by Merck.

We are engaged in the vaccine for children program, which is a federal program in cooperation with NYSDOH that provides vaccines to children under 19 years old for a small fee. The LHD is responsible for monitoring this program for all of the enrolled providers in the county. We serve as a research center for their questions and provide education on vaccines and their proper storage and handling per the guidelines of the CDC. We advocate for the CDC vaccine recommendations and use our influence whenever possible to see that the rules are followed.

A requirement for the VFC Program is an assessment of a provider’s practice to ascertain what percentage of their 2 year old patients are up to date with vaccines. This assessment is done using the NYS vaccine registry in cooperation with the providers. Many of the practices in Warren County are near the 90% goal and two of the practices exceeded 90%. We are very proud of the increase in vaccination rates.

Warren county Public Health continues to offer hepatitis vaccine from the NYSDOH Adult Hepatitis Program. This allows us to offer, free of charge, Hepatitis B and Hepatitis A vaccines at our STD/HIV clinics or to anyone who meets the criteria of the program.

We held flu clinics at senior meal sites or town halls of each town in Warren County. In addition to these clinics, we held an increased number of clinics in the Public Health Office. The attendance at clinics was slightly less than in previous years. We attribute this to the increased number of sites offering flu vaccine. We are most pleased with statistics that show that more people receive their flu vaccine from their provider.

Warren County Public Health is striving to have 100% of their employees receive the flu vaccine as per the recommendation of the CDC and the major medical organizations. Relative to this effort, Warren County Public Health strongly urges the recommendations that everyone of all ages receive the flu vaccine.

This year we offered the High dose flu vaccine from Sanofi and were pleased with the reception of it. We also offered the “intra-dermal flu vaccine from Sanofi but we were not pleased with the reaction and do not plan to use it again.

FluMist, the nasal spray was offered again this year and some recipients are happy with it. We plan to continue to have this available next season.

As a part of the influenza season, we collaborated with the Emergency Preparedness personnel of Warren County Public Health and offered a free flu vaccine clinic, provided by NYSDOH, to all Warren County employees and their families as well as any uninsured person. This clinic was special in that everything was done using computers, there was almost no paperwork. It was an interesting and enlightening clinic.

Immunization Clinics are held three times a week in the Public Health Office – appointments are encouraged.

REMARKS REGARDING SPECIFIC VACCINES FOR ADULTS

Zostavax (shingles vaccine) is the most expensive adult vaccine but very much in demand. We were fortunate to receive a large number from ARRA, which have been quickly dispensed. We are finding that more and more insurances will cover this vaccine; however, we will take advantage of the Merck Vaccine Assistance Program to enable more people to receive the vaccine.

Tdap (tetanus, diphtheria, pertussis or whooping cough) is in demand as more people become aware of the danger of pertussis to newborns. We have dispensed many doses of this vaccine obtained through ARRA; however, we have depleted our supply and must now charge full price.

Pneumovax (pneumonia) has been a popular vaccine with the elderly and is reimbursed through Medicare; however, now it is highly recommended for people of any age who smoke or people with chronic respiratory disease. We have encouraged this population but have not seen an increase in demand.

TRAVEL CLINIC

CLINIC OFFERING VACCINES FOR INTERNATIONAL TRAVEL

For several years, Warren County Public Health received many inquiries regarding vaccines required or recommended for international travel. Finally, after consulting with other county health departments and after having a Travel Clinic consultant come to Warren County to give a seminar on “Organizing a Travel Clinic” we decided in 2009 to offer vaccines for international travel. The main objective was to meet the needs of the traveling public but this had to be done in a fiscally responsible manner so that the County would not bear any costs for this clinic. Dr. Richard Leach agreed to be the medical consultant for the clinic and since the opening, we have served 200 clients.

We had to make a difficult choice in order to be financially viable: Do we require all clients have the consultation or do we allow clients to bring us prescriptions from their private provider. (We cannot administer yellow fever vaccine, typhoid vaccine or Japanese encephalitis without a specific doctor order) We felt that our consultant, who is certified in Tropical Medicine, would provide valuable information to the clients, so we opted to keep our consultant. In order to do this financially, we have to refuse to accept prescriptions from other physicians.

The clinic is held weekly for two hours and can accommodate a maximum of four clients. Many of our clients have sent postcards from their trips and have been grateful for the service we provide. We are a recognized Yellow Fever vaccinator and can give the certification necessary for admission to countries that require it.

This clinic has proved to be educational and inspirational. We have become aware of countries that we did not know existed and we have met people who travel for their pleasure and people who go to third world countries to try to improve the lives of the less fortunate.

We are grateful that the clinic has been able to be financially independent, in part because our consultant is not compensated for clinics that have no clients scheduled.

We are hopeful that we can maintain the quality of service of the Travel Clinic and remain financially independent of Warren County.

Summary of Travel Clinic - 2011

	COST	CHARGE	PROFIT/LOSS
1 st	\$5,748.78	\$5,894.00	\$ 145.22
2nd	\$3,698.89	\$3,939.00	\$ 240.11
3rd	\$5,199.61	\$6,058.00	\$ 858.39
4 th	\$5,220.14	\$6,746.00	\$1,525.86
Totals	\$19,867.42	\$22,637.00	\$2,769.58

INFLUENZA CLINICS

Warren County Public Health held 15 flu clinics that were advertised and were open to all citizens. Several of these were held at Senior Meal Sites and several were held at Senior Housing Facilities. Others were held at town halls. Every town was represented with a flu clinic. In addition to those clinics, 13 unadvertised clinics were held by request for staff of schools and residents of senior housing. We dispensed over 1300 doses of flu vaccine. The past two years have seen a decline in flu vaccine administered, which we attribute to the increased availability of vaccine offered at pharmacies. Our most unusual flu clinic was the one required by the NYS branch of Emergency Preparedness and required use of scanners and computers and had no “paperwork”. The vaccine was provided by NYS and the clinic/pod was observed by representatives from the state. We followed their guidelines by having volunteers help staff the clinic. The entire event went well and the experience was valuable.

Warren County Public Health continues to offer the nasal flu mist vaccine and this year offered the high dose flu vaccine that is recommended for ages 65 and over. We continue to charge \$25 per dose of vaccine or we will bill Medicare.

INFLUENZA VACCINE ADMINISTRATION

	2007	2008	2009	2010	2011
Clinics Offered Throughout the County	46	51	23	22	24
Vaccine Doses Administered at Clinics	2550	2952	2311	732	904
CHHA/Long Term Home Visits For Administration	122	101	81	33	63
Homebound Visits For Administration	26	9	9	7	0
Miscellaneous Administration i.e. PH Appointments And Other Home Visits	199	232	311	951	365
Total Doses Administered	2897	3294	2712	1723	1332

BLOOD PRESSURE CLINICS

<p>Clinics are offered for free. General health education materials are available at clinics and the Health Educator works in conjunction with Office for the Aging to develop and implement education programs at various sites. A Public Health Nurse attends the annual Senior Citizen Picnic held in Lake George to take blood pressures, answer health related questions, and distribute health education materials. This picnic has an average of 50 people who get their BP taken. A library of appropriate health education resources is also available. Reimbursement is received from Office For The Aging to cover a portion of the services provided to the senior population.</p>	BP Clinic Site	2007	2008	2009	2010	2011
	Bolton Meal Site	86	60	51	62	63
	Chester Meal Site	77	67	59	45	87
	Cronin HighRise	75	55	104	91	105
	Johnsburg	114	72	80	83	113
	L.Luzerne Meal Site	116	117	108	105	133
	Presb. Church (GF)	89	68	76	77	64
	Queensbury Center	110	97	101	78	98
	Solomon Heights	134	88	91	82	94
	Stichman Towers	30	21	52	60	48
	Warrensburg	59	58	88	78	80
	TOTALS:	890	703	810	761	885

COLLABORATIVE INITIATIVE WITH WARREN WASHINGTON COUNTIES MENTAL HEALTH ASSOCIATION

Each week a public health nurse spends an hour at East Side Center, talking with the clients about their health concerns, accessing blood pressures and weights and giving general advise regarding health. The administration of East Side Center is very pleased with this program and helps cover the cost of public health expenses.

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

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.

2011 UR Committee members:

Thank you all for your participation and dedication to Public Health

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

QUALITY ASSURANCE

Charts Reviewed in 2011

Meeting Date	MOMS	MCH	Synagis	Child Find	Other
3/09/11	2	10	0	0	2 Lead
6/08/11	0	14	2	0	
9/21/11	3	13	3	0	
12/11	No meeting in December				
Total	5	37	5	0	2 Lead

Summary of Findings: Appropriate

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

Strengths:

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

Areas Needing Improvement:

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

Summary of Recommendations

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

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

QUALITY ASSURANCE

2012 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 2012

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 2012 will be to continue to plan and deliver programs that do not serve abstract purposes but are tangible and reach out to individuals, families, neighborhoods, and institutions at the community level. Through collaboration with many multidisciplinary service providers we seek to foster personal responsibility - not dependency on others. We know, however, various strategies must be constantly employed to assist and educate people with many diverse health care needs and agendas. We will continue to expand and utilize technology to optimize patient health outcomes, prevent and/or reduce the number of unnecessary hospitalizations, and use our nursing and support staff time more efficiently.

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

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

1-800-755-8102

or

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

Email: auerp@warrencountyny.gov

Website: www.warrencountyny.gov