2016 Annual Report

Washington County Public Health Nursing Service
Preventive & Family Health Services
Bio-terrorism & Disaster Preparedness
Women, Infants & Children Program
www.washingtoncountyny.gov

Find us on Facebook
Washington County Public Health Nursing Service is proud to present the Annual Report for the year 2016.

We have moved forward and towards accomplishing higher standards of health and well-being in our communities.

Public Health & Preventive Mission Statement

By partnering with the family and community, Washington County Public Health Service has a commitment to maximize the quality of life for all – through intervention to eliminate the causes of poor health, education to improve health of families and the community and provision of support necessary to maintain a healthy Washington County.

Women, Infants & Children Mission Statement

Washington County WIC Program is committed to improving the nutrition and health status of women, infants and children by providing nutritious foods, nutrition and health education and referrals to health and human service providers for all eligible families within Washington County.
RESPONSIBILITIES OF THE PUBLIC HEALTH SYSTEM

All programs are in collaboration and support of each other

PUBLIC HEALTH

◆ Prevent epidemics and the spread of disease
◆ Prevent injuries
◆ Promote and encourage healthy behaviors
◆ Respond to disasters and assist communities in recovery
◆ Assure the quality and accessibility of health services
◆ To provide health care education for individuals, families and our community

WOMEN, INFANTS & CHILDREN

◆ To provide nutritious supplemental foods to eligible women, infants and children
◆ To improve prenatal health and birth outcomes
◆ To promote breast feeding as the preferred infant feeding method
◆ To promote physical activity at all age levels
◆ To promote healthy eating habits through the Eat Well Play Hard initiative
◆ To link families with health and human service providers
Core Functions of Public Health Agencies

- **Assessment:** Regular, systematic collection, assembly, analysis and distribution of information on the health of the community, including statistics on health status, community health needs and epidemiological and other studies of health problems.

- **Policy Development:** Using the scientific knowledge base in decision making about public health and taking a strategic approach to leadership for public health policy with a positive appreciation for the democratic political process.

- **Assurance:** Engaging policy makers and the public in determining those services that will be guaranteed to every member of the community, and making services necessary to achieve agreed upon goals available by encouraging action by public and private entities implementing regulatory requirements, or directly providing services.

(4) Adapted from The Future of Public Health, Institute of Medicine, National Academy Press, 1988
A subcommittee of the Washington County Board of Supervisors constitutes the **Health & Human Services Committee** and advises the full Board of Supervisors regarding Health & Human Services concerns. We appreciate the direction and services provided by the 2016 Health & Human Services Committee Members:

Mr. Robert Shay, Chairman

Mr. Brian Campbell

Ms. Catherine Fedler

Mr. John LaPointe

Mr. Richard Moore

Mr. Seth Pitts

Mr. Mitchell Suprenant

**We also thank:**

Mr. Robert A. Henke, Board Chairman

Mr. Brian Campbell, Budget Officer

Mr. Chris DeBolt, County Administrator

Mr. Roger Wickes, County Attorney

Ms. Melissa Fitch, Personnel Officer

Mr. Glenn Gosnell, Director of Public Safety

Mr. Tim Hardy, Deputy Director of Public Safety

Mr. Jonathan Pease, Emergency Management Coordinator

Mr. Philip Spiezio, Safety Officer
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2016 Annual Report

**Purpose:** To make recommendations to the governing authority on professional issues, including the adequacy and appropriateness of services based on an assessment of health care services in the community, patient’s needs, available reimbursement mechanisms and availability of qualified personnel. The Agency Evaluation shall consist of:

A) An overall policy and administrative review to include the extent to which the agency:
   ✓ Meets service area needs, including under-serviced geographic areas;
   ✓ Meets the needs of special populations, including persons with intense service needs mentally, cognitively or physically disabled persons, and financially indigent persons; and
   ✓ Coordinates patient care services provided by other community agencies and organizations; and

B) A review of the results and outcomes of the clinical record reviews (Quality Assurance/Improvement and Utilization Review).

**It may also serve to:**

1) Provide public record of individual program statistics and outcomes;
2) Display trends and/or deficits thereby monitoring change; and
3) Provide measures for comparisons.
DIRECTOR’S MESSAGE

The theme of change and transformation continued to dominate the Public Health/Health Care world in 2016. Public Health remained actively engaged in the process and at the table to present public health perspectives. Through the change and uncertainty, Health Department staff’s dedication to their work, programs and constituents was unwavering. Approaching all areas masterfully, through scientific and medically solid evidence, and with undeniable enthusiasm, they continued to tend to their patients, working to improve the health of our communities. Training and broadening understanding of the impact of social determinates of health, trauma, and poverty on health and wellbeing continues. Working on coalitions, teams, and with a variety of collaborators, keeps the staff energized and constantly searching for sound evidence based and cost effective approaches to deal with community health challenges.

The Agency remains fully engaged in the unprecedented health care transformation occurring via the Delivery System Reform Incentive Payment (DSRIP) implementation. Staff serves on a variety of work and advisory groups. We maintain many partnerships to work collaboratively, in a multidisciplinary manner, on improving health and wellbeing for our communities.

This is our Annual Report for 2016 to you, our leaders and our consumers. The following pages account for our challenges and proud accomplishments for the last year.

The dedicated, hard-working and always persevering professionals of this Department have my unending respect and deepest gratitude for all they do every day to make a difference. We are motivated, more than ever, by continuously striving to put our communities first and to make Washington County the healthiest place to live, work, learn, play and visit!
PROFESSIONAL ADVISORY COMMITTEE

The Professional Advisory Committee consists of a group of professional personnel, including one or more physicians, registered professional nurses, representatives from therapies and other professional organizations as well as at least one “consumer” who is either eligible to receive or has received services. Their purpose is to advise the Agency on professional issues, participate in the evaluation of Agency programs and assist the Agency in maintaining liaisons with other health care providers.

We express our appreciation to the following 2016 members for their commitment and advice at our quarterly meetings:

Beth Bruno, RN, Director of Home & Community Services, Fort Hudson Nursing Home

Marie Capezzuti, Infection Control Nurse, Bioterrorism Coordinator WCPH

Philip Gara, MD, Medical Director WCPH

Patricia Godnick, CM, GFH, CR Wood Cancer Center

Patricia Hunt, Director of Public Health WCPH

Marion Jessen, Community Representative

Tracey LeBelle, Patient Care Coordinator, High Peaks Hospice

Kathy Jo McIntyre, Assistant Director of Public Health WCPH

Debra Pauquette, Holbrook’s Adult Home

Theresa Roberts, Supervising Public Health Nurse WCPH

Courtney Shaler-Smith, Adirondack Rural Health Network Manager

Suzanne Smith, Interim Health Care

Tammy Whitty, CFFS, HCR
These services are based on the 10 Essential “Key” Public Health Functions:

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

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<td>Well Child / Immunization Clinic Visits</td>
<td>0</td>
<td>277</td>
<td>255</td>
<td>263</td>
<td>588</td>
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<td>Well Child / Immunization Clinics Held</td>
<td>0</td>
<td>71</td>
<td>51</td>
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<td>Well Child / Immunization Doses Administered</td>
<td>0</td>
<td>229</td>
<td>136</td>
<td>182</td>
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<td>Lead Screening Program – Children Screened</td>
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<td>1,166</td>
<td>1,161</td>
<td>1,036</td>
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<td>Lead Screening Program – Home Visits/Case Follow-Up</td>
<td>18</td>
<td>5</td>
<td>23</td>
<td>6</td>
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<tr>
<td>Flu Clinics</td>
<td>5</td>
<td>4</td>
<td>6</td>
<td>9</td>
<td>8</td>
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<tr>
<td>Flu Vaccines Administered</td>
<td>168</td>
<td>161</td>
<td>121</td>
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<td>Pneumococcal Administered</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>3</td>
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<td>0</td>
<td>0</td>
<td>1</td>
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<tr>
<td>Maternal Child Health Patients</td>
<td>161</td>
<td>218</td>
<td>293</td>
<td>293</td>
<td>232</td>
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<td>336</td>
<td>506</td>
<td>587</td>
<td>637</td>
<td>541</td>
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<td>MOMS Participants</td>
<td>22</td>
<td>27</td>
<td>51</td>
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<td>MOMS Clinic Visits</td>
<td>54</td>
<td>46</td>
<td>41</td>
<td>58</td>
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<td>Animal Bite Investigations</td>
<td>301</td>
<td>325</td>
<td>359</td>
<td>274</td>
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<td>People Receiving Post-Exposure Rabies</td>
<td>21</td>
<td>20</td>
<td>24</td>
<td>20</td>
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<td>Rabies Inoculations – Dogs, Cats, Ferrets</td>
<td>1120</td>
<td>928</td>
<td>879</td>
<td>1,100</td>
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<td>Animals Positive for Rabies</td>
<td>1</td>
<td>4</td>
<td>5</td>
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<td>Animals Submitted for Testing</td>
<td>33</td>
<td>43</td>
<td>79</td>
<td>61</td>
<td>80</td>
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### Blood Pressure Clinics

Health Educator conducted Blood Pressure Clinics at Earl Towers the first Tuesday of each month. 112 Blood Pressures were taken. Public Health attended the Office for The Aging Senior Health Fair on October 6th and checked 35 blood pressures.

### Flu Clinics

Due to continued emphasis on a medical home and pharmacy participation in providing early flu vaccine, no public flu clinics were held in 2016. Clinics were held for Washington County employees and patients of Washington County Public Health were offered vaccine.

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<tr>
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<td>141</td>
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<td>3</td>
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<tr>
<td># of Clinics</td>
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<td>3</td>
<td>6</td>
<td>9</td>
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The health and well-being of mothers and children are fundamental to overall population health. Improving health outcomes for women, infants and children is a priority for the New York State Prevention Agenda, aligning with goals of the State’s Medicaid program and Title V/Maternal Child Health Services Block Grant.

The overall goal for the Maternal Child Health nursing team is to promote health for women and infants during the perinatal, postpartum and newborn period. Services are available during a woman’s pregnancy through the following programs; Medicaid Obstetrical Maternal Services (MOMS) and antepartum preventive services. The goal is for the mom to stay well during pregnancy and to be prepared for childbirth and parenting. Prenatal visits are arranged with the expecting mom and can occur at the Washington County Public Health office or at another site. Postpartum visits occur in the home through the agency’s Licensed Home Care Service Agency (LHCSA). Our Registered Nurses assess the mother and newborn. Transition from hospital to home is a stressful time. One of the main focuses of the home visit is to identify any issues being experienced and to refer to community resources. The nurse provides support, reassurance, guidance and collaboration with the family’s health care provider. Standardized teaching is provided utilizing evidence-based best practice materials. Key areas taught include: nutrition, SIDs prevention, newborn care, growth/development, safety (lead poisoning prevention, car seat), maternal depression, immunizations, exercise, healthy lifestyle choices, emergency preparedness, and community resources. All referrals receive a phone call from a registered nurse and are mailed a newborn information packet.

2016 Maternal Child Health (MCH) Highlights

Strengthening referral base and acceptance of referrals.

Our goal is to provide a home visit to every pregnant and postpartum woman who is in need of our services. The focus for a visit is to provide health guidance and support through the professional assistance of a Maternal Child Health Nurse. During a visit, any needs identified are addressed by providing further education utilizing evidence based materials or referring to community resources.
Outreach to our community partners to emphasize the referral process and to promote service availability is crucial. Continued dialogue and site visits with our community partners assists in the seamless transition across service providers and to destigmatize any misconceptions regarding Maternal Child Health Care services. Our partners include: Glens Falls Hospital, South Western Vermont Medical Center, Albany Medical Center, Head Start, WIC, Wait House, Open Arms, School Nurses, Community Maternity Services, NAS Subcommittee, Economic Opportunity Council, Department of Social Services, Pediatric and OB/GYN offices.

**2016 implemented new electronic medical record system, Medent.**

The nursing department was familiar with EMR documentation, but this program was modeled to meet the needs of a physician's medical office. Regulatory requirements for the LHCSA had to be followed and integrated into the system. Medent personnel worked efficiently to adapt the product to meet the needs of the agency. There were many hours devoted to the development of documentation templates and processes for each program. Work tools “cheat sheets” were developed for recording information and to create standardized operating procedures. Quality Improvement audit tools were created and revised as needed to evaluate the compliance with agency policy and procedure.

**Postpartum Depression:**

![Postpartum Depression Image]

Depression affects women of all backgrounds at a rate of one in five women. Over one-third of women of childbearing and childrearing years have depressive symptoms. Mothers living in poverty are over three times more likely to have depression than other mothers. The New York State Community Action Association reported in February 2016 the poverty rate in Washington County with women as head of households with children present is 41.4%.

The symptoms of postpartum depression are similar to symptoms for depression, but may also include

- Crying more often than usual.
- Feelings of anger.
- Withdrawing from loved ones.
- Feeling numb or disconnected from your baby.
- Worrying that you will hurt the baby.
- Feeling guilty about not being a good mom or doubting your ability to care for the baby.

**Depression is treatable, and treatment can help needless suffering.**

The earlier a woman is identified with maternal depression, the earlier she can receive treatment. Evidence-based treatments exist. They include: cognitive and interpersonal therapies, medication, peer-to-peer support programs and support groups. Currently there are no support groups available in Washington, Warren or Saratoga County. A high percent of mothers with depression are not receiving treatment due to barriers. They include the following: lack of awareness of what depression looks like, how to seek help, negative attitudes and misconceptions about depression, cost, travel, and lack of availability of treatment providers.

Maternal Depression impacts the family. Children of parents with depression are at increased risk for behavior, attention, anxiety and depression. Fathers who partners are experiencing maternal depression have an increased risk of depression.
Maternal Depression Project Goals and Action Steps for 2016:

- Providers will identify signs and symptoms of Maternal Depression through universal screening using a validated tool.

**Action Step:**

- Maternal Child Health nurses utilize the Edinburg Postnatal Depression Scale for all start of care visits. The score is documented and reported to physician.
- Mothers and families who are experiencing Maternal Depression will be provided with resources, support and assistance with obtaining access to treatment.

**Action Step:**

- All WCPH referrals are mailed postpartum depression materials
- Primary Care Provider is notified of all scores from the Edinburgh Postpartum Depression Scale Score
- Utilize existing interagency work groups (e.g. NAS subcommittee, WIC, Head Start) to disseminate information regarding assessment of women for signs and symptoms of Maternal Depression, education, treatment, resources, and support.

**Action Steps:**

- Head Start Homebased Program’s policy is to have the home visit within two weeks of birth. The agency’s policy offers the following visit options: WCPH MCH nurse, Head Start nurse, or declination of visit. Head Start Home visitor has a Mother Of Child signed form indicating which option she prefers. The Edinburg Postnatal Depression Scale screening tool is completed at the home visit. The completed form is evaluated by a Head Start Mental Health counselor who reviews and makes follow up recommendation regarding any treatment needs.
- Women in attendance at Washington County WIC clinics were asked about interest in a support group. The overall response is that they felt there was a need and they would attend if offered in their communities.
- Utilize social media regarding issue of Maternal Depression and access to services and resources.

**Action Steps:**

- Posted on Washington County website “We are Warrior Moms”. There were 3000 views in the first month.
- Obtain training funding for Public Health MCH Nursing staff to improve knowledge and skills in assessment, care planning, and providing a local support group for women with Maternal Depression/Mood Disorders. Pursue training through Postpartum Support International program that is web based.

**Action Steps:**

- Applied for Adirondack Health Institute Prevention Agenda Grant for 2017

**LHCSA Survey follow-up.** The agency was surveyed by NYSDOH in March 2016. This was the first full survey post the initial LHCSA start up survey. Based on surveyor recommendations all DOH programs and MCH Skilled Nursing the community will be documented in the agency electronic Medical records system. The Agency amended policy and procedure to include all nursing programs. Nursing staff were provided training
on policy changes and applicability to program admissions. Programs that were on paper (MOMS, Lead, Child Find) have been added to the Medent software program. Audits were conducted to ensure compliance.

**Neonatal Abstinence Syndrome (NAS)**

NAS is a condition in which a baby has withdrawal symptoms after being exposed to certain substances. Many times, the baby is exposed when the mother uses substances such as medications or illicit drugs during pregnancy. Opioid use is the most common cause of NAS. After the baby is born, the baby goes through withdrawal because it is no longer receiving the substances through the mother. Less commonly, very sick babies may receive medications after birth to help control pain or agitation, and once those medications are stopped, the baby may go through withdrawal. Symptoms of withdrawal include feeding intolerance, seizures, diarrhea, and respiratory distress.

At CDC’s Website: 2000–2012, the incidence of NAS in the United States significantly increased. CDC examined state trends in NAS incidence using all-payer, hospital inpatient delivery discharges compiled in the State Inpatient Databases of the Healthcare Cost and Utilization Project (HCUP) during 1999–2013. Among 28 states with publicly available data in HCUP during 1999–2013, the overall NAS incidence increased 300%, from 1.5 per 1,000 hospital births in 1999, to 6.0 per 1,000 hospital births in 2013. The findings underscore the importance of state-based public health programs to prevent unnecessary opioid use and to treat substance use disorders during pregnancy, as well as decrease the incidence of NAS.

**Neonatal Abstinence Syndrome Subcommittee**

Established April 2015 as a subcommittee of Hometown vs Heroin and Addiction

Our NAS subcommittee has the following goals:

- Share information and collaborate with clinical and human service partners to develop policies, procedures, and educational messages to improve the delivery of services to pregnant and parenting women with a substance abuse disorder.

- Provide an evidence based standard of care for infants withdrawing from opiates and narcotics.

- Improve screening of pregnant women and make it a standard of practice that they are screened throughout pregnancy.
• Provide standardized patient education in relation to prescription and recreational drug use to all women during preconception counselling and/or receiving substance abuse treatment.

• Provide an evidence based standard of care for drug-addicted mothers during pregnancy.

• Reduce barriers to treatment through a fast track available to assist women into a treatment program that works for them.

• Empower women to self-disclose an addiction and to enter treatment.

• Help women to navigate through services that are available.

• Improve the transitions through care services with “warm” handoffs and better communication across disciplines and services.

• Provide anticipatory education and guidance to women regarding withdrawal symptoms and how to support their newborn.

• Improve acceptance of Maternal Child Health Nurse referrals and home visits.

• Promote family-centered care during treatment and recovery.

**NAS Subcommittee Highlights 2016:**

• Washington applied for and awarded grant by Adirondack Health Institute (AHI). Grant money has been used for printing brochures, posters and obtaining speakers to provide education to clinical and human service partners. March 2016, training was provided by the Vermont’s Children and Recovering Mothers (CHARM) Team on “A collaborative approach to supporting pregnant and parenting women with opioid addiction and their infants”.

• Following the CHARM training it was determined that the NAS brochures and posters needed revision to correspond with acceptable practice.

• 2016, NAS Educational committee created to develop educational modules and outreach towards the above goals. Informational flyers were developed regarding Medication Assisted Treatment and Neonatal Abstinence Syndrome Resources and distributed to clinical and human services partners.
- Washington County WIC provides the NAS brochure in their third trimester interview process and offers referrals to Maternal Child Health Nursing Home visits.

- GFH Snuggery increased the amount of time NAS infants spent “rooming in” vs admission to special care nursery. The effect has been lower Finnegan scores (the tool used to assess NAS). Lower scores indicate the infant is not experiencing as severe a withdrawal and therefore they don’t require medication (morphine) to control their symptoms.

- Saratoga Hospital is developing policy, procedures, and training for NAS infants. Once this is in place, treatment for NAS can occur at Saratoga Hospital and not require transfer to Albany Medical Center.

- All treatment centers prioritize pregnant women. The Center for Recovery established a walk-in service at their Hudson Falls office. Through this change in care delivery they were able to significantly increase the number of units of assessment and treatment they provided. Due to that success, they changed to a walk-in process at their Glens Falls office.

- To improve acceptance of home visits, Maternal Child Health (MCH) nurses make rounds at GFH Snuggery. Hospital nurses and MCH nurses worked collaboratively on referrals to improve care transition from hospital to home.

- The following members of National and State organizations have joined and or shared their expertise: OASAS, The Children and Family Futures/National Center on Substance Abuse and Child Welfare (NCSACW), Harm Reduction Coalition, NYDOH Division of Family Health, Rural Health Network, Surveillance, Prevention, Drug User Health and Administration AIDS Institute.

- Information meetings held with legislative representatives NYS Senator Betty Little, United States Assemblywoman Elise Stefanik and NYS Assemblywoman Carrie Woerner. Representatives were supportive of the goals of the NAS subcommittee and will maintain lines of communication to inform of upcoming legislative agenda and funding.

- There has been tremendous growth in membership in less than two years. The NAS subcommittee has grown from the original ten members to over forty members. Members Include representatives from four Local Health Departments (Washington, Warren, Saratoga, and Essex), Hudson Headwaters Health Network case managers, Washington County WIC, Warren and Washington County DSS, Glens Falls Hospital, Saratoga Hospital, Physicians (Pediatric & OB/GYN), nurses from GFH Snuggery and Pediatrics, Neonatal Nurse Practitioner, Council for Prevention, Baywood Treatment, Center for Recovery, Harm Reduction Coalition, NYS Division of Family Health, Rural Health Network and NYS Surveillance, Prevention, Drug User Health and Administration AIDS Institute.
Maternal Child Health Statistics

*NTUC – Not Taken Under Care

**PREVENTIVE**

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<tr>
<th></th>
<th>2016</th>
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<th>Change</th>
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<td>Total Patients Served</td>
<td>-57</td>
<td>161</td>
<td>218</td>
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<tr>
<td>Skilled Nursing</td>
<td>-92</td>
<td>331</td>
<td>423</td>
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<tr>
<td>Child Find</td>
<td>-27</td>
<td>5</td>
<td>32</td>
</tr>
<tr>
<td>Lead</td>
<td>-4</td>
<td>1</td>
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<tr>
<td>MOMS</td>
<td>-60%</td>
<td>-40%</td>
<td>-20%</td>
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PREVENTIVE REVENUE BY PAYOR

- Expenditures: $1,082,564
- Commercial Revenue: $60,800
- Total Revenue: $60,800

Change 2015-2016: -20%

PREVENTIVE VISITS BY PAYOR

- Commercial: 192 - 152%
- Free Care: 199 - 40%
- Total: 391 - 60%

Change 2015-2016: -115%
WELL CHILD CLINICS / IMMUNIZATION CLINICS

Immunization clinics are held on Wednesdays and reserved for Washington County residents only. All publicly funded vaccine will continue to serve eligible children, adolescents and adults:

- Uninsured
- Under-insured
- Enrolled in Medicaid
- Medicaid Managed Care
- Child Health Plus
- American Indian or Alaska Native

For adult immunizations, we have contracted with several private insurance companies for vaccine and administration billing. However, some insurance companies will not contract with a local health department as they contract with physicians to provide immunizations as part of the services they provide as a primary care provider.

The Public Health agency continues to provide support and guidance to school districts regarding immunizations. Due to the changes in the New York State Department of Health Bureau of Immunization policy, the majority of children were referred for vaccinations through their primary care physician and not through school clinics.

The impact of changes in the health delivery system as noted above as well as the increase of those who now are supported by a medical home has affected the number of people utilizing Public Health services. Managed care, mandatory Medicaid managed care, primary care provider delivery and third party health insurance via Child Health Plus and their coverage have led clients away from county clinics. Child Health Plus coverage is more widespread and inclusive secondary to the hard work of facilitated enrollment contractors covering this geographic area.

Residents residing throughout the county can utilize this site. The children attending the well child clinics are typically awaiting insurance and are in need of a physical and immunizations to clear them for school admission.
Those uninsured, who have Medicaid or Managed Medicaid, are an American Indian or Alaskan Native, are eligible to receive VFC vaccine. There will be no out of pocket expense for these individuals. For those who are under-insured, they are eligible for vaccine, but subject to an Administrative fee of $25.00. There is a sliding fee scale will be available for those who qualify. Insured children and adolescents must schedule an appointment with their primary care physician for vaccinations. For individuals who are fully insured and wish to utilize the services of Washington County Public Health, they will be required to pay the full fees for vaccine and administrative fees.

Vaccine Charges 2016

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Clinic Data

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**IAP – Immunization Action Plan**

Each year Washington County participates in an Immunization Action Plan Grant. 2016 was the fourth year in a five year funding cycle. As with previous grant years there are specific goals delineated. New accountability standards were established including the utilization of immunization rates as a performance measure. The five year plan from 2013-2018 is designed to move LHDs to a performance-based reimbursement structure. **Throughout our lifespan vaccines play an important role in preventing disease.** The overall mission is to promote and improve vaccination status of all residents through meeting the following goals.

**GOAL 1: Increase Childhood and Adolescent Immunization Rates**

**NYS Objective:** In accordance with Healthy People 2020, the New York State (NYS) Bureau of Immunization seeks to meet or exceed an 80% statewide immunization coverage level for 19 – 35 month old children with 4 doses of DTaP or DTP, 3 doses of polio, 1 dose of MMR, 3 doses of Hib, and 3 doses of hepatitis B, 1 dose of varicella and 4 doses of pneumococcal vaccine (4:3:1:3:3:1:4) AND meet or exceed a 50% statewide Human Papillomavirus (HPV) vaccine 3-dose series completion (≥ to 3 doses) rate among 13 year olds.

**LHD Objective 1:** Increase 4:3:1:3:3:1:4 childhood immunization rates in the county by 1-2 percentage points annually through AFIX visits and/or daycare/preschool audits and increase HPV vaccine 3-dose completion rates in 13 year olds by 1-2 percentage points annually through AFIX visits.

**GOAL 2: Increase Adult Immunization Rates**

**NYS Objective:** Within five years, increase adult immunization rates for influenza and Tdap vaccines by 10% among NYS adults aged 19+ years as measured through the BRFSS and increase the number of adult care providers who enter data on adult immunizations into NYSIIS.
LHD Objective 2-A: Conduct activities to increase county specific influenza and Tdap immunization rates among pregnant women, their partners, and other adult (19+ years) caregivers of infants and to increase the number of health care providers who enter data on adult immunizations into NYSIIS.

GOAL 3: Ensure that all vaccination records are completely and accurately entered into NYSIIS.

NYS Objective: Increase the number of NYS registered health care providers who enter vaccination records into NYSIIS by 10% by 2018.

LHD Objective 3-A: Increase the number of health care providers who are registered with NYSIIS and maintain immunization records through the system by 2% annually.

GOAL 4: Increase Education, Information, Training, and Partnerships

NYS Objective: Increase immunization focused education, and training opportunities available to local health department staff, the public, and health care providers.

LHD Objective 4-A: Provide information, education and training for local health department (LHD) staff and health care providers who provide immunizations.

Goal 5: Eliminate Perinatal Hepatitis B

NYS Objective: Reduce perinatal hepatitis B transmission.

LHD Objective 5-A: Facilitate and coordinate local perinatal hepatitis B initiatives and activities mandated by Public Health Law 2500-e and Title 10 NYCCR, subpart 69-3.

2016 IAP Highlights

- Continue to promote and provide immunizations through the Vaccines for Adults (VFA) program (initiated by NYSDOH in 2015). This program is similar to the Vaccine for Children (VFC) program. Adult immunizations are covered at no cost for adults who don’t have insurance or their insurance does not cover immunizations/shots. Education provided to community partners regarding availability of VFA vaccine. Partners included: Treatment Centers, Jail, Department of Social Services, Health Care Providers, Head Start, Food Pantries, Facilitated Enroller, Hometown vs. Heroin/NAS subcommittee, Economic Opportunity Council, Aging and Disabilities Resource Center, Supplemental Nutrition Assistance Program, Head Start, and WIC.

- On-site visits to offices that provide immunizations through the Vaccine for Children program. During the visit, Assessment, Feedback, Incentive, Exchange (AFIX) occurs. Immunization rates provided and office practices are reviewed. Quality Improvement initiatives are presented and selected by the practice to improve immunization rates.

- Outreach with HPV immunization educational materials distributed to community partners. January is Cervical Health Awareness Month. Utilize materials from the National Cervical Cancer Coalition. Website, Tweets, and Facebook messages throughout month. Posters placed in libraries, convenience stores, town offices, health centers, schools. Community partners include: Health Care Practices, annual School Nurse meeting, Berkshire Farm Center, Washington County Fair, WIC, Community Maternity Service, County Youth Bureau and Probation, SUNY Adirondack, Local Early Intervention Coordinating Council (LEICC) and to adolescents who seek services at Public Health.
• National Infant Immunization Awareness Week Flyers distributed throughout county.

• WCPH implemented new Electronic Medical Record (Medent). Immunizations are recorded in EMR. Clinic processes written to coincide with new EMR. Many hours spent in training and setting up system that support billing electronically to insurance providers.

• Diverse and underserved populations received information through Legal Aid Society representative. Informational flyers distributed to DSS/Assistance Programs (temporary assistance, SNAP, Home Energy Assistance Program, ADRC, EOC), informational flyer distributed to townships, soup kitchen, consignment shops, laundromats, car seat program, WIC, MOMs program, Newborn/postpartum care visits, Head Start, and facilitated enrollee.

• Washington County jail. Provided Washington County jail inmates with adult immunization screening questionnaire to determine need for immunizations and administer upon request. Developed new form for jail nurses to utilize when determining what immunizations are being requested for each inmate. 2016 Adult immunization recommendations by age and health condition sent for nurse to review with inmate. WCPH runs report through New York State Immunization Information System (NYSIIS) to see if the individual has already received or started a series. Strongly recommend that immunizations received at jail clinic be entered into NYSIIS. WCPH nurses hold clinic every third Wednesday at the jail.

• 210 immunization surveys distributed to EMS leaders in January. The results of this survey are depicted in the following graph. Educational materials distributed to EMS leaders. Due to the low numbers of EMS personnel who receive a Flu vaccine, this was strongly recommended. There are many sites available to receive Flu vaccination throughout the county. WCPH Vaccine for Adults program may be a source to obtain Flu vaccination to those who qualify.

• Kingsbury Senior Health Fair information and display regarding adult immunizations
• **National Influenza Vaccination Awareness Week (NIVW):** Outreach to medical practices in Washington County with immunization materials. Flyers distributed and social media utilized to promote NIVW. Joint campaign with Warren County Public Health to purchase and display signage on the interior and exterior of the Glens Falls Greater Transit buses.

![Flyer promoting flu prevention](image)

• Two local Certified Home Care Agencies added Adult Immunization information to their admission packets. WCPH provides the written information and links to websites.

• Immunization information to mailings sent to families regarding reminder to have children tested for lead poisoning
• All Newborn visits receive “Your Baby’s First Year Calendar” and literature which contains reminders to obtain immunizations, a current children/teen immunization schedule, clinic schedule, and After the Shots educational flyer.

• Worked with our local Adult Immunization Coalition to promote and conduct educational and outreach activities about the benefits of adult immunization. This committee is working on increasing membership and providing education to the community. Shared educational materials with the group members from the toolkit for National Immunization Awareness Month. This committee decided to include childhood immunizations as a focus along with Adult immunizations with the goal of increasing immunizations throughout the lifespan.

• Warren and Washington County outreach at SUNY Adirondack. January Cervical Cancer Awareness/HPV Immunization and February Adults need immunizations too! Met with registrar regarding students who have not submitted immunization records.

• MCH nurses and Health Educators presented information at Washington County Fair booth. Displays and educational materials regarding immunizations throughout lifespan.

• At Washington County Fair went to farm booths regarding availability of vaccinations for migrant and seasonal farmworkers. Created Resource Binder. Delivered to farm for support person to review materials prior to clinic. Spanish with English copy for support person at farm to review with workers. MCH nurses and Health Educators presented information at Washington County Fair booth. Displays and educational materials regarding immunizations throughout lifespan.
- Disseminate information through outreach to our community partners to keep them informed about current immunization recommendations. WIC, Maternal Child Health, MOMS Program, County Youth Bureau and Probation, Department of Social Services visits, Lead Poisoning Prevention Program, Head Start, Fort Ann Health Fair, Early Intervention, Community Maternity Services, ADRC, and Child Find. In addition this year provided Fort Hudson, Morcon and General Electric immunization literature and posters for their staff break rooms.

- Hepatitis A, Hepatitis B, and Twinrix vaccines are offered to all high-risk adults seeking services through health department sponsored clinics and service settings, including contracted services. Education provided to Council for Prevention, Center for Recovery, Baywood Treatment, Hometown vs Heroin, Washington County Jail Nurses.

- Partnered with Information Technology Department who maintains Public Health website regarding immunization, National Infant Immunization week, and National Influenza Awareness Week. The IT website manager noted that the Child immunization video has 4,586 views!

- Families screened during prenatal and postpartum visits about immunization history. Education provided about the need to cocoon newborns from vaccine preventable disease (Pertussis and Influenza) as they are most vulnerable during the first months of life.

- 100% of employees who have contact with public/patients were vaccinated to meet Section 2.59 of the New York State Sanitary Code within Title 10 of the New York Codes Rules and Regulation pertaining to “Prevention of Influenza Transmission by Healthcare and Residential Facility and Agency Personnel”

- (New York State Immunization Information System (NYSIIS) consent for individuals 19 years of age and older is strongly encouraged at all WCPH clinics. The public was educated about NYSIIS at the Washington County Fair. Health Care Providers are encouraged to utilize NYSIIS and to enter data timely into the system.

- Shared up to date information, education and training for employees who participate in maintaining storage and administration of vaccines. The body of knowledge regarding immunizations is frequently evolving as new scientific evidence emerges. Recommendations regarding immunizations are updated via federal and state communications. The New York State Department of Health and Center for Disease Control websites were monitored and referenced frequently.

- Updated providers through site visits and/or via fax blast about current immunization recommendations

- Updated office manual to have the most current resources available for clinic nurses to access and distribute

- Met with Albany Medical Center NICU staff Elayne Frank, RN and Ericka Cotugno, MSW. Discussed and provided information regarding WCPH services including immunizations (emphasis on cocooning).

- National Immunization Awareness Month (NIAM). Flyer developed and distributed to Fort Hudson, Family Health Centers, Town Offices, Post Offices, Stewarts Shops, Washington County Fair, WCPH Website, Twitter, and Facebook. Partnered with Warren County Immunization Action Plan and immunization messaging ran on the Glens Falls Greater Transit Line during NIAM.
• Many pharmacies offer influenza vaccines for individuals over 18. Pharmacies are accessible with convenient times and locations. Due to this, there has been decrease utilization of LHD for influenza vaccines. WCPH continues to serve as a gap service for the community, offering influenza vaccines to high risk populations. Flu clinic held at Loaves and Fishes food pantry.

• IT Website manager noted that Flu video posted on website had **almost 4000 views**.

• Monitored birth dose of Hepatitis B through review of birth certificates. MOMs and antepartum assessment/plan of care for: client assessed for history of Hepatitis B, completion of Hepatitis B vaccination series, and risk factors. Provide education regarding Hepatitis B transmission and prevention. Coordination with hospital that any infants born to women who are Hepatitis B positive receive HBIG and Hepatitis B vaccination within twelve hours of birth.
Lead Poisoning Prevention Program

Washington County’s Lead Poisoning Prevention Program is funded via a grant from the New York State Department of Health.

Lead Poisoning is Preventable!

The key to Lead Poisoning Prevention is to prevent and eliminate any exposure by taking the following steps:

- Keep children away from peeling or chipped paint.
- Make home repairs safely by following the EPA Lead Hazard Pamphlet and EPA Repair, Renovation, and Painting Rule (Effective April 2010). Hire contractors with Lead-Safe certification and training. Children and pregnant women should stay away until the area is properly cleaned with wet cleaning and HEPA vacuuming.
- Wash dust off hands, toys, bottles, windows and floors.
- Check toys for recall at [www.cpsc.gov/cpsclist.aspx](http://www.cpsc.gov/cpsclist.aspx)
- Avoid exposure children’s jewelry and costume jewelry
- Remove clothing prior to coming home whenever possible or have a designated changing room and wash thoroughly if you have a hobby or occupation that involve contact with lead (painting, plumbing, construction, car and computer repair, firearms, pottery, stained glass)

NYSDOH Lead Poisoning Prevention Program Grant has delineated key components to be addressed:

<table>
<thead>
<tr>
<th>GOAL #1</th>
<th>PROGRAM ADMINISTRATION: Local Health Departments (LHD) will effectively administer a Lead Poisoning Prevention Program (LPPP).</th>
</tr>
</thead>
</table>

Policies and procedures within the agency follow the Lead Poisoning Prevention set forth by the New York State Department of Health.

2016 Highlights

- Maintained standard operating manual for management of blood lead levels
- NYS now recommends that a venous blood lead level (BLL) is obtained for any capillary result of $>5$ mcg/dL. Outreach to physician offices to inform of this recommendation. Follow-up on a case by case basis to inform parents and physicians to obtain venous BLL when indicated. Presentation provided at two practices.
- Letters mailed to the village mayors and town supervisors explaining LPPP. Handouts sent along with the letters included: EPA/HUD Fact Sheet, What Your Child’s Blood Lead Test Means, and Become Lead Aware
- Maintained CLIA (Clinical Laboratory Improvement Amendment) waiver to allow testing for blood lead levels at WCPH using the Lead Care II
- Be Lead Free News! Newsletter which is geared for families was distributed to: Family Health Care Centers, Pediatric offices, WIC, Head Start

| GOAL #2 | EDUCATION: Increase knowledge and awareness of the public, healthcare providers, other professionals, and local policy makers regarding lead poisoning and lead poisoning prevention in children and pregnant women, based on the needs of the county, including the specific impact on the local community. |
Environmental lead exposure is a recognized health hazard. Children are particularly susceptible to its affects and pose lifelong health and learning consequences. These affects include learning disabilities, kidney damage, hearing loss, growth problems, anemia, and behavior problems. Symptoms of lead poisoning may not be apparent or may be mistaken for other illnesses. The symptoms may include fatigue, crankiness and stomachaches. However, there are usually no signs. Lead poisoning in its most severe form can be fatal. It is important to remember that lead poisoning is preventable.

2016 Highlights

- Visual learning tool Lead Poisoning Prevention Doll House. The house had lead poisoning prevention messages in each room. Utilized this display at Washington County Fair and at Head Start Sites
- Developed It’s Summertime - low cost tips on ways to reduce the amount you and your children are exposed to lead. Distributed to WIC, EOC, DSS, Head Start
- New folders from LPPP (Lead Poisoning Prevention Program) and packets made up and distributed to Main Street Pediatrics and the following GFH Health Centers: Whitehall, Granville, Greenwich, and Cambridge.
- Continue to partner with WIC. New WIC recipients receive “Welcome Packet”. Children who receive WIC services are screened for low Hgb levels. Low Hgb levels are referred for lead testing either to their HCP (Health Care Providers) or WCPH. WCPH updates Recall Resource Binder in WIC waiting area. Continue to have a nurse attend WIC clinics held throughout county. Nurse has LPPP display materials, brochures and is available to answer questions to clinic attendees.
- “Your Baby’s First Year” calendar provided to all new moms who receive a home visit. Education is provided at initial visit(s) regarding lead poisoning prevention. This tool will provide reminders on lead poisoning prevention throughout child’s first year.
- Children referred to Early Intervention and Child Find will have their lead levels checked in NYSIIS or Lead Web. If the child has not had lead testing at age one or two information will be provided to parents regarding testing and assistance will be provided in getting the child tested if they have no health insurance
- Consult with Dr. Shottler-Thal, Regional Lead Poisoning Resource Center on all open lead cases. Dr Shottler-Thal makes recommendations for repeat venous levels and any other additional labs. Her recommendations are forwarded to the child’s primary care physician who decides the best plan of care for the child.
• Distribution of 242 Back Packs with LPP materials to EOC and the following food pantries: Whitehall, Granville, Greenwich, Salem, Hartford, Argyle

• National Lead Poisoning Prevention Week-October 23-29, 2016. Halloween Bag distribution with LPP materials: 155 to Medical offices, 243 Head Start, 50 WIC, 20 EOC, 20 Salem Town Hall, 30 bags Hudson Falls Police Office, 18 bags Fort Ann Trunk or Treat, 3 bags Early Intervention

• Building Permits obtained at Washington County Code Enforcement office receive “Become Lead Aware” Code Enforcement officers distribute EPA materials.

• WCPH utilizes social media, Facebook and Twitter accounts, LPP information shared via these modes

• A wide variety of educational materials and screening tools were distributed by Maternal Child Health staff at health fairs, well child visits, to the physician provider community, on all referrals and via the MOMS Program. Also included are hardware stores, code enforcement, food pantries, building inspectors,

• Reminder letters sent prior to child’s second birthday to have blood test for lead

• Attended and provided immunization information and display at Economic Opportunity Council Winter Coat Boutique & Family Info Fair.

• All MOMs referrals receiving mailing regarding “Pregnancy and Lead Poisoning What Every Woman Should Know”

GOAL #3
EDUCATION: All children and pregnant women are tested for lead poisoning consistent with requirements outlined in NYS Public Health Law, Administrative Rules and Regulations, and CDC guidelines.

A blood lead test is the only way to determine exposure. Exposure usually occurs when children lick, swallow, or breathe in dust from old lead paint. NYS requires physicians to test all children with a blood lead test at one and again at two years of age when children are at highest risk for hand to mouth ingestion. Physician practices
should also screen children up to age six at every well child visit through questioning about possible exposure risks. Children who have any possible exposure should have a blood lead level obtained. Testing compliance has been enhanced with the use of the Lead Care II testing device in the County’s pediatric and family health practices. In order to enhance compliance with testing for 1 and 2 year olds, proof of lead testing is recommended but not required for preschool entry. Children are not excluded for lack of testing as they may be for lack of immunization. There has been steady improvement demonstrated in children being tested at ages one and two. Most health care providers now have the ability to provide on-site capillary testing. The results from the blood sample are obtained within three minutes. This is less stressful and convenient because families do not have to go to a lab for venous testing.
2016 Highlights

Direct Lead screening provided by WCPH when no insurance and/or medical care provider at clinics and Head Start.

- Transitioned from a paper documentation system to utilizing MEDENT EMR for all Lead Poisoning Prevention open cases. This was entirely from scratch as there were no processes to follow.
- MOMs participants are screened for Lead risk and receive education regarding Lead poisoning prevention. Lead Care II testing offered to participants identified at risk. Physician notified if risk identified and request lead testing.
- MOMs program assessment forms and care plan updated to include standardized assessment and care planning to include knowledge deficit regarding Lead exposure and lead poisoning in infants.
- Washington County does not have any OB/GYN practices. Many Washington County residents receive obstetric care at three major practices in Glens Falls. Site visits to these practices with Lead prevention educational materials, lead screening risk question tear off sheets.
- Provided education and guidance to physician practices when a false blood level elevation occurred with the use of Lead Care II device.
- Reminder letters mailed prior to child’s second birthday to have blood test for Lead
• Mailings sent to parents/guardian for all blood Lead levels results ≥5 and ≤10 mcg/dL. A letter explains the function of the Lead Poisoning Prevention Program, resources, and contact information. Emphasis is placed on the prevention measures you take will make a difference. NYSDOH educational form #2526, “What Your Child’s Blood Lead Test Means” is enclosed.

• Total of 23 children were tested across Head Start sites. 22 children <5 mcg/dL. One child had a capillary result which required venous confirmation.

**GOAL #4**

**EDUCATION:** Follow-up for children with elevated BLLS <18 years of age: All children with elevated blood levels receive timely and appropriated follow-up services, consistent with the Public Health Law, Administrative Rules and Regulations, and CDC guidelines.

The Lead Poisoning Prevention Nurse provides case management for all children in the county with a blood Lead level of ≥10 mcg/dL. For levels 10-14 mcg/dl a letter and educational packet of information is sent to the family. A follow-up telephone call is made to take a lead risk assessment and exposure history and offer a home visit. The Lead Poisoning Prevention Nurse explains the program and the child will be followed until they meet criteria for discharge. Reminder letter are sent when repeat blood lead levels are due. For children with a blood lead level >15mcg/dL, a home visit is made. During the home visit the nurse takes a lead exposure history, risk assessment is done along with a general health assessment. Education is provided and a plan established on how to reduce the child’s lead exposure. Referrals are made to other programs based on the nurse’s assessment. The Lead Nurse works closely with New York State Department of Health District Office in Glens Falls for environmental management for cases with a BLL ≥15mcg/dL. NYSDOH criteria for medical discharge is two consecutive venous levels < 15 mcg/dL, taken at least six months apart OR one venous blood lead level < 10 mcg/dL, and all required follow-up activities, including environmental management, have been completed consistent with the child’s blood lead level.

**2016 Highlights**

Provided case management and monitoring of blood lead levels for open cases. Reminders sent to primary care physician and parents/guardians when follow- up lab work is due.

• There were 18 cases managed in 2016. 6 new cases were opened. 11 cases were discharged in 2016.

**Cases Managed by Township with Elevated Blood Lead Level results in 2016**

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GOAL #5
PRIMARY PREVENTION: Lead hazards in the community are identified and controlled before children become lead poisoned.

2016 Highlights

Washington County Fair: visual display utilizing our Lead dollhouse. The house had lead poisoning prevention messages in each room. Health educators and nurses manned the booth and answered questions.

- Advocate Assistance Programs utilizes client checklist “Was home built before 1978?” The checklist is a guide for clients to assist them in having lead exposure conversations with prospective landlords. LPP materials made available for distribution to those applying/receiving DSS assistance.
- Education is provided at initial newborn home visits. “Your Baby’s First Year” calendar is presented and lead poisoning prevention is highlighted throughout child’s first year.
- The Lead Poisoning Prevention Nurse worked to educate providers and community agencies through site visits, meetings, and educational materials.
- A wide variety of educational materials were distributed by Maternal Child Health staff at health fairs, well child visits, to the physician provider community, on all referrals and via the MOMS Program. Also included are hardware stores, code enforcement and building inspectors.

![Percentage of Cases with Elevated Blood Lead Levels by Township](image)
Prenatal Program

Washington County Maternal Child Health nurses provide prenatal services to twenty-six women in 2016. Women can self-refer or they can be referred for services by their Health Care Provider or one of our community partners (WIC, Head Start, Community Maternity Services, etc.). Our prenatal programs are designed to work in collaboration with a woman’s health care provider by establishing a plan of treatment. Services focus on the assessment of the woman’s health and risk factors. Education is provided regarding: child birth, prenatal care, labor and delivery, postpartum care, infant care, parenting skills, family planning options, infant growth and development, prevention of risk to toxic exposure (Lead), STD and HIV counseling and testing. Women are provided with assistance in obtaining services such as WIC (food assistance), transportation to MD appointments, birthing and breastfeeding classes. By utilizing evidenced based standardized assessment and education, the goal is “Healthy Mothers, Healthy Babies!”

There are two programs for pregnant women. The programs are identical in terms of the assessment and educational services provided. The only difference in the programs is the source of payment. One of the prenatal programs is our Antenatal program. Prior authorization for services is obtained through the women’s health care insurance. Prenatal services can also be provided through the MOMS (Medicaid Obstetrical Maternal Services) program. This program is designed to assist women is obtaining Medicaid for themselves and/or their newborn. Women who already have Medicaid also qualify for this program. Our Maternal Child Health nurses are trained in completing the presumptive Medicaid insurance documentation. Once the documentation is completed the woman can use the presumptive eligibility form to verify insurance coverage to a Health Care Provider. This form can also support they meet the eligibility requirements for WIC. Eighty-six percent of the prenatal referrals were for the MOMS program. During the pregnancy the insurance provider may change from traditional Medicaid to a Managed Medicaid Care provider. If this should occur, and the woman still is need of MCH nursing visits the nurse can work with the insurance provider in obtaining authorization for visits.

Of the twenty-two women seen under the MOMs program 32% had a history of a Mental Health diagnosis. Depression during pregnancy is not as well-known as postpartum depression. However, it is very common and may go undiagnosed due to mimicking of other symptoms associated with pregnancy (low energy, decreased appetite). It is estimated that between 14-23 percent of women experience a depressive disorder during pregnancy. Depression during pregnancy has been associated with poor prenatal care. Therefore, the American College of Obstetricians and Gynecologists (ACOG) encourages screening patients for depression during and after pregnancy. By March 2016, the MCH team utilized the Edinburg Postpartum Depression Scale 100% of the time for MOMs start of care assessments and at their postpartum initial visit. The tool was integrated into our Medent Electronic Medical Record system. 9% prenatally and 11% postpartum scored greater than ten on their Edinburg Postpartum Depression Scale. The nurse notified the physician and of the scores and a treatment plan was established.

Twenty-two women began enrollment in the MOMS program during 2016. The average age was 21.7 years. Eight-two percent were twenty-five and younger. Frequently they were still enrolled in insurance through a parent’s insurance program and they were seeking insurance for their unborn child. 55% of the women entering this program were in their third trimester (24-40 weeks) of pregnancy. 82% were going to be first time mothers. 23% had a history of domestic violence. 9% scored at risk for Lead exposure and were referred to their physician for Lead testing. Typically the women enrolled in the MOMS program have more psychosocial needs and are at higher risk for complications. Due to the complexity of the cases we noted that more women are accepting revisits and postpartum services. 73% of our MOMS participants accepted more than one visit and 45% accepted a postpartum visit.
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<tr>
<td>1&lt;sup&gt;st&lt;/sup&gt; Trimester Care</td>
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<td>28%</td>
<td>31%</td>
<td>43%</td>
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<tr>
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<td>3&lt;sup&gt;rd&lt;/sup&gt; Trimester Care</td>
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<td>41%</td>
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<td>1</td>
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LBW = Low Birth Weight  
Primip = 1<sup>st</sup> Pregnancy  
Multip = More than 1 Pregnancy
Child Find Program

The Child Find program is a cooperative effort involving parent, child, Washington County Public Health and New York State Department of Health. The program provides an opportunity for screening, guidance and education in age appropriate developmental milestones for infants and toddlers (age 0-3) that could be at risk for developmental delay.

If there are development concerns or delays are suspected, parents can initiate referrals to the Child Find program, called “self-referrals”. Referrals can also be made by physicians, agencies or hospitals.

Child Find is voluntary and there is no charge to families for the program. Once Child Find is open and if it is determined that further evaluation is needed then referral can be made to Early Intervention or CPSE. If developmental concerns are identified the Child Find program works closely with Early Intervention program to assure appropriate transition.

2016
Children Served: 2
# Home Visits: 5

2015
Children Served: 11
# Home Visits: 31

2014
Children Served: 9
# Home Visits: 11

2013
Children Served: 18
# Home Visits: 15

2012
Children Served: 16
# Home Visits: 13
Early Intervention Program

The Early Intervention Program is a New York State Department of Health Program which provides a variety of services for eligible infants and toddlers with disabilities or strong suspicion of disability as it relates to a diagnosed condition such as Down’s Syndrome. The program works with parents and families teaching them to meet the special needs of their child. These services are provided in the child’s natural environment. For most children this often is their home or day care site.

Early Intervention Services include:

- Early identification, screening and assessment
- Service Coordination
- Family Training, counseling, home visits, parent support groups
- Special instruction
- Speech pathology and audiology
- Occupational Therapy
- Physical Therapy
- Nutritional Services
- Vision Services
- Hearing Services
- Assistive technology devices and services
- Assistance with transportation
- Respite services if qualified

If a child qualifies and their parents agree to services, an Individualized Family Service Plan (IFSP) is developed. This plan describes the services the child and family will receive. Only services agreed to by the family are provided to the child regardless of the professional recommendations made by the service providers.
Eligibility Requirements For The Early Intervention Program

Children less than 3 years of age with a developmental delay or diagnosed physical or mental condition with a high probability of a delay in any of the following areas:

a) Physical development (vision, hearing also)
b) Cognitive development (thinking)
c) Communication (understanding or expressing language)
d) Social/Emotional (relating to others)
e) Adaptive development (self-help skills)

Services are provided at no cost to families. Washington County is reimbursed by New York State at a rate of 49% for amount paid. Private insurance (licensed and regulated by New York State) and Medicaid are billed for Early Intervention Services. All attempts are made to maximize reimbursement and defray Washington County expenses. Starting April 1, 2013, regulations changed to require Early Intervention Program providers to enter into agreement directly with New York State Department of Health in order to provide Early Intervention services. This change also required providers to bill insurance companies and Medicaid directly for the services they have provided. Insurance companies and Medicaid pay the provider for any covered service and then the county pays the provider for any outstanding balance. A state fiscal agent assists the provider with this process. During the transition period to this new payment model, there were providers who decided to discontinue their provision of Early Intervention Services. This has had a direct impact in the number of providers Washington County has available for the Early Intervention Program and many of these providers are shared by surrounding counties. Washington County continually monitors our provider capacity levels to ensure that children are receiving the services which are determined appropriate on a child’s Individualized Family Service Plan. The New York State Bureau of Early Intervention is working to evaluate provider capacity needs and improve their resource of qualified providers.

A developmental delay for the purposes of the Early Intervention Program is a developmental delay that has been documented as:

a) A twelve month delay in one functional area as described; or
b) A 33% delay in a functional area or a 25% delay in each of two areas; or
c) If appropriate, standardized testing tools are individually administered in the evaluation process, a score at least 2.0 standard deviations below the mean in one functional area or a score at least 1.5 standard deviation below the mean in each of two functional areas; or
d) Due to the child’s age, condition, or the type of diagnostic instruments available in the specific domain, a standardized score is either inappropriate or cannot be determined, a child may be deemed eligible by the documented informed clinical opinion of the multi-disciplinary team.
e) For Speech only children, 2 standard deviations below the mean are required for the evaluation team to determine a child is eligible for Early Intervention Program Services, or the evaluation team must use other qualitative criteria included in regulation/clinical practice guidelines on communication disorders.

A child must qualify according to the written standards to be eligible for services under the Early Intervention Program. If a child does not meet the degree of delay required, parents may pursue services via their primary care physician and primary health insurance.

The New York Early Intervention System (NYEIS) electronically manages Early Intervention Program administrative tasks and provides for information exchanges. New York State continues to make improvements
Preschool Program For Children With Disabilities – Committee on Preschool Special Education (CPSE) Serving Children 3-5 Y.O.

New York State Education Department has oversight of the Preschool Special Education Program. Children potentially eligible are referred directly to the Committee on Preschool Special Education (CPSE) either by parents, providers or through the transition process from the Early Intervention Program. The child is referred to their home school district. Parents are provided with a list of approved evaluators for Washington County. Parents then select the agency they wish to evaluate their child. All appropriate consents and documentation are secured by the school district CPSE office. Following the child’s evaluation the committee is convened to review the evaluation, determine qualification and eligibility, and discuss the child’s needs. Recommendations for services are made at this time if the child qualifies for services. A representative from Washington County Public Health attends all CPSE meetings. Other members include the school district CPSE chairperson, child’s parent, evaluator, and/or service provider, and the parent representative at parent request. Parents have the right to appeal decisions if they wish. All CPSE recommendations must be approved by the District Board of Education before services can begin.

Children are identified as a “Preschool Child with a Disability”. More specific classification will occur at the time they become school age, if needed. These services are voluntary and the parent may withdraw the child from any program at any time. The county is reimbursed for its costs at a rate of 59.5% by New York State Education Department. Medicaid is billed for related services such as speech therapy, occupational therapy, physical therapy, nursing, counseling for all Medicaid eligible children. All attempts are made to maximize reimbursement and defray Washington County’s expenses.

The preschool budget and payment process is extremely complicated and not at all timely. It takes a tremendous amount of county staff time to assure all reimbursement is secured. Accurate documentation is submitted to the New York State Education Department and Medicaid office in a timely and consistent matter.
The receipts shown above are strictly cash received during 2016 and may include cash received in 2016 for prior year services. For Early Intervention services, the NYS Department of Health reimburses the County 49% of any service not paid for by another source, such as Medicaid or a commercial insurance.
**El & 3-5 Year Program**

- **Total**
  - 2015: $2,393,493
  - 2016: $2,045,117
  - Early Intervention: $250,382
  - 3-5 Year Program: $2,143,111

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</table>

**EI / CPSE Combined Stats**

- **Children Served (0-3 Y)**
  - 2012: 252
  - 2013: 253
  - 2014: 199
  - 2015: 204
  - 2016: 153

- **Home Visits to EI Children (0-3 Y)**
  - 2012: 12,432
  - 2013: 10,418
  - 2014: 10,872
  - 2015: 10,346
  - 2016: 12,220

- **CPSE Children (3-5 Y)**
  - 2012: 254
  - 2013: 224
  - 2014: 243
  - 2015: 246
  - 2016: 266
The home visits (HV) are reflective of service utilization by children in the Early Intervention Program; this includes:

The children in the CPSE Program are the number of children classified as preschool children with a disability receiving group or individualized programs or services under that program.
Trend Toward A Need For Multi-Cultural Service Provision

The Migrant Farm Labor Market has drawn a core of people into the southern and northern parts of the county, most notably in White Creek and Fort Ann. There is also emerging populations along the eastern border of the county with workers drawn to the stone quarries. These families tend to be young, uninsured and have little or no ability to speak English. This has presented a particular challenge as very few, if any bilingual services are readily available. The agency has addressed this issue and continues to look for ways to more effectively deliver services. Bilingual interpreters have been identified (there are only 1-2), Spanish/English dictionaries and medical dictionaries are used. Spanish written materials are utilized. The agency utilizes Language Line phone services as a means by which telephone conversations can be held with the assistance of an interpreter. This can be utilized for the Spanish speaking as well as other foreign language using residents. This will continue to be an area of evolving need and adaptation of staff.

We have noted the uptake of several county services by this population including immunization and well child clinics, the MOMS Program and the Lead Poisoning Prevention Program. We are just beginning to see young migrant children entering the Early Intervention Program. There are limited resources for bilingual evaluation and service delivery in this region. This will need to be carefully monitored for issues related to this capacity.

A New York State Department of Health supported Migrant Vaccine Program has been initiated with the local farms and nurseries. Uptake of this service has been gradual as a level of trust and rapport are established with this Spanish speaking population. The Agency anticipates continued need and capacity building in this area.

The agency continues to work to build services to meet the health needs of this emergent population. Developing consistent, trusting relationships with leaders in this community is ongoing.

Camp Counselor Education

Camp counselors and other personnel are encouraged to contact Washington County Public Health Nursing Service with questions regarding West Nile Virus, Rabies, Lyme disease, communicable disease, hand washing, and any other health related topics as needed.

The New York State Department of Health District Office in Glens Falls coordinates and provides an annual Camp Directors meeting to review Public Health Environmental topics and to review Camp regulations. Public Health is consulted as needed for issues related to infection control, communicable disease potential outbreak, rabies control and other health related topics.
School Nurse Program

Washington County Public Health continues its success with hosting the annual school nurse meeting.

There was time set aside before the speakers for nurses to check out exhibits from Council For Prevention, Department of Social Services, Planned Parenthood, Fidelis, AHI Facilitated Enrollment, SNAP Outreach, Warren Washington CARE Center, and the Washington County Public Health’s MCH team.

8 School Nurses from 7 School Districts attended, as well as 3 Nurses from BOCES and 2 Nurses from Head Start. Public Health Maternal Child Health team and Health Educator were also in attendance as well as several of the exhibitors that stayed for the presentations.

The Agenda included the Annual Immunization Update by NYSDOH, Information on Asthma and the newly formed Asthma Coalition, Mental Health in Children and Mental Health Training Opportunities.

All attendees received a packet loaded with information, including:
Public Health Brochure, Immunization Schedules, Presenter Handouts and more.

Each School District also received Toothbrushes, Hygiene Kits, Lice Combs and Various Posters:

- Wear a Helmet,
- Eat your Colors,
- Brush/Floss,
- Do Something Healthy Every Day,
- Don’t Spread Germs-Wash Your Hands,
- Don’t Smoke
- My Plate
- Skin Cancer Awareness Gigi Giraffe
- Rethink Your Drink
- Right Size Portion Poster
- Choose Health
- Say No To Smoking
- Launch Your Day with Breakfast
- Tobacco Free for Life
- Tooth Defenders- Know how to brush
- Wash Your Hands- Steps for Proper Washing
- Super Hero Handwashing
Infection Control / Communicable Disease Control

The number of investigations of communicable disease cases in 2016 totaled 508 cases of confirmed reportable diseases. This was a 17% decrease overall in confirmed cases of reportable disease over 2015. Although the overall total number of reportable cases declined there was a notable increase overall in foodborne related cases as well as Legionella.

Food-borne illness increases were noted with Salmonella, Campylobacter and Yersiniosis. A total of 33 food-borne illnesses were investigated in 2016. A Campylobacter case (n=21) again was the most reported food-borne illness in 2016, same as the previous year. Campylobacter is a common gastric illness usually caused from ingestion of raw milk or by handling raw poultry products or animal exposure. Proper hand hygiene, prevention of cross-contamination, proper washing and storage of food are the best defenses to prevent food borne illness. Education regarding measures to prevent food-borne illness occurrences is provided to community residents.

In addition to the increase in Campylobacter, there were 2 cases of Yersiniosis. No cases of this disease had been reported since 2013. This is an illnesses usually associated with pork. Salmonella increased slightly with 10 cases versus 8 in 2015.

Legionella cases showed a sharp increase (n=11). Several of these cases were associated with long term care facilities. Overall in the U.S. Legionella cases reported are increasing, etiology for this is unknown.

Washington County Public Health Communicable Disease staff continues to respond rapidly and collaborate with the Regional New York State Department of Health Epidemiology staff and the NYSDOH District Office in the event of any outbreak or incidents of concern. Washington County Public Health Communicable Disease staff monitors surveillance locally, regionally and nationally on a daily basis. The Washington County Public Health infection control team continues to work closely with other area facilities and school districts in regard to issues of concern related to infection control.

Annual infection control training is mandatory for all Washington County Public Health staff and is updated annually to meet the most current evidenced based standards of practice. Infection control policies and procedures area also reviewed and updated annually to reflect the current best practices.

Ebola

In 2016 Ebola drills were required to be conducted on a bi-annual basis. Nursing staff are required to drill complete personal protective equipment with donning and doffing.

Sexually Transmitted Diseases

In 2016 Washington County the number of chlamydia (n=148) rose slightly over the previous year however gonorrhea (n=23) cases increased by 109%. Outreach education through schools and public posters regarding awareness continue and Washington County continues to sponsor a weekly STD clinic with Warren County held every Tuesday evening. Reminders for the clinic are posted via social media every week. A social media campaign was also pushed out over several weeks to increase STD awareness reminding people to get tested and use protection.
## Washington County Communicable / Infectious Disease Data

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<td>0</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>--Congenital Syphilis</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>--Early Latent</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
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<tr>
<td>Gonorrhea Total</td>
<td>23</td>
<td>11</td>
<td>4</td>
<td>11</td>
<td>16</td>
</tr>
<tr>
<td>--Gonorrhea</td>
<td>23</td>
<td>11</td>
<td>4</td>
<td>10</td>
<td>15</td>
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<tr>
<td>--Pelvic Inflammatory Disease</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>1</td>
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<tr>
<td>Chlamydia</td>
<td>148</td>
<td>143</td>
<td>135</td>
<td>126</td>
<td>150</td>
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<tr>
<td>Chlamydia P.I.D.</td>
<td>0</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td><strong>Total NYS Reportable</strong></td>
<td><strong>679</strong></td>
<td><strong>617</strong></td>
<td><strong>426</strong></td>
<td><strong>435</strong></td>
<td><strong>444</strong></td>
</tr>
</tbody>
</table>

*Based on month case created, or December for cases created in Jan/Feb of following year
**Confirmed and Probable cases counted; Campylobacter confirmed and suspect
****Not official number
Mosquito Virus Surveillance

There have not been any human cases of West Nile Virus to date diagnosed in Washington County. This is a reported disease and any suspect or confirmed case would be investigated by the infection control team. In late 2015, Washington County Public Health began training for surveillance of the Zika virus. In 2016, Washington County had one confirmed case of Zika which was travel related. The mosquito responsible for transmission of the Zika virus is not present to date in Upstate New York. Surveillance and planning is still being undertaken.

Lyme and Arthropod Diseases

Reported cases of Lyme disease dropped in 2016 (n=51) confirmed cases that met case definition. This is a slight decline again from previous years. A total of approximately 94+ additional suspected cases of Lyme disease were also investigated, but did not meet the current case definition. Washington County Public Health continues outreach education to the public regarding prevention of Arthropod diseases. Health care providers are not following the required mandated reporting to the local health department. This is evident by the health care facilities not responding to the “Dear Dr. Letter” that are send out when the health department receives a positive lab report. Lack of complete reporting from the health provider community who cite time constraints as a barrier makes it difficult to maintain accurate statistics. Phone inquiries from county residents serve as an opportunity to educate regarding ways to reduce the risk of arthropod exposures. Lyme disease awareness as well as other vector-borne education is distributed to area health providers and anyone else who makes a request, as well as being on display for the public yearly at the Washington County Fair.

Another arthropod disease specifically, Anaplasmosis, was still prevalent within this region in 2016. Anaplasmosis, Babesiosis and Ehrlichiosis are now all reportable to local health departments in NYS. These diseases are also caused from tick bites. Washington County had 48 confirmed cases Anaplasmosis in 2016. Ehrlichiosis cases numbered 1 and Babesiosis 5. Exposure to tick-borne illnesses can be reduced by taking precautions when outdoors. Dressing to repel by wearing light colored clothing and tucking pants into socks when outside and use of a DEET based insecticide help reduce the incidence of these exposures. In addition, animals and humans should be checked for ticks after every outdoor activity especially in wooded areas. There is no human vaccine on the market for the prevention of Lyme disease or any other tick borne illnesses at this time.

For more information on tick illnesses visit: [http://www.cdc.gov/ticks/](http://www.cdc.gov/ticks/)
**Rabies Program**

In accordance with New York State Public Health Law and New York State Sanitary Code the Rabies Plan establishes a comprehensive rabies response for the residents of Washington County. The rabies program operates 24 hours, 7 days a week with the assistance of the Public Health nursing staff.

In 2016, three hundred and one case numbers were assigned based on initial contact via telephone, fax or email. Calls typically involve reporting and handling of bites from victim and/or owner perspective, medical providers, veterinarians, law enforcement, dog/animal control questions or concerns about potential and actual exposures.

To maximize rabies prevention and control on-going education and awareness was provided to the community, health care providers and other local agencies. Informational meeting was held for Washington County Board of Supervisors (BOS). This opportunity provided additional media coverage in a local newspaper about wildlife rabies in the community.

We continued to work closely with Town and County dog and animal control. In 2016 there were no changes in Town Dog Control officer(s).

Twenty one people received authorization for rabies post-exposure prophylaxis (PEP). The majority of services provided to victims for rabies boosters or PEP was coordinated and managed with Saratoga Hospital, Wilton Medical Arts or Glens Falls Hospital.

The majority of animal confinements were accomplished through approved home observation. One pet required shelter confinement with fees. Some pets were held and observed at veterinarian office.

There were thirty three specimens submitted for rabies testing. Specimen submission was accomplished through the services of twelve veterinarian offices. There was one positive bat from the Town of White Creek. There were two specimens reported with unsatisfactory results.

There were 1120 dogs, cats, and ferrets vaccinated at Washington County rabies clinics. The clinics are operated with the assistance of two veterinarian practices. This year an extra clinic was held at Washington County DPW Fort Edward complex. This was considered a successful location for clinic attendance. This location has been added to make eleven free rabies clinics available March through November. Donations are accepted but not required for rabies vaccine. The Rabies Clinics are open to anyone needing rabies vaccine for their dog, cat or ferret.

Advertising strategy was increased through coordination with other Public Health programs. Distribution of rabies clinic information was accomplished by utilizing local newspapers, local banks, laundromats, libraries, food pantries, WIC clinics and school fairs throughout the county, along with Face Book and County web site.

The Rabies Program can be time intensive and complex. Bite investigation and case scenarios can be unique and challenging. Washington County Public Health Nurses continue to provide prompt case investigation, communication and education as part of a coordinated comprehensive rabies response to minimize the spread of rabies disease.
<table>
<thead>
<tr>
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</tr>
</thead>
<tbody>
<tr>
<td>Confirmed Rabid Animals</td>
<td>1</td>
<td>4</td>
<td>5</td>
<td>4</td>
<td>9</td>
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<tr>
<td>Animal Specimens Sent for Testing</td>
<td>33</td>
<td>43</td>
<td>79</td>
<td>61</td>
<td>83</td>
</tr>
<tr>
<td>Animals Received Vaccine at County Clinic</td>
<td>1120</td>
<td>928</td>
<td>879</td>
<td>1100</td>
<td>1315</td>
</tr>
<tr>
<td>Individuals Receiving Post-exposure Vaccine Series or booster (all RIG &amp; 1st rabies injections given at GFH and nearest hospital)</td>
<td>21</td>
<td>20</td>
<td>24</td>
<td>20</td>
<td>44</td>
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<tr>
<td>Reported Animal Bites / Guidance Calls</td>
<td>301</td>
<td>325</td>
<td>359</td>
<td>274</td>
<td>341</td>
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<tr>
<td>Animal Clinics</td>
<td>11</td>
<td>11</td>
<td>10</td>
<td>10</td>
<td>10</td>
</tr>
<tr>
<td>Blood Titers Drawn for Human Rabies Titers</td>
<td>0</td>
<td>26</td>
<td>19</td>
<td>15</td>
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**2016 Rabies Animal Vaccination Clinics**

<table>
<thead>
<tr>
<th>Town</th>
<th>Held</th>
<th>Dogs</th>
<th>Cats</th>
<th>Ferrets</th>
<th>Total Given</th>
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<tr>
<td>Salem</td>
<td>March</td>
<td>41</td>
<td>9</td>
<td>0</td>
<td>50</td>
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<tr>
<td>Whitehall</td>
<td>April</td>
<td>88</td>
<td>27</td>
<td>0</td>
<td>115</td>
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<tr>
<td>Kingsbury</td>
<td>May</td>
<td>137</td>
<td>25</td>
<td>0</td>
<td>162</td>
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<tr>
<td>Hampton</td>
<td>May</td>
<td>113</td>
<td>41</td>
<td>0</td>
<td>154</td>
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<tr>
<td>Granville</td>
<td>June</td>
<td>51</td>
<td>32</td>
<td>0</td>
<td>83</td>
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<tr>
<td>Argyle</td>
<td>June</td>
<td>96</td>
<td>20</td>
<td>0</td>
<td>116</td>
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<tr>
<td>Cambridge</td>
<td>July</td>
<td>29</td>
<td>46</td>
<td>4</td>
<td>79</td>
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<tr>
<td>Greenwich</td>
<td>August</td>
<td>51</td>
<td>29</td>
<td>8</td>
<td>88</td>
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<tr>
<td>Fort Ann</td>
<td>September</td>
<td>63</td>
<td>16</td>
<td>0</td>
<td>79</td>
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<tr>
<td>Kingsbury</td>
<td>October</td>
<td>55</td>
<td>34</td>
<td>0</td>
<td>89</td>
</tr>
<tr>
<td>Kingsbury</td>
<td>November</td>
<td>62</td>
<td>41</td>
<td>2</td>
<td>105</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td></td>
<td>786</td>
<td>320</td>
<td>14</td>
<td>1120</td>
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Health Education

 символь
Health Educator administers posts for the Public Health Facebook page to promote all types of health topics. Topics are based on Health Observance Calendar for each month as well as Public Health events, Public Health Staff suggestions and Public Health services.

690 Facebook Posts were made in 2016

Health Educator conducted 5 “Good Health Rules” programs with 113 preschoolers. The program Highlights Keeping Clean, Eating Healthy, Getting outside and Playing, Covering Germs and Going to bed when it’s bedtime. Children listen to a presentation about unhealthy creatures, then they watch a video that includes those creature. Finally, they play a matching game that pairs healthy behaviors with unhealthy creatures.

Health Educator coordinated and conducted blood pressure clinics at Earl Towers the first Tuesday of each month. Checking 112 Blood Pressures.

Health educator completed the Tai Chi for Arthritis Certification in July and attended an additional In-service/Refresher training in September. (A Maternal Child Health Nurse also completed the Tai Chi for Arthritis Certification in January.)

Three Tai Chi for Arthritis Classes were conducted in 2016. Our Maternal Child Health Nurse Taught a class in Whitehall at Skenesborough Harbor in the Spring. In the fall, our Health Educator taught Seniors in Cambridge at the Brieman Building and a Maternal Child Health Nurse taught the Class in Hartford.

Health educator organized 2 Blood Drives for Employees. In February there were 31 units collected and in August there were 17 units collected.

Health Educator continues to be part of the County New Employee Orientation Team and presents NEO as needed. In 2016, teaching March, May, August, and November.

Health Educator organized the Public Health display for the Washington County Fair, which included information on Immunizations, Lead Poisoning, NAS (Neonatal Abstinence Syndrome), Rabies, Zika Virus, Preparedness, Safety, Early Development and the Human Body. There was also a matching game using the Human Body display for finding answers.

Health Educator and MCH attended the Office for the Aging Health Fair on October 6th with health information and checking 35 blood pressures.

Health educator assisted teaching Car Seat Technician certification courses in Niskayuna which included a car seat check.

Health Educator conducted three Car Seat 101 presentations for Head Start and Social Services Transporters in March. 3 sessions were held and 58 transporters were educated. In addition, 8 car seat technicians from surrounding areas came to help out with the hands-on portion of the training. Additionally, a Car Seat 101 presentation was held for Head Start Family Workers in October for 22 staff members.
Health Educator attended various trainings throughout the year, including Bridges out of Poverty Training, Vermont’s CHARM Program, Human Trafficking and Trauma Informed Care.

Health Educator attended Fort Ann School “Trunk or Treat” event and Health Fair on October 28, 2016 with a display on Public Health Programs, Dental Health, Healthy eating choices and more.

Health Educator partnered with AAA Northway to organize a CarFit Coordinator training on June 22nd. 10 new technicians/Coordinators were trained. Following the training, a CarFit Event was held on June 23rd at Public Health. 24 drivers went through the check.

Health Educator sits on several committees/coalitions, including Domestic Violence Community Coordination Council (DVCCC), Hometowns vs Heroin & Addictions, Suicide Prevention Coalition, Head Start Health Advisory etc.

Health Educator Present to Housing First: Creating a Wellness Vision on October 21st - 6 residents attended.

Health Educator Presented “Surviving the Holidays without Gaining Weight” to TOPS in Hudson Falls (Taking off Pounds Sensibly): on November 29th – 12 Members attended.

Health Educator continues to sit on the Head Start Health Advisory Board, attending meetings semi-annually.

Health Educator Presented information about Tai Chi and CarFit at the Senior Safety Day program in Cambridge in November.

Washington County once again partnered with the Washington County Youth Bureau and Cornell Cooperative Extension to hold Winterfest in February 2016. Despite the lack of Snow, there were plenty of activities for participants to enjoy, including Ice Fishing, Ice Skating, Bird Feeder Making, Bonfire, Cold Water Rescue Demonstration, Geocaching, K-9 Demonstration by the Washington County Sheriff’s Department and more.

Health Educator helped organize and Agency Mixer between Head Start, WIC and Public Health. Due to a large turn over in staff in some of the agencies involved, the program was provided to let new staff know about each of the programs involved. Staff from all three agencies had time to view exhibits from each agency, as well as a few additional agencies and then there was time for each agency to give a brief presentation about their program.

Health Educator completed the online Public Health Educator Continuing Education Program through NYSDOH Learning Management. Course included: From Evidence to Practice: A Systematic Approach to Address Disparities in Birth Outcomes; Community Dimensions of Public Health Practice (Part 1); Community Dimensions of Public Health Practice (Part 2); Health Literacy and Public Health: Introduction (Module 1 of 2); Strategies for Addressing Low Health Literacy (Health Literacy & PH, Module 2 of 2); Orientation to Public Health; Program Development and Evaluation; Introduction to Logic Models; Evaluating a Public Health Program; Public Health Educator Continuing Education Program Tracker; Public Health Live! Community Health Assessment: Finding the Information You Need.

Health Educator Completed FEMA online Course IS-00100.b, Introduction to Incident Command System ICS-100 and IS-00700.a National Incident Management System, An Introduction
**Worksite Wellness**

The County transitioned its Worksite Wellness Program to the Personnel Department and they created CLIP (County Lifestyle Improvement Program.) However, they did ask the Health Educator to organize the 10th Annual Employee Wellness Celebration for CLIP (County Lifestyle Improvement Program) 249 (74 Male, 175 Female) employees signed in on the day of the Wellness Celebration, 231 Evaluations returned (93% return rate)

Participants received a Double Wall Tumbler with Straw from Public Health for returning their evaluation.

Exhibitors included:

- Washington County Public Health-Emergency Preparedness
- Right Touch Massage- Chair Massages and Essential Oil & Reiki
- Elizabeth Call- Acupressure Display
- EAP- Stress & Mental Health
- Cornell Cooperative Extension- Eating Healthy on a Budget
- Steven Nacu- Tai Chi
- YMCA- Family Fitness Activity Ideas
- Capital Financial- Healthy Habits at Work
- Blue Shield- Benefit info
- MetLife- Dental info

**Child Passenger Safety**

Health educator attended the Tri-State Child Passenger Safety Conference in Lake Placid in May and completed Recertification to keep her status as a Nationally Certified Child Passenger Safety Technician Instructor.

$13,500 from the Governor’s Traffic Safety Committee was received to continue the Car Seat Safety Programming.

- **Schedule A- Permanent Fitting Station**
  - 39 seats were checked for 25 families in the office, of which 12 were found unsafe and were replaced.

- **Schedule B-Child Passenger Safety Awareness Training**
  - Health Educator conducted three Car Seat 101 presentations for Head Start and Social Services Transporters in March. 3 sessions were held and 58 transporters were educated. In addition, 8 car seat technicians from surrounding areas came to help out with the hands-on portion of the training.
  - Health Educator conducted three Car Seat 101 presentations for Head Start Family Workers in October for 22 staff members.
  - 13 Seat Belt Safety Preschool programs were completed with 322 children. All children were able to demonstrate proper use of a booster seat by buckling themselves in appropriately.

- **Schedule C- Child Passenger Safety Check Events**
  - Granville Car Seat Check held June 11th. 6 seats checked, 0 seats arrived installed correctly, 1 seats replaced

- Fort Edward Check Held at the FE Rescue Squad on September 1st 3 seats checked, all corrections were made.
Schedule D- Child Safety Seat Distribution and Education Program
  o 112 seats provided were provided to 79 families. All participants are required to go through an hour long lesson on seat use, which includes information on what happens during a crash, why car seats are needed, how to correctly harness a child into a seat, how to correctly install the car seat into the vehicle and more. All demonstrate correct use of the seat by installing the seat before leaving.

Injury Prevention – Bicycle Safety

Bike Helmet Distribution Program
  o 30 Bike Helmets were given away to low income families and 4 helmets were provided to Youth Bureau Bike Drawing winners from the Washington County Fair. Education given regarding appropriate use and application.

Bike Rodeos
  o Hartford Elementary. 127 students in 2-5th grade.
  o Fort Ann School for 36, 3rd graders.

Chaired the Healthy Communities Coalition of Washington County and sustained the group hosting quarterly meetings to address health disparities countywide and share resources.

Coalitions/Councils & Initiatives

Domestic Violence Workplace Initiative (DVWI)
DVWI is a project of the Domestic Violence Community Coordination Council (DVCCCI), which is convened by the Domestic Violence Project of Warren & Washington Counties, a program of Catholic Charities. DVWI is a community based group of leaders and victims’ advocates in Warren and Washington County working together to raise awareness and provide tools to address domestic violence in the workplace.
  o Attended regular DVWI meetings with Jeanne Noordsy of the Domestic Violence Project

Healthy Communities Coalition of Washington County
In the fall of 2009, Washington County Public Health applied and received a non-competitive grant which ultimately resulted in the formation of this group. The Healthy Communities Coalition of Washington County is county-wide coalition made up of community stakeholders interested in making Washington County a healthier place to live, work, learn, and play. After recognizing similarities of others in Washington County, the Healthy Communities Coalition is moving forward as a resource sharing group and also assisted Public Health with the Community Health Improvement Plan and Community Health Assessment process.

The Coalition played a vital role in the development of the Washington County Community Health Improvement Plan (CHIP) to address the prioritized community health needs of the residents, communities, and families within the Washington County service area. The two priority areas and specific focus areas are:
**Chronic Disease**
- Reducing Obesity in Children and Adults
- Reduce Illness, Disability, Diagnosis, and Deaths Associated with Tobacco and Second Hand Smoke Exposure

**Promote Mental Health and Prevent Substance Abuse**
- Prevent Substance Abuse and Mental Emotional Behaviors

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**Hometown Vs. Heroin & Addiction Coalition of Warren/Washington County**

The Hometown Vs. Heroin & Addiction Coalition of Warren/Washington County was formed in March of 2014 to address the misuse and abuse of opiates and heroin within our borders. We are community stakeholders working together to provide awareness, education and hope in the battle of heroin and opiate addiction.

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**Warren/Washington County Suicide Prevention Coalition**

This coalition has been born on September 30, 2014 as a result of receiving $4,000 in mini-grant funds from Mental Health Association of New York State for Suicide Prevention. Our mission is to prevent suicide in our community by educating the community about suicide prevention, providing resources and trainings to our schools and community members. We will work to increase awareness and reduce the stigma of getting help. We will strive to strengthen communication and coordination of services to support those impacted by mental illness and suicide. Washington County Public Health continues its support of and partnership in this important program.

**Washington County HIV Counseling & Testing Program**

- Washington County Public Health HIV Counseling and Testing Program is managed to meet NYS Department of Health regulations and state HIV confidentiality and testing laws.
- 7 HIV counseling and testing session was conducted at Public health. HIV counseling and Rapid Testing is offered to the public by appointment at Washington County Public Health Monday through Friday. Anonymous and confidential testing is conducted using the Rapid HIV ½ Testing Kits and test results are available in 20 minutes. Testing may be conducted on oral fluids, via venipuncture, or finger stick.
- Washington County Public Health continues to follow policy and procedure in place for Mandated Court Order HIV Counseling and Testing for Victims of Sexual Assault. No court orders were received requesting the perpetrator of a sexual assault be ordered to be tested for HIV per the request of the victim in 2016.
- 37 Washington County residents were tested for HIV through the Warren/Washington STD Clinic.

**Warren/Washington County’s STD Clinic Report**

A STD/HIV Clinic is held each Tuesday from 6:00 to 7:00 p.m. The clinic is financed by Warren and Washington Counties. Although counties are encouraged to bill insurance companies, clients have indicated
they would not want their insurance utilized. (i.e. are not comfortable with insurance EOB’s being sent to their home).

HIV testing is also performed at the clinic. The HIV clinic counselors are from the HIV/Ryan White program under the sponsorship of Hudson Headwaters. Any positive test is referred immediately for verification and follow-up care.

STD clinic routinely tests for gonorrhea, chlamydia and syphilis on all clients. These tests are taken to the Glens Falls Hospital Laboratory and are billed to Warren County Public Health at the Medicaid rates. The New York State Department of Health is notified of any positive tests and is in direct communication with Warren County Public Health regarding treatment and “follow-up” care.

The age range of the participation at the clinic remains from teenagers to the elderly, (17 yrs. – 60 yrs.)

The number of clients has been declining steadily over the past five years, but the clinic remains a valuable resource to the community and to those in need of services.

Prevention is stressed at the clinic. Condoms, supplied by NYS are available for no charge at the clinic.

The clinic is staffed by two nurses, one support staff and one physician.
**Perinatal HIV Transmission**

Consenting to HIV counseling and testing is strongly encouraged for all pregnant women. HIV counseling and testing is offered multiple times throughout prenatal care due to the window period for testing of HIV. New York State Department of Health at the AIDS Institute defines the HIV window period of testing as the amount of time the human body needs to respond, once exposed to the HIV virus, to produce antibodies that would be detected when testing for HIV. The human body will produce enough antibodies for accurate test results within 1-3 months of the person’s last possible exposure to the HIV virus.

Although it is not mandatory for a pregnant woman to consent to HIV counseling and testing in New York State, it is strongly encouraged by their prenatal care provider. It is however mandatory for the baby to be tested at birth. When a baby is born, a heel stick testing procedure for numerous illnesses, including HIV, will be conducted. If the baby’s test is positive at birth for HIV, this result reflects the mother’s result up to 18 months of baby’s life. After 18 months of age, if baby tests negative for the HIV virus, the baby’s test result can be considered reliable. If after 18 months of age, baby still tests positive for the HIV virus, medical intervention and case management services are strongly recommended.

Washington County has integrated HIV education, risk assessment, counseling and referrals within the county’s Maternal Child Health Program. In the event that a mother is positive for the HIV virus during pregnancy, the Public Health nursing staff tries to ensure that the mother is utilizing all services available for optimal health outcomes for mother, baby and significant other.

**Perinatal Hepatitis B**

Women are routinely screened for Hepatitis B as part of prenatal blood work. In the event the pregnant woman tests positive for Hepatitis B, the information is transferred by the local health department and physician to the hospital where the mother plans to deliver to assure that the infant receives treatment within 12-hours after birth. In these cases, a mechanism is in place where a referral is made to the local health department to assure that the child receives the Hepatitis B vaccine series on a timely basis. Reports are submitted for statistical tracking to New York State Department of Health whenever a case is identified.

Hepatitis B is a virus that affects the liver. It is transmitted through contact with infected blood and body fluids. Pregnancy and Hepatitis B combined can put the baby at risk for contracting the virus. Prenatal testing for Hepatitis B is important because there are interventions to prevent or minimize the baby’s chance of contracting Hepatitis 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 the woman’s partner and others. They 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 Hepatitis B transmission to baby. Within twelve hours of delivery, the baby receives Hepatitis B Immune Globulin and the first dose of the Hepatitis B vaccine series. The other two vaccines are given at one month and 6 months of age. When the child is between 9 and 12 months old, 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 Hepatitis B. Public Health has an exciting role in the prevention of Hepatitis B transmission from mother to baby. Through education efforts and prophylaxis, disease can be prevented. There were no cases of Perinatal Hepatitis B transmission in 2016.
**Tuberculosis Program**

Washington County entered into a contractual partnership with Saratoga County Chest Clinic to provide consultation and treatment for residents of Washington County in May 2014. In 2016, there were no new cases of active TB disease. Two county residents with latent tuberculosis infection were followed by Dr. Desmond DelGiacco through the Chest Clinic in 2016. Dr. DelGiacco also provided guidance on two additional patients with potential tuberculosis infection that did not require clinic follow-up.

All individuals with positive PPD skin tests or positive IGRA blood tests are offered recommendations for additional diagnostic testing and treatment. Clients are interviewed by the Washington County Infection Control Nurse. Residents may choose to be treated by their own physician or attend the Saratoga County Chest Clinic held monthly at Saratoga County Public Health. Washington County provides follow-up for anyone testing positive and provides payment for diagnostic tests, preventative therapy or treatment for current disease in those diagnosed. There is no out of pocket expense for the resident for the diagnostic testing or treatment related to tuberculosis.

Washington County Public Health continues to be a tuberculosis resource within the community, providing guidance to health care agencies and physician offices. The New York State Department of Health acts as a consulting agency when needed.

Routine PPD skin testing for employment or college requirement is provided to community residents during weekly immunization clinics. Individuals needing skin testing can contact Public Health for details.

![STOP TB]

**Women, Infants and Children Nutrition Program – “WIC”**

The WIC Program is an intervention program designed to improve the health of pregnant and breastfeeding women, infants and children up to the age of five. WIC is a United States Department of Agriculture (USDA) program and provides nutritious foods, information on healthy eating, and referrals to health care.

The goals of the WIC Program are to:

- Improve pregnancy outcomes
- Reduce the incidence of obesity in children
- Support and encourage breast feeding as the optimal method of infant feeding
- To promote healthier habits by encouraging healthier lifestyle choices

In 2016, there were 93 WIC Programs sponsored by various health and medical providers in New York State. In Washington County, WIC is sponsored by Washington County Public Health Services. To be eligible for WIC, a family must be at or below 185% of the poverty guidelines.
Funding for the Washington County WIC Program is approximately 92% USDA and 8% New York State. Washington County is reimbursed 100% for sponsoring the WIC Program. In 2016, the cost of operating Washington County WIC was $1,575,460. The following shows the breakdown of how those funds are allocated:

- **Food Dollars - $1,041,744.**
  - Food dollars are the value of all redeemed vouchers given to WIC families to purchase foods at approved stores. All foods provided to WIC participants must be prescribed by the WIC nutritionist.

- **Administrative Budget - $490,968.**
  - Administrative funds are used to support the administration of the WIC program to include salaries and fringe benefit costs for 11 full and part-time staff, physical space and satellite clinic space costs, travel costs and all other operating expenses. This dollar amount includes an addition of a cost of living adjustment of $35,978.

- **Farmers Market Coupons - $22,992.**
  - Coupons are provided to every WIC family once per year during the local growing season. Families use these coupons help to support our local agricultural economy while also being exposed to fresh, locally grown produce. Washington County works with Cooperative Extension so that families can receive support while visiting a local market. Of the total amount issued, 41.79% were redeemed.

- **Breastfeeding Peer Counseling Program - $18,304.**
  - The Peer Counseling Program is intended to increase the initiation and duration rates of breastfeeding. As a "Peer" program, a Peer Counselor can encourage breastfeeding and other appropriate parenting habits by mentoring mothers.

- **Breast Pump Program - $1,452.**
  - Funds for the breast pump program are supplied by USDA and are considered additional food dollars. A woman that breastfeeds not only provides a healthier start for her infant but also incurs fewer cost by eliminating the need to spend money on formula. Many mothers requesting a pump do so at the time they want to return to work. Funds received for pumps were again reduced for 2016 since insurance companies now provide pumps through the Affordable Care Act to those returning to work who have a doctor’s prescription.

The WIC Program saves money by improving the health of our growing families. Pregnant women enrolling in WIC receive prenatal care earlier, and have fewer pre-term and low birth weight infants. Improved birth outcomes result in a reduction in health care costs associated with these risk factors. WIC helps children to consume more key nutrients such as iron, protein, calcium, and Vitamins A and C. WIC also helps to ensure children’s normal growth, reduces the incidence of iron deficiency anemia and other health problems caused by poor diet. Nationally, the obesity rate of children continues to decline among WIC participants.

Families on WIC acquire healthier habits that can last throughout life. WIC accomplishes this by providing participant-centered nutrition education and counseling, WIC checks for healthy foods and referrals to numerous agencies and health services. The WIC food package includes fruits and vegetables, whole grains, low fat dairy, canned beans, and peanut butter. Children on WIC have the opportunity to develop healthier habits that may last a lifetime.

**Breastfeeding Promotion and Support**

Washington County receives a portion of its funding to promote breastfeeding as the optimal method of infant feeding. Research shows that breastfeeding provides health benefits to both the mother and her infant, therefore, helping to reduce their health care costs. Breastfeeding lowers a child’s risk for obesity, type II diabetes, and asthma. For infants, it lowers the risk of SIDS, and hospitalization due to respiratory tract infections. Breastfeeding improves infant feeding practices.
At WIC, we monitor breastfeeding initiation rates and also duration of breastfeeding. The Healthy People 2020 goal is to have a greater than 80% initiation rate. This means that 80% of all babies being born will be breast fed. Many factors can affect a mother’s success with breastfeeding. WIC has a great impact on women choosing to breastfeed their babies and also on supporting them to breastfeed longer, ideally to the infant’s first birthday.

Washington County has the Breastfeeding Peer Counselor Program, a breast pump loan program and also offers extra foods to the mothers choosing to exclusively breast feed their infants. Since 2007, Washington County has improved their initiation rates from 48% to the current rate of 70.8%.

Washington County WIC has always been successful in serving the residents of Washington County. According to New York State’s Estimated Need Report by County, Washington County provides benefits to approximately 63% of the families that are eligible for WIC and is in line with New York’s statewide average of percent served.
All Hazard Disaster Preparedness Planning

Washington County continues to work closely with many regional partners for comprehensive emergency planning and attends monthly tabletop exercises in collaboration with the Glens Falls Hospital. Two bi-annual County partners meetings are also hosted by Washington County.

Washington County Disaster Preparedness Coordinators also attend monthly regional meetings with 17 other County representatives for networking and training as it relates to County preparedness and deliverables. Washington County continues to meet or exceed all NYSDOH deliverables.
Visits By Town 2016

<table>
<thead>
<tr>
<th>Town</th>
<th>Visits</th>
</tr>
</thead>
<tbody>
<tr>
<td>Argyle</td>
<td>2</td>
</tr>
<tr>
<td>Cambridge</td>
<td>19</td>
</tr>
<tr>
<td>Dresden</td>
<td>8</td>
</tr>
<tr>
<td>Easton</td>
<td>2</td>
</tr>
<tr>
<td>Fort Ann</td>
<td>8</td>
</tr>
<tr>
<td>Fort Edward</td>
<td>20</td>
</tr>
<tr>
<td>Granville</td>
<td>46</td>
</tr>
<tr>
<td>Greenwich</td>
<td>5</td>
</tr>
<tr>
<td>Hampton</td>
<td>9</td>
</tr>
<tr>
<td>Hartford</td>
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<td>Hebron</td>
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<td>Jackson</td>
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<tr>
<td>Kingsbury</td>
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<td>Putnam</td>
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<tr>
<td>Salem</td>
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<td>White Creek</td>
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<tr>
<td>Whitehall</td>
<td>60</td>
</tr>
<tr>
<td>Other – MOMS – out of County</td>
<td>4</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>391</strong></td>
</tr>
</tbody>
</table>
Family Health consists of the following: Child Health, Maternal and Infant Health, and Reproductive Health

Disease Control/Chronic Disease consists of the following: Arthropod, General Communicable Disease, Immunization, Rabies, STD/HIV, and Outpatient Tuberculosis

Environmental Health consists of: Injury Prevention and Control and Lead Poisoning Prevention

Per Article 6 guidance from New York State Department of Health, Health Education and Laboratory Services are no longer distinct categories but are distributed throughout the other categories.

Also per Article 6 guidance from New York State Department of Health, Emergency Preparedness is now a stand-alone category and Injury Prevention and Lead Poisoning were moved to Environmental Health.

State Aid Funding from 2015 to 2016 remained fairly consistent with a 4% decrease in total Article 6 funding.