

**Warren County Health Services  
Health Services Committee Meeting  
February 26, 2010  
Information Submitted By: Patricia Auer, DPH/DPS**

**Pending Items**

**Emergency Preparedness Activities**

Please see the attached detailed information.

**Request Resolution:**

To Amend the 2010 County Budget for the Bioterrorism Program in the amount of \$51,432.

**Rationale:**

This will allow placement of approved grant funds to be utilized and reimbursed in the categories where the expenses occur. Because this is a large grant (\$201,934) which must be expended by August 31, 2010, and we are looking at assisting other departments within the county with emergency preparedness needs, we will likely need to amend the budget again in order to maximize the grant.

**Request Resolution:**

To approve the updated Emergency Preparedness Plan for Warren County Health Services.

**Rationale:**

This is necessary as a deliverable for the Emergency Preparedness Grant, and is annexed to the overall Warren County Emergency Plan. We last submitted this in 2008 as requested by New York State Department of Health. A copy of the plan will be on file with the minutes of the meeting, as well as a copy available should any of the committee members wish to review it.

**Sexually Transmitted Disease Clinic Move**

As you recall from last month's meeting, we had requested a resolution to authorize the Chairman of the Board of Supervisors to obtain a certificate of insurance to for the clinic location to move from the McEchron House to 526 Glen Street. Following the meeting, we learned that the zoning laws in that area do not permit a public health clinic to be held at that address so we pulled the resolution request from the full board agenda.

Resultantly, the clinic has been relocated to our offices here at the Municipal Center, and clinic information has been advertised.

**Salary Increases for Per Diem Nurses**

This request for a referral to the Personnel Committee was tabled last month. If you recall, per diem hourly rates for nurses were set at the beginning of the last CSEA Contract for the contract duration. A resolution of the board is currently in place that keeps all non-bargaining unit employees salaries frozen at the 2009 rates.

Since the per diem rates were set higher at the beginning of the contract and remain higher than the current 2010 hourly rates for nurses, we have decided to withdraw the request and keep the per diem at the 2009 rates. It is not the plan we would prefer, but in light of the current fiscal climate, it is what we will live with at the present time. If it becomes a major issue, we will return to committee.

### **Grants Administrator**

In follow-up to our discussion at last month's meeting regarding the feasibility of working with the Warren County Planning Department, and allocating a portion of Health Services' funding from various grants to the Planning Department for assistance in overseeing grant reimbursements, we have been trying to connect with Pat Tatich to review the needs, but we haven't been able to schedule a time. Hopefully, by the next meeting we will have some definitive information.

### **Chart Regarding the Cycle of Payments as Related to Point of Care (POC) System**

In follow-up to Mr. Champagne's request at last month's meeting, Tammie DeLorenzo has put together a chart to provide clarification. She will be present at the meeting to answer any questions. (Please see the attachment)

### **Prospect Child and Family Center Contractual Issues**

This concern goes back to April 2009, when it was brought to the committee's attention that speech services had not been delivered to several children, so Medicaid could not be billed. The services were paid for as part of the tuition rate. For those committee members that were here last year, you may recall that Larrie Gouge, Executive Director of Prospect, came to the committee to discuss the situation and no action was taken. Trish Nenninger, Second Assistant County Attorney, has been in contact with the New York State Education Department, and to date has gotten no resolve to the issue regarding the rate setting. As you are aware these are mandated services. The State Education Department has visited Prospect, and they now have adequate staff, and have made attempts to provide compensatory services. At this point if the committee is agreeable, we could remove this situation from the Pending Items, and should a concern happen again, we would bring it to the committee's attention.

### **Preschool Program Issue**

In furtherance to the discussion at last month's meeting regarding the issue of a contracted Preschool for Special Needs Children not providing speech services for two children for a 4 - month period. A formal complaint was filed to the New York State Education Department by the school district in which the children reside. It is our understanding that when the state visited the facility, the complaint was sustained. We are awaiting a copy of the report, which we FOILED last week.

Although we do have the funds for the tuition based services encumbered, we have not paid for the time frame in question following the committee's direction last month. We did pay for the January services as appropriate service documentation was received. We would request leaving this item on the agenda for an update at the next meeting. Meanwhile, is it still the decision of the committee not to pay for the time period in question?

### **New Business**

#### **Request Resolution:**

To update the charges for vaccines purchased and administered in the Division of Public Health Clinics to reflect that the revenues received cover the costs of the pharmaceuticals as well as the associated clinic costs. (charges on file with minutes)

#### **Rationale:**

This is done annually, or as needed.

**Request Resolution:**

To ratify the actions of the Chairman of the Board of Supervisors in authorizing a contract agreement with the United Health Care Insurance Company of New York Empire Plan that allows for increases in rates for all services we provide to patients enrolled in the plan.

**Rationale:**

We have a resolution on file that allows us to accept rate increases for services, as we are able to negotiate them without coming to committee each time. What happened with this is when the new rates were sent along came a new contract with minor revisions. Trish Nenninger, Second Assistant County Attorney, upon reviewing it, felt it would be best to get a new resolution for the new contract. Mr. Monroe agreed to execute it and have his actions ratified to enable us to receive our increased rates sooner. We would request that this contract be on the list of those insurers that when future rates are negotiated, we may accept them without coming to committee.

**Request Resolution:**

To amend the contract with Richard Leach, MD, Medical Director for Infectious Diseases, to include that payment for services provided for the Travel Clinic will be paid at \$75.00 per hour.

**Rationale:**

The contract was executed before the Travel Clinic was started. Now that we know that this clinic is viable, we will continue to offer it on a fee for service basis by appointment. Dr. Leach will act as our medical advisor and be on site weekly for 2 hours to provide consultation to patients. Thus, we need to amend his contract to reflect this. Charges paid by the Travel Clinic patients will cover this expense, so there will be no cost to Warren County.

**Request Resolution:**

To amend the 2008 Personal Care Aide rates for North Country Home Services, Inc. to the approved 2009 Medicaid approved rates as follows:

Personal Care Aide Level 1: 2008 rate: \$20.91/hr to 2009 rate: \$21.56/hr (increase 0.65)

Personal Care Aide Level 11: 2008 rate: \$21.24/hr to 2009 rate: \$21.93/hr (increase 0.69)

We would also request the resolution to authorize paying the approved 2009 amounts retroactively back to January 1, 2009, and to continue to pay the 2009 rates until such time as New York State approves the 2010 rates.

**Rationale:**

The 2009 approved rates were received 1/22/10. The amount to be retroactively paid for 2009 is \$532.84.

**Request Resolution:**

To amend the contract with Upper Hudson Primary Care Consortium that provides Medical Director services for both the Division of Home Care and the Division of Public Health to reflect a name change to Hudson Headwaters Health Network.

**Rationale:**

Upper Hudson has requested this and there are no changes to the terms of the contract. The physicians are actually paid by Hudson Headwaters Health Network. A resolution is needed, per the County Attorney's office to authorize this change.

**Request Resolution:**

To amend the contracts with our Business Associates Physical Therapists and Occupational Therapists to include the provision to allow them the ability to sign out for specific patient treatments, the departments' ultrasound equipment in a form approved by the County Attorney.

**Rationale:**

Business Associate Contractors under most circumstances provide all of their own equipment. Occasionally such as with the Point of Care Projects and the use of laptops for documentation, an exception occurs. Physicians sometimes order ultrasound treatments as part of a patient's rehabilitative care. If the patient is admitted to our service, and we do not provide the care, we will be obligated to pay for it in another venue (such as outpatient therapy) and our agency would lose the revenue. We have the equipment, and because of its expense (about \$3,000 a unit and we already have 3), it is not prudent to require contractors to purchase their own units. This practice has been in effect for years and came to my attention in light of the fact that the contractors requirements have been more specified in the last year, and because of the need to have the equipment calibrated for routine maintenance.

**Request Resolution:**

To authorize a contract agreement with Sammon Preston Inc. for calibration and repair services to ultrasound equipment in a form approved by the County Attorney.

**Rationale:**

Westmount currently has a contract with this company for the same purpose. The amount of expense is \$35.00 service fee for each visit to agency, \$22.50 calibration fee, and \$\$80.00 per hour billed at 15-minute increments for any repair service. We would request the contract be written to state that any repair amount would need to be pre-approved. Since we only have three units that are not used routinely for all patients we would not anticipate much expense.

**Request Resolution:**

To authorize a contract agreement with Strategic Health Care Programs, LLC, to provide Benchmarking and CAHPS (Consumer Assessment of Health Care Providers and Systems) Survey Administration as required by the CMS (Centers for Medicare and Medicaid Services) in an amount of \$6,995/year paid annually and \$1.95 per survey.

**Rationale:**

CMS Regulation requires us, to do this or our revenues will be compromised 2% for each patient. We have quotes from three approved CAHPS survey vendors that offer this service. We would be canceling our current contract with OCS (Outcome Concept Systems) where we have \$11,000 budgeted for 2010, and entering into the new contract with Strategic Health Care Programs, LLC, so we would not need any additional funds. Tammie DeLorenzo, Fiscal and Informatics Coordinator, will be present at the meeting to answer any questions and we will also provide the results of the 3 vender quotes obtained to be on file with the meeting minutes.

**Request Committee Approval:**

To host a "Thank You Luncheon" for the volunteers who gave many hours of assistance for our H1N1 and Seasonal Flu Clinics during the past few months.

**Rationale:**

The efforts of these individuals were instrumental in saving the county monies that would have been needed to provide coverage for the clinic. The Emergency Preparedness Grant will cover 100% of the cost for the luncheon, and we will obtain quotes from three establishments.

**Request Resolution:**

To amend the contract with the New York State Department of Health Division of Nutrition Bureau of Supplemental Foods to reflect a reduction in the amount of \$14,521 for the contract year October 1, 2009 through September 30, 2010 bringing the contract amount from \$549,953 to \$535,432 and amend the county budget accordingly.

**Rationale:**

These contract savings must begin immediately and be fully realized by March 31, 2010. The funds will be taken from the WIC Supplies line, and will not compromise the program overall.

We are hopeful that this will be the end of the reductions for this contract year, but that remains to be seen. As you are aware the WIC Program is a fully funded grant program, with Warren County as the sponsor agency.

**Report of Revenues and Expenditures (see attached)****Report of Overtime and Per Diem Use (see attached)**

Tawn Driscoll, Fiscal Manager, will be present to review the reports and answer any questions.

**News on New York State Budget that may impact Warren County Health Services.**

There are many proposals out there, with nothing settled yet. There are new rates and program reimbursement changes being discussed for the Early Intervention Program, and cuts proposed with Medicare and Medicaid for all services, but nothing final. Currently, Medicaid billing for Preschool remains on hold. The county is expected to pay the bills for these mandated services provided to the children, yet we cannot submit for reimbursement. And, as we discussed, the WIC Program contract grant has been decreased. We will keep you updated as we receive information, but there will be cash flow implications for sure, as timely reimbursement will be an issue.

**County Health Rankings**

This information will be sent via e-mail to committee members for their information. A hard copy will be submitted for the minutes, and a copy will be available at the meeting, and if committee members have questions or comments, we can discuss them at the meeting.

**Attachments:**

Emergency Preparedness Monthly Activities Report

Copy of Warren County Health Services Emergency Response Plan (at meeting)

Chart Explaining Cycle of Patient Payments for Services

Report of Expenditures and Revenues

Report of Overtime and Per Diem Use

County Health Rankings

**WARREN COUNTY BUDGET ANALYSIS**

REVENUE AND EXPENDITURES FOR 2010 AS OF 2/23/2010 11:32:45 AM

FUND(S): A, CL, D, DM, EF, GI, MS, SD, V  
 CODE(S): 4010, 4011, 4013, 4016, 4018, 4046, 4054, 4189, 9061, 4025

EXPENSES	2010 BUDGETED	2010 YTD ACTUAL	2009 Prior Year Totals
Salaries - Regular	\$3,010,719.79	\$350,006.06	\$2,977,994.12
Salaries - Overtime	\$155,554.20	\$26,179.17	\$181,571.28
Salaries - Part Time	\$412,599.22	\$29,701.18	\$268,308.45
Salaries - Sick Leave Incentive	\$3,578,873.21	\$405,886.41	\$800.00
100's PERSONAL SERVICES	\$18,800.00	\$175.00	\$3,428,673.85
200's EQUIPMENT	\$10,459,641.00	\$425,492.29	\$3,430.29
400's CONTRACTUAL	\$38,638.00	\$35,013.56	\$8,541,582.48
800's EMPLOYEE BENEFITS	\$14,096,002.21	\$866,567.26	\$59,899.69
<b>TOTALS</b>			<b>\$12,033,586.31</b>
<b>REVENUES</b>			
	<b>2010 BUDGETED</b>	<b>2010 YTD ACTUAL</b>	<b>2009 Prior Year Totals</b>
	\$13,138,574.00	\$61,313.75	\$9,545,717.64

Note: For 2010, an accrual of \$10,739 has been made for the January 2010 BT Grant. We are currently finalizing January revenues for 2010 for CH-HA.LTC and MCH. Revenues for 2009 do not yet reflect Preschool billings for the 2009 school year which can not be billed until May 2010, however revenue accruals have been made for the 2009 BT Grant revenue as of 12/31/09 of \$47,396 and December billing of \$385,000 for CH-HA.LTC, MCH programs.

**Warren County Health Services**

**Salaries Comparison**

2009 vs 2010  
 as of 2/19/10 for 4 payroll

Total of All Depts	YTD 2010	YTD 2009	YTD 10v09	Percentage Change	Annual Expenses	Budget 2010	Actual 2009
Regular Salaries	\$350,006.06	\$385,864.98	-\$35,858.92	-9.29%	\$2,275,039.39	\$3,010,719.79	\$2,977,994.12
Overtime Salaries	\$26,179.17	\$28,482.28	-\$2,303.11	-8.09%	\$179,164.61	\$155,554.20	\$181,571.28
Part Time Salaries	\$29,701.18	\$32,491.74	-\$2,790.56	-8.59%	\$193,057.67	\$412,599.22	\$268,308.45
Sick Leave Incentive	\$0.00	\$0.00	\$0.00	0.00%	\$0.00	\$0.00	\$800.00
<b>TOTALS for 26 Pay periods</b>	<b>\$405,886.41</b>	<b>\$446,839.00</b>	<b>-\$40,952.59</b>	<b>-9.16%</b>	<b>\$2,638,261.67</b>	<b>\$3,578,873.21</b>	<b>\$3,428,673.85</b>
					<b>Estimated Savings</b>	<b>-\$940,611.55</b>	<b>-\$790,412.19</b>

\*Source: Detail GL report for all Salary Category from 1/1/09-2/19/10  
 Note: Payroll reflects the annual 3% increase in union salaries for 2010.

# Warren County Health Services

## POC - Cash Flow

### Visits entered in Encore

Electronically - Skilled Nursing, PT, OT, MSW, Nutrition  
Manually - ST, Home Health Aides, Personal Care Aides  
Lifeline, Home Delivered Meals



### Bills to Payers

All Electronically (via Encore or Zirmed) with the exception of:  
Empire Home Infusion, No-Fault & Workmen's Compensation



### Payments Received

EFTs (Medicare and Blue Shield) to Treasurers Dept A.380  
Checks to Health Services (All other Payers) - Weekly Transmittal to Treas



A/R Reconciliation to Treasurers for A.380 Account - Monthly

WARREN COUNTY HEALTH SERVICES

BT ACTIVITY SHEET

GY 10 - 8/10/2009 - 8/9/2010

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Topic Color Codes

Red/Chempack; Green/SNS; Blue/Mass Fatality; Black/Training; Orange/Drill; Purple/Pan Flu

Date	Type	Subject/Comments	Attendees	Topic (i.e. Drill, SNS, Chempack, Mass Fatality, Training, Pan Flu)
February	HINI	Fit Testing, education, meetings, NYSDOH surveys, clinics, NYSIS data entry etc. (See also 1st quarter HINI Deliverables submitted to state)	All	Pan Flu Pan Flu Training, Pan Flu
2/8/10	Fit Testing	All Glens Falls Schools at Kensington School	Laura Saffer	Pan Flu
2/9/10	Meeting	At monthly BT Coordinators re: Closed POD Planning for MRDD Voluntary Agencies	Laura Saffer	Pan Flu
2/17/10	Tabletop	Monthly GFH - Evacuation of telecommunications and the lab (lessons learned from drill)	Barb Orton	
2/24/10	Webinar	Clinic Ops - HINI Review	Barb Orton, Angela Meade, Laura Saffer, et al	Pan Flu

# RESOLUTION REQUEST FORM NO. 7

## Request to Amend County Budget\*

**\*If this is the result of a grant award, also complete and submit Form No. 5 or 6**

**DEPARTMENT NAME:** Warren County Health Services-Disease Program

**DATE:** February 26, 2010

(a) **Purpose of Amendment:** To amend the 2010 budget for the current Bioterrorism Grant for \$51,432. Authorizing Resolution 615/2009 with Health Research Inc. Total Grant is for \$201,934 and final approval from state was received January 2010. This grant does cover in full salaries that were utilized during H1N1 and Flu season. Both part time staff and overtime for input by clerical staff are fully covered and therefore those salary lines need to reflect these expenses in the current budget.

(b) Appropriation Code (with title), Object Code (with title) and Amount:

<b>Bioterrorism- Overtime Salaries</b>	<b>A.4189.120</b>	<b>\$3,000.00.</b>
<b>Bioterrorism -Part Time Salaries</b>	<b>A.4189.130</b>	<b>\$8,000.00</b>
<b>Bioterrorism –Other Equipment</b>	<b>A.4189.260</b>	<b>\$15,000.00</b>
<b>Bioterrorism-Supplies</b>	<b>A.4189.410</b>	<b>\$13,000.00</b>
<b>Bioterrorism-Telephone Exp.</b>	<b>A.4189.423</b>	<b>\$5,000.00</b>
<b>Bioterrorism- Medical Supplies</b>	<b>A.4189.435</b>	<b>\$5,432.00</b>
<b>Bioterrorism-Advertising</b>	<b>A.4189.436</b>	<b>\$1,000.00</b>
<b>Bioterrorism –Contract Expense</b>	<b>A.4189.470</b>	<b>\$1,000.00</b>

Revenue Code (with title), and Amount: **Bioterrorism Grant Revenue A.4189.4401 \$51,432.00.**

## RESOLUTION REQUEST FORM NO. 20

### MISCELLANEOUS\*

**\*Please List All Other Requests Not Covered by Previous Resolution Request Forms Here. Please attach any backup information available and be as detailed as possible.**

**DEPARTMENT NAME:** Health Services

**DATE:**

- (a) Purpose of Request: To approve the updated Warren County Health Services Emergency Response Plan that is required by NYS DOH as a deliverable in the Emergency Response Grant
- (b) Details: The plan is annexed to the overall Warren County Emergency Response Plan
- (c) Previous Resolution Number: 572/2008 see attached

# Warren County Board of Supervisors

RESOLUTION NO. 572 OF 2008

Resolution introduced by Supervisors Sokol, Sheehan, Haskell, Thomas, Tessier, Champagne and O'Connor

## APPROVING 2008 EMERGENCY RESPONSE AND PREPAREDNESS PLAN FOR WARREN COUNTY HEALTH SERVICES - HEALTH SERVICES DEPARTMENT

WHEREAS, the Director of Public Health/Patient Services of the Warren County Health Services Department, pursuant to New York State Department of Health requirement, has submitted the <sup>updated</sup> 2008 Emergency Response and Preparedness Plan for Warren County to the Warren County Board of Supervisors for approval, now, therefore, be it

RESOLVED, that the <sup>updated</sup> Warren County Health Services Emergency Response and Preparedness Plan for ~~2008~~, as presented to the Warren County Board of Supervisors, be, and hereby is, accepted and approved.

(Note: not required every year as part of grant deliverables.)

## RESOLUTION REQUEST FORM NO. 20

### MISCELLANEOUS\*

**\*Please List All Other Requests Not Covered by Previous Resolution Request Forms Here. Please attach any backup information available and be as detailed as possible.**

**DEPARTMENT NAME:** Health Services

**DATE:** February 26, 2010

- (a) Purpose of Request: To adjust cost of immunizations administered in the Division of Public Health in order to cover cost of pharmaceuticals and related clinic expenses
- (b) Details: Charges are updated annually or as needed to assure revenues cover expenses
- (c) Previous Resolution Number: 120/2009

# Warren County Board of Supervisors

RESOLUTION NO. 477 OF 2009

Resolution introduced by Supervisors Sokol, Sheehan, Thomas, Champagne, O'Connor, Strainer and Pitkin

**AMENDING RESOLUTION NO. 120 OF 2009, TO INCLUDE  
NEW VACCINES OFFERED WITH THE TRAVEL CLINIC AND  
INCREASE ADMINISTRATION FEE FOR PRIVATE PAY PATIENTS  
- HEALTH SERVICES DEPARTMENT**

WHEREAS, Resolution No. 120 of 2009 authorized an increase in the charge for immunizations administered in the Public Health Division to reflect the cost of pharmaceuticals and related clinic expenses of the Health Services Department, and

WHEREAS, the Director of Public Health/Patient Services has requested that Resolution No. 120 of 2009 be amended to include the new vaccines that will be offered with the travel clinic and to increase the administration fee from Fifteen Dollars (\$15) to Twenty-Five Dollars (\$25) for all immunizations and the Health Services Committee has recommended that Resolution No. 120 of 2009 be amended accordingly, now, therefore, be it

RESOLVED, that Resolution No. 120 of 2009 is hereby amended to include the new vaccines that will be offered with the travel clinic and to increase the administration fee for all immunizations from Fifteen Dollars (\$15) to Twenty-Five Dollars (\$25), as set forth in Schedule "A" attached, and be it further

RESOLVED, that other than the amendments described in the preambles of this Resolution, Resolution No. 120 of 2009 shall remain in full force and effect.

## SCHEDULE "A"

## WARREN COUNTY PUBLIC HEALTH PRICE LIST FOR IMMUNIZATIONS

Appointments: Tues. 3:00-4:30pm, Wed. 9:00-11:00am, Fri. 3:00-4:30pm. Travel Clinic: Wed. 4:00-6:00pm  
 If someone needs to come at a different time, check with nurses to see who is available.

<b>Adacel (Tdap)</b>	\$58.00 \$15.00 for VFC-qualified children 11 to 18 years old
<b>Boostrix (Tdap)</b>	\$58.00 \$15.00 for VFC-qualified children 10 to 18 years old
<b>Hepatitis A</b>	\$46.00 for each in a series of two shots \$15.00 for VFC-qualified children or "at-risk" adults
<b>Hepatitis B</b>	\$53.00 for each in a series of three shots \$15.00 for VFC-qualified children or "at-risk" adults
<b>HPV (Gardasil)</b>	\$15.00 for VFC-qualified girls \$155.00 for older
<b>Influenza (Flu) Injection or Mist</b> <i>Encourage public clinics if possible</i>	\$25.00 or Medicare Part B \$15.00 VFC-qualified children
<b>IPV (Polio)</b>	\$15.00 for VFC-qualified children for each in a series of 3 shots \$49.00 for older
<b>IXIARO (Japanese Encephalitis)</b>	\$220.00 for each in a series of two shots
<b>Menactra</b>	\$15.00 VFC-qualified children \$124.00 for adults up to age 55
<b>Menomune</b>	\$15.00 VFC-qualified children \$126.00 for adults up to age 55 and older
<b>MMR (Measles/Mumps/Rubella)</b>	\$15.00 for child/adult student or health care workers, \$71.00 otherwise
<b>Pneumovax</b>	\$67.00 (if not Medicare Part B or other insurance eligible)
<b>PPD (TB Test)</b>	\$28.00 If patient comes back to Public Health office in 2-3 days to have site read. If read by Clinic Nurse off-site, there will be an additional 5.00 charge.
<b>Pre-Rabies</b>	\$203.00 for each in a series of three shots, given over a period of 3 weeks. MUST have prescription from MD.
<b>Td (Tetanus)</b>	\$45.00
<b>Twinrix (Combination Hep B &amp; A)</b>	\$69.00 for each in a series of three shots \$15.00 for "at-risk" adults
<b>Typhim (Typhoid Fever)</b>	\$69.00
<b>Varivax (Chickenpox Vaccine)</b>	\$15.00 for VFC-qualified children \$92.00 for older
<b>Zostavax (Shingles vaccine)</b>	\$179.00 for people 60 years old and older
<b>4F-VAX (Yellow Fever)</b>	\$100.00

Uninsured children 18 years old and younger qualify for the VFC (Vaccine for Children) Program. If child (or adult) is insured, encourage going to their physician. VFC Vaccine is provided to us free of charge by NYSDOH to which we add an administration fee of \$15.00, however no child is denied vaccine. Cash, checks, and charge cards accepted.

## SCHEDULE "A"

### WARREN COUNTY PUBLIC HEALTH PRICE LIST FOR IMMUNIZATIONS

Appointments: Tues, 3:00-4:30pm, Wed, 9:00-11:00am, Fri, 3:00-4:30pm. Travel Clinic: Wed, 4:00-6:00pm  
 If someone needs to come at a different time, check with nurses to see who is available.

Adacel (TdaP)	\$56.00 \$15.00 for VFC-qualified children 11 to 18 years old
Boostrix (TdaP)	\$58.00 \$15.00 for VFC-qualified children 10 to 18 years old
Hepatitis A	\$45.00 for each in a series of two shots \$15.00 for VFC-qualified children or "at-risk" adults
Hepatitis B	\$52.00 for each in a series of three shots \$15.00 for VFC-qualified children or "at-risk" adults
HPV (Gardasil)	\$15.00 for VFC-qualified girls \$155.00 for older
Influenza (Flu) Injection or Mist Encourage public clinics if possible	\$25.00 or Medicare Part B \$15.00 VFC-qualified children
IPV (Polio)	\$15.00 for VFC-qualified children \$49.00 for older
IXIARO (Japanese Encephalitis)	\$220.00 for each in a series of two shots
Menactra	\$15.00 VFC-qualified children \$123.00 for adults up to age 55
Menomune	\$15.00 VFC-qualified children \$125.00 for adults up to age 55 and older
MMR (Measles/Mumps/Rubella)	\$15.00 for child/adult student or health care workers, \$72.00 otherwise
Pneumovax	\$61.00 (if not Medicare Part B or other insurance eligible)
PPD (TB Test)	\$28.00 if patient comes back to Public Health office in 2-3 days to have site read. If read by Clinic Nurse off-site, there will be an additional 5.00 charge.
Pre-Rabies	\$192.00 for each in a series of three shots, given over a period of 3 weeks. MUST have prescription from MD.
Td (Tetanus)	\$43.00
Twlnrix (Combination Hep B & A)	\$67.00 for each in a series of three shots \$15.00 for "at-risk" adults
Typhim (Typhoid Fever)	\$72.00
Varivax (Chickenpox Vaccine)	\$15.00 for VFC-qualified children \$92.00 for older
Zostavax (Shingles vaccine)	\$179.00 for people 60 years old and older
4F-VAX (Yellow Fever)	\$100.00

Uninsured children 18 years old and younger qualify for the VFC (Vaccine for Children) Program. If child (or adult) is insured, encourage going to their physician. VFC Vaccine is provided to us free of charge by NYSDOH to which we add an administration fee of \$15.00, however no child is denied vaccine. Cash, checks, and charge cards accepted.

6/09

## RESOLUTION REQUEST FORM NO. 3

### Request for New Contract

DEPARTMENT NAME: Health Services

DATE: February 26, 2010

- (a) Is this a Result of a Bid or Request for Proposal? No
- (b) Purpose of Contract: To ratify action of the Chairman of the Board of Supervisors to authorize contract agreement with United Health Care Empire Plan to allow receipt of reimbursement of nursing and other health related therapeutical services
- (c) Name of Contractor: United Health Care Empire Plan
- (d) Address of Contractor: 71 Spy Glass Hill Road, Hopewell Junction, NY 12533
- (e) Contractor's Contact Person and Telephone Number: Cheryl Zeoli, 845-223-4654, cherylzeoli@uhc.com
- (f) Has or will the Contract be provided, if so, please attach: Yes
- (g) Commencement Date of Contract: 4/1/2010
- (h) Termination Date of Contract: 60 days written notice by either party
- (i) Payment Provisions: Monthly per visit/service rate for each service provided
- i) lump sum amount
  - ii) hourly rate amount
  - iii) total amount not to exceed
  - iv) how will payments be made (i.e. monthly, quarterly, upon completion of the project, etc.
- (j) Where are the Funds for this Contract ? List Budget Code, (with title), Object Code (with title), and Amount: OR Capital Project OR Capital Reserve Project Number, and Title, and Amount: A4016.1610 CHHA, A4018.0030.1613 Immunizations, A4054.0060.1604 Early Intervention

# PRODUCT DESCRIPTION EXHIBIT

## **SECTION 1 Participating Entities**

The following entities have access to our agreement, and we may change these entities at any time:

- New York State and eligible political subdivisions (ie, The Empire Plan);
- General Motors Corporation;
- Delphi Automotive Systems;
- New York Power Authority

## **SECTION 2 Products and Services**

You shall participate in networks where your patients are enrolled in benefit contracts of the types generally described below:

- Benefit contracts where individuals are offered a network of participating physicians and other health care professionals and must select a primary care physician, who in some cases must approve any care provided by other health care providers. An option for this benefit contract allows individuals to receive health services from non-participating physicians.
- Benefit contracts where individuals are offered a network of participating physicians and other health care providers but are not required to select a primary care physician. An option for this benefit contract allows individuals to receive health services from non-participating physicians.

# APPENDIX 1

## Home Care Service Provider

We include as part of our agreement the following additional materials that bind you and us:

<b>Product Description Exhibit</b>	Defines "participating entities" and lists the type of benefit contracts offered to our customers.
<b>Compensation Exhibit 418 Home Care Services Provider Payment</b>	Provides definitions and stipulations regarding payment for services.
<b>Credentialed Home Care Services Provider Exhibit</b>	Defines "credentialed Home Care Provider" as it pertains to this Agreement. Outlines the Home Care agency name that have been credentialed by United HealthCare and are covered by this Agreement
<b>Covered Service Area Exhibit</b>	Outlines the geographic area(s) served by Ancillary Provider encompassed by this Agreement.
<b>Home Care Service Standards Exhibit</b>	Outlines level and quality of services expected from Ancillary Provider in regard to both Covered Persons and Plan.
<b>Physician &amp; Provider Manual</b>	Clarifies the mechanics of our relationship.

# The United HealthCare Empire Plan Provider Agreement

## - HOME CARE SERVICES PROVIDER -

### I. INTRODUCTION

The words "we," "us," "our," and "United HealthCare" in the Agreement refer to the applicable United HealthCare related corporation which offers or administers the product or products in which you participate. The words "you," and "your" refer to the undersigned Ancillary Provider.

### II. DEFINITIONS

#### 2.0 United HealthCare and its Affiliates, or United HealthCare Related Corporations

United HealthCare Insurance Company of New York and its appropriately licensed affiliates.

#### 2.1 Coverage Documents

The contract, agreement, or policy between us and an employer, group, individual, or employee health and welfare benefit plan ("Plan") which sets forth the Product(s), level, and type of health care benefits available to Covered Persons.

#### 2.2 Covered Persons

Individuals eligible to receive benefits under a Coverage Document.

#### 2.3 Covered Services

Those services and benefits which a Covered Person is entitled to receive.

#### 2.4 Payor

The party financially responsible for payment for Covered Services, which are: (i) for an HMO Product, the applicable United HealthCare licensed HMO; (ii) for other insured Products, the applicable United HealthCare licensed insurer; or (iii) for Administrative Services Only ("ASO") business, the applicable self-funded Plan.

#### 2.5 Products

Those Products offered by us in which you participate, as set forth in the Product Description Exhibits to this Agreement.

#### 2.6 HMO

HMO means a licensed health maintenance organization.

#### 2.7 NYDOH

The New York State Department of Health and/or the Commissioner thereof.

### III. PROVIDING AND ARRANGING FOR HEALTH CARE SERVICES

3.0 You will provide Covered Services to Covered Persons in accordance with this Agreement, the applicable provider Manual(s), and the applicable Coverage Documents.

3.1 You will not unlawfully discriminate against Covered Persons in any way in your provision of or arrangement for health care services. You will provide or arrange for Covered Services to Covered Persons in the same manner, in accordance with the same standard, and with the same availability as offered to other patients.

3.2 You will maintain all licenses and certifications required under State and Federal law for Ancillary Providers rendering the type of services you provide. Such licenses and certifications must be maintained in good standing and not be subject to any restrictions, suspensions, or probations. You will provide us upon request with evidence that you comply with this requirement.

3.3 You will participate in, and cooperate and comply with our administrative policies and procedures and Medical Management Programs, including but not limited to referral, authorization, and claims procedures, Covered Person grievance procedures, performance standards, audit programs, and our Utilization Management and Quality Improvement Programs, as are generally described in the

applicable provider Manual(s). You will continue to have an independent responsibility to provide appropriate medical care to Covered Persons.

3.4 You will notify us in writing by certified mail or hand delivery within ten (10) working days of the occurrence of any of the following:

3.4.1 The revocation, suspension, restriction, probation, termination or voluntary relinquishment of any of the licenses, certifications or accreditations required by this Agreement;

3.4.2 Any legal action pending against you for professional negligence which may reasonably be considered to be a material loss contingency, and the final disposition of the action;

3.4.3 Any indictment, arrest or conviction for a felony or for any criminal charge related to the practice of your profession;

3.4.4 Any determination that you are bankrupt, order appointing a receiver for you, or order approving a petition seeking your reorganization under federal bankruptcy law;

3.4.5 Any judgment against you which might materially impair your ability to carry out your responsibilities under this Agreement;

3.4.6 Any change in your name or ownership;

3.4.7 Any lapse or material change in the liability insurance coverage required by this Agreement;

3.4.8 Any restriction, suspension, revocation or voluntary relinquishment of your medical staff membership or clinical privileges at any health care facility. You need not notify us of any action which will last thirty (30) days or less.

3.5 You will provide us with any information we may reasonably require to perform our functions under this Agreement.

3.6 You will assist us in providing orientation services to your staff, to the extent we reasonably request, about the operation of the United HealthCare Products in which you participate.

3.7 You will cooperate with us in coordinating benefits with other payors in accordance with the procedures set forth in the applicable provider Manual(s).

#### **IV. ADMINISTERING PRODUCTS**

4.0 We will administer the Products described in the Product Description Exhibits. We will conduct the Utilization Management and Quality Improvement Programs. We will provide means for you to identify Covered Persons and to determine the Product which covers them. You will allow United HealthCare related corporations to share and use internally Utilization Management and Quality Improvement Program information obtained through any Product.

4.1 Generally speaking, our Utilization Management Programs include requirements for pre-authorization of certain services rendered in the physician's office and in outpatient, inpatient and ancillary provider settings. Failure to notify us of services requiring preauthorization may result in non-payment for those services. Utilization Management Programs also may require concurrent and retrospective review of certain services, and procedures for assuring that care is delivered in the most appropriate setting.

4.2 Our Quality Improvement Programs consist of review of credentials and performance of Ancillary Provider applicants and participating Ancillary Providers to determine whether the Ancillary Provider meets our standards for quality, availability, accessibility and cooperation.

4.3 The Utilization Management and Quality Improvement Programs are described in the applicable provider Manual(s). Determinations made according to the Programs may affect the amount you are paid and your continued participation with us. We will provide you with applicable Manual(s) and with periodic updates or modifications to the Manual(s). Manual updates or modifications will become effective thirty (30) days from the date you receive them.

4.4 You will be paid for making health care services available to Covered Persons. You will be paid according to the applicable Compensation Exhibits. You are responsible for collecting from Covered Persons that portion of any payment which constitutes a copayment, coinsurance or deductible, if any. You will be paid for Medically Necessary Covered Services only. The procedure for determining what services are Medically Necessary and the definition of Medically Necessary are in the

applicable provider Manual. You agree that we may obtain reimbursement for overpayments by offsetting against future payments due.

4.5 We administer benefits for certain self-funded Plans on an ASO basis. We do not underwrite or insure the benefits. The Plan and not us is the Payor and is financially responsible for all the Plan's benefits. When a Product is sold on an ASO basis, the Plan, as Payor, will pay you for Medically Necessary Covered Services rendered under the applicable Product on the same basis that we would have paid you had the Product been sold on an insured basis.

4.6 In accordance with the law, for all HMO Products, management activities in connection with our services as described in this Article IV are either performed by the licensed HMO or are performed in accordance with a management services agreement which has received appropriate regulatory approval.

## V. BILLING

5.0 You agree that in no event, including, but not limited to non-payment by Payor, a Payor's insolvency or breach of this Agreement, shall you bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against Covered Persons or persons other than Payor for services provided pursuant to this Agreement. This provision shall not prohibit collection of any applicable copayment, coinsurance or deductible billed in accordance with the terms of our Coverage Documents. Deductibles are generally not applicable to HMO Products but may be applicable to other Products such as the HMO Plus point of service Product. Any such billing and collection of a copayment, coinsurance or deductible shall be as specified in the explanation of benefits form for the applicable claim. You further agree that: (1) this provision shall survive the termination of this Agreement regardless of the cause giving rise to such termination and shall be construed to be for the benefit of Covered Persons; and (2) this provision supersedes any oral or written agreement to the contrary now existing or hereafter entered into between you and the Covered Person or persons acting on the Covered Person's behalf.

5.1 You may bill Covered Persons for health care services which are not Covered Services; however, you may not bill Covered Persons for any administrative charges which we consider to be included in our payment for Covered Services or non-covered charges which result from Payor

reimbursement methodologies. You may not bill Covered Persons for Covered Services which we determine are not Medically Necessary unless you obtain the Covered Person's prior written informed consent. The Covered Person's consent will not be considered informed unless you explain to the Covered Person before you render the specific services in question that the Covered Person will be financially responsible for those services, and that Payor will not pay for the services.

5.2 You may conduct Coordination of Benefits activities as permitted by State and Federal law and required by this Agreement subject to reimbursement to the HMO or other applicable Payor of Payor's funds.

## VI. UNITED HEALTHCARE PRODUCTS

6.0 The Products offered by us are described in the Product Description Exhibits. We may notify you of the addition of new products or the modification or elimination of existing products by sending you new Product Description Exhibits and related Compensation Exhibits. New Product Description Exhibits/Compensation Exhibits will become effective and a part of this Agreement sixty (60) days from the date that you receive them.

6.1 Whenever there is a conflict between the Product Description Exhibits/Compensation Exhibits and this Agreement, the Product Description Exhibits/Compensation Exhibits will control.

Whenever the application of the terms of the Product Description Exhibits/Compensation Exhibits would constitute a material amendment to the agreement such exhibits shall be subject to the prior approval of NYDOH.

## VII. MAINTAINING RECORDS

7.0 You will maintain adequate medical, financial and administrative records and will provide copies of such records, at no cost, to us or Covered Persons, and to State and Federal agencies, as may be required for us to comply with the laws which govern us, and as we may require for claims payment purposes or to conduct our Utilization Management and Quality Improvement Programs. You will give us and State and Federal agencies access at reasonable times upon request to such records. You will maintain these records for the longer of two (2) years or the time required by State and Federal law.

- 7.1 You will maintain the confidentiality of all medical, financial and administrative records related to this Agreement to the extent required by State and Federal law.
- 7.2 These responsibilities will survive the termination of this Agreement for any reason.

**VIII. MARKETING**

- 8.0 We may list your name, address, telephone number, public credentials and a factual description of your facilities and services in Ancillary Provider directories, rosters, and marketing materials. You may represent yourself as a participating Ancillary Provider in those United HealthCare Products in which you participate. When this Agreement terminates neither you nor United HealthCare will engage in any activity which implies a continuing relationship.
- 8.1 Except as stated above, the parties reserve the right to and the control of the use of their respective names, symbols, trademarks or service marks which they now use or may later develop. In addition, except as stated above, neither party shall use the other party's name, symbols, trademarks or service marks in advertising or promotional materials or other materials without the prior written consent of the other party.

**IX. TERM AND TERMINATION**

- 9.0 The effective date of this Agreement is the date set forth on the signature page, and will continue in effect for one (1) year, unless terminated by you or us as set forth below. After the Agreement has been in effect for one (1) year, this Agreement will automatically renew for successive one (1) year terms unless terminated by you or us.
- 9.1A Either party may terminate this Agreement at any time by giving the other party at least sixty (60) days advance written notice. If we terminate this Agreement, we will provide you with a written explanation of the reasons for termination. We will give you an opportunity to request a hearing or review of the termination. You must request such hearing or review within thirty (30) days of receipt of our termination notice.
- 9.1B We may terminate this Agreement immediately upon notice to you if we determine that there is imminent harm to a Covered Person, a determination of fraud or a final disciplinary action by a state licensing board or other governmental agency that impairs your ability to practice. Imminent harm

includes, but is not limited to: (i) you fail to maintain any of the licenses, certifications or accreditations required by this Agreement, (ii) you are indicted, arrested or convicted for a felony or for any criminal charge related to the practice of your profession, (iii) we determine that the immediate termination of this Agreement is necessary to protect the health, safety, or welfare of Covered Persons, or (iv) we have other good cause. We may transfer Covered Persons to another Ancillary Provider upon either delivery or receipt of the requisite notice of termination.

- 9.1C We may not terminate this Agreement solely because of you (1) advocating on behalf of a Covered Person; (2) filing a complaint against us; (3) appealing a decision made by us; (4) providing information as specified in New York Public Health Law, Section 4406(c); or (5) requested a hearing regarding a termination decision.
- 9.1D Termination notices must be sent by certified mail or hand delivery.

**X. OBLIGATIONS AFTER TERMINATION**

- 10.0 Both parties will remain liable for any obligations or liabilities arising from conduct prior to termination. You shall notify any Covered Person seeking your professional services after the date of termination that you are no longer participating as a Ancillary Provider with us.
- 10.1 You will continue to provide and to accept payment at the rates stated in this Agreement for health care services pursuant to this Agreement to Covered Persons who are under your care when this Agreement terminates or in the event of HMO insolvency until: (1) medically appropriate completion of the care you are providing to the Covered Person or medically appropriate discharge; or (2) the Covered Person's care has been transferred to another Ancillary Provider consistent with the Covered Person's medical needs; or (3) the Covered Person ceases to be covered; whichever is sooner. In the event of a termination of this Agreement for any reason, you agree to assist in the orderly transition of Covered Persons' case to other Ancillary Providers, where medically appropriate.

**XI. INSURANCE AND INDEMNIFICATION**

- 11.0 You will maintain at all times professional and comprehensive general liability insurance covering

you, your employees, and agents against liability arising in connection with your performance of this Agreement. The professional and general liability insurance will have limits of coverage as required by us. You will provide us upon request with evidence of your compliance with these requirements.

11.1 We will indemnify and hold you harmless from loss, damage or cost (including reasonable attorney fees) arising from our actual wrongful acts or omissions in performing this Agreement. You will indemnify and hold us and the applicable Payor harmless from loss, damage or cost (including reasonable attorney fees) arising from your actual wrongful acts or omissions in performing this Agreement.

11.2 The provisions set forth in Section XI will survive termination of this Agreement for any reason.

## **XII. GENERAL TERMS**

12.0 The parties will use reasonable care and due diligence in performing this Agreement. You will be solely responsible for the health care services you perform under this Agreement.

12.1 The provisions of this Agreement are independent of and separate from each other. If any one provision is determined to be invalid or unenforceable, it shall not render any other provision invalid or unenforceable.

12.2 You may not assign this Agreement without our prior written consent. We may not assign this Agreement without your prior written consent, except that we may assign this Agreement to an entity related to us by ownership or control without your prior written consent.

12.3 The parties are independent entities. Nothing in this Agreement shall be construed to create a relationship of employer and employee, principal and agent, joint venturers, partners, or any relationship other than independent contractors.

12.4 Except as provided in Paragraph 5.0, nothing in this Agreement shall create any rights or remedies in any third parties.

12.5 Waiver of any part of this Agreement shall not be considered a waiver of any other part of this Agreement.

12.6 This Agreement shall be governed by the Employee Retirement Income Security Act of 1974, as amended ("ERISA"), if applicable, or by the laws of

the state in which you are located. This provision will survive termination of this Agreement for any reason.

12.7 Notices required or permitted by this Agreement must be in writing and must be hand delivered, sent by U.S. mail or overnight courier service, to the following addresses:

If to you:

Your Name and Address as it appears on the signature page hereto.

If to us:

Network Administration  
United HealthCare  
505 Boices Lane  
Kingston, NY 12401

These addresses may be changed by sending a notice as required by this paragraph. Notices, including new Product Description Exhibits/Compensation Exhibits, and Ancillary Provider Manual updates, will be considered to have been received three (3) working days after mailing. This provision will survive termination of this Agreement for any reason.

12.8 Except as provided in Paragraph 6.0, no part of this Agreement, including this paragraph, may be modified or amended except in writing signed by both parties, but we may modify or amend this Agreement, effective immediately, by sending you a notice if any State or Federal law, regulation or agency requires us to make the modification or amendment. Any material amendment to this Agreement requires the prior approval of the New York State Department of Health for the purpose of New York HMO Products.

12.9 This Agreement and its present and subsequent Exhibits form the entire contract between you and us and supersede all other agreements relating to the subject matter herein as of the effective date of this Agreement.

12.10 The headings and captions in this Agreement are for ease of reference only and are not part of this Agreement.

12.11 NYDOH is not bound by any arbitration decisions concerning the HMO Products under this Agreement. NYDOH shall be given notice of all such issues going to arbitration and copies of all decisions. Nothing in this provision shall cause the parties to be required to arbitrate any dispute absent

any requirement to do so elsewhere in this Agreement.

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IN WITNESS WHEREOF, the parties hereto have executed this Agreement effective as of the date executed by us below (the "Effective Date").

**The United HealthCare Insurance  
Company of New York**

By: \_\_\_\_\_

Effective Date: \_\_\_\_\_

**Ancillary Provider**

Please print or type the following information:

By: \_\_\_\_\_  
(Signature)

Name: \_\_\_\_\_

Title: \_\_\_\_\_

Date: \_\_\_\_\_

**WARREN COUNTY HEALTH SERVICES**

\_\_\_\_\_  
(Ancillary Provider Name)

**1340 STATE ROUTE 9**

\_\_\_\_\_  
(Street Address)

**LAKE GEORGE**

\_\_\_\_\_  
(City)

**NY**

\_\_\_\_\_  
(State)

**12845**

\_\_\_\_\_  
(Zip)

**14-6002576**

\_\_\_\_\_  
(Tax Identification #)

# COMPENSATION EXHIBIT 418

## Ancillary Home Care Services Provider Payment

### APPLICABILITY

Unless another Exhibit to this Agreement applies specifically to a particular Plan as it covers a particular Covered Person, the provisions of this Exhibit apply to Home Care Covered Services rendered by Ancillary Home Care Services Provider to Covered Persons covered by Plans sponsored, issued or administered by all Participating Entities outlined in the Product Description Exhibit.

### SECTION 1

#### Definitions

Unless otherwise defined in this Section 1, a capitalized term used in this Exhibit shall have the meaning assigned to it in this Agreement.

- 1.1 Ancillary Home Care Services Provider:** Ancillary Provider who renders home care Covered Services.
- 1.2 Per Unit Payment:** The payment rate made to Ancillary Provider for all authorized services rendered to a Covered Person by Ancillary Provider during one hour of time.
- 1.3 Per Visit Rate:** Consists of two Per Unit Payments made to Ancillary Provider for services performed during an encounter wherein authorized services are rendered to Covered Person for a maximum period of two (2) consecutive hours.
- 1.4 Per Hour Rate:** Consists of one Per Unit Payment made to Ancillary Provider for additional time beyond the initial consecutive two-hour visit.
- 1.5 Per Diem:** The payment rate made to Ancillary Provider for all authorized services rendered to a Covered Person by Ancillary Provider during one day.
- 1.6 Covered Service:** A health care service or product for which a Covered Person is entitled to receive coverage from a Participating Entity, pursuant to the terms of the Covered Person's Plan with that Participating Entity.
- 1.7 Covered Person Expenses:** Copayments, deductibles, or coinsurance that are the financial responsibility of the Covered Person according to the Covered Person's Plan.
- 1.8 Customary Charge:** The fee for health care services charged by Ancillary Provider that does not exceed the fee Ancillary Provider would ordinarily charge another person regardless of whether the person is a Covered Person.
- 1.9 Eligible Charges:** The Customary Charge for Covered Services that are eligible for reimbursement to the Ancillary Provider.
- 1.10 Payment Policies:** The guidelines adopted by United for calculating payment of claims under this Agreement. United will make its Payment Policies available to Ancillary Provider at UnitedHealthcare Online. United may change its Payment Policies from time to time.
- 1.11 Physician:** A Doctor of Medicine ("M.D.") or a Doctor of Osteopathy ("D.O.") or another health care professional as authorized under state law, facility bylaws and the applicable Plan to refer patients for Covered Services.
- 1.12 Protocols:** The programs, protocols, and administrative procedures adopted by United or a Payor to be followed by Ancillary Provider in providing services and doing business with United and Payors under this Agreement. These Protocols may include, among other things, credentialing and recredentialing processes, utilization management and Care Coordination processes, quality improvement, peer review, Covered Person grievance, concurrent review, or other similar United or Payor programs. The Protocols will be available to Ancillary Provider upon request. Some or all Protocols also may be disseminated in the form of an administrative manual or guide or in other written communications. United may change the Protocols from time to time. United will use reasonable commercial efforts to inform Ancillary Provider at least thirty days in advance of any material changes to the Protocols. United may implement changes in the Protocols without Ancillary Provider's consent if such change is applicable to all or substantially all of the providers in United's network located in the same state as Ancillary Provider and that practice the same specialty as Ancillary Provider. Otherwise, changes to the Protocols proposed by United to be applicable to Ancillary Provider are subject to the terms of section 12.8 of this Agreement that are applicable to amendments.

# COMPENSATION EXHIBIT 418

## Ancillary Home Care Services Provider Payment

- 1.13 Ancillary Medical Supplies:** Include dressing supplies (gauze pads, sterile/unsterile gloves – per pair, ABDs, Kerlix, Tape, Band-Aids); betadine wipes; peroxide; syringes for nurse-administered injection; laboratory tubes and needles for drawing lab work; vacutainers; KY jelly; cotton balls; alcohol sponges; thermometers; ostomy and/or diabetic supplies required during a nursing visit.
- 1.14 Extraordinary Sterile Medical Supplies:** Those not defined as Ancillary Medical Supplies.

### SECTION 2 Payment for Covered Services

**2.1 Payment.** For Covered Services rendered by Ancillary Provider to a Covered Person, Ancillary Provider shall be paid by Payor the lesser of (1) Ancillary Provider's Customary Charges, less any applicable Covered Person Expenses and subject to the Payment Policies, or (2) the contract rates set forth in Section 2.2, 2.3 and 2.4 of this Exhibit, less any applicable Covered Person Expenses and subject to the Payment Policies. Payment under this Exhibit is subject to the requirements set forth in the Agreement regarding timely submission of a complete claim and compliance with applicable Protocols. We or the other applicable participating entity will promptly adjudicate and pay your complete claim for services covered by your patient's benefit contract. If you submit claims that are not complete,

- You may be asked for additional information so that your claim may be adjudicated; or
- Your claim may be denied and you will be notified of the denial and the reason for it; or
- We may in our discretion attempt to complete the claim and have it paid by us or the other applicable participating entity based on the information that you gave in addition to the information we have.

If governing law requires us to pay interest or another penalty for a failure to pay your complete claim for covered services within a certain time frame, we will follow those requirements. The interest or other penalty required by law will be the only additional obligation for not satisfying in a timely manner a payment obligation to you. In addition, if we completed a claim of yours that was not complete, there shall be no interest or other late payment obligation to you even if we subsequently adjust the payment amount based on additional information that you provide.

**2.2 Home Care Covered Services.** For the provision of home care Covered Services rendered to a Covered Person, the contract rates are as noted in the Home Care Services Maximum Rate Table below, subject to the Payment Policies. Ancillary Provider must utilize the coding specified in the table and where applicable must include shift hours worked per day on the claim form.

**Table 1: Home Care Services Maximum Rate Table For A Minimum of Three (3) Years from the effective date:**

SERVICE CODE	DESCRIPTION	RATE
<b>HOME HEALTH AIDE</b>		
Home health aide services consist of a visit by a Home Health Aide, who is supervised by a registered nurse (RN), assisting the Covered Person, who is stable, recovering and/or improving, with personal care, ambulation and exercise, nutrition and food preparation, essential household services, and simple procedural extensions of therapy services. In addition, the Home Health Aide visit will consist of the Home Health Aide observing the Covered Person and reporting any changes in the Covered Person's status.		
<i>Included in the Payment Rates for Home Health Aide:</i>		
All ancillary medical supplies, professional and non-professional services associated with a Home Health Aide visit, educational materials, Covered Person education, clinical management (i.e. monitoring, on-call, record keeping, etc.), and mileage associated with the care rendered by the Ancillary Provider during an encounter wherein the authorized Health Services are rendered by Ancillary Provider.		
S9122	<b>HOME HEALTH AIDE, PER HOUR</b> [equal to one Per Unit Payment]	<b>\$ 50.00 PER HOUR</b>
S9122*	<b>HOME HEALTH AIDE, PER VISIT (UP TO 2 HOURS)</b> [equal to two Per Unit Payments]  * The code and fee for a home health aide visit is subject to the Centers for Medicare and Medicaid Services (CMS) releasing a HIPAA compliant code for a 2-hour visit. In the event CMS does not release such a code, Ancillary Provider shall continue to use S9122 until such time CMS prevents the use of it. S9122 represents one Per Unit Payment - Ancillary Provider should	<b>\$ 100.00 PER VISIT</b>

# COMPENSATION EXHIBIT 418

## Ancillary Home Care Services Provider Payment

identify a home health aide visit in hourly increments using two (2) Per Unit Payments (ie, list S9122 twice).		
<b>NURSING – SKILLED (REGISTERED NURSE)</b> Skilled nursing services consist of a visit by a Registered Nurse (RN), who may have specialty certifications (i.e., Infusion Nursing), for evaluation and management of a Covered Person. In most cases, the Covered Person may be unstable, recovering responding inadequately to a therapy regimen or may have developed a significant complication that requires skilled nursing services. <b>Included in the Payment Rates for Skilled Nursing Services:</b> All ancillary medical supplies, professional services associated with skilled nursing services, educational materials, Covered Person education, clinical management (i.e., monitoring, on-call, record keeping, etc.), and mileage associated with the care rendered by the Ancillary Provider during an encounter wherein the authorized Health Services are rendered by Ancillary Provider.		
S9123	<b>REGISTERED NURSE (RN) SERVICES, PER HOUR</b> [equal to one Per Unit Payment]	<b>\$ 80.00 PER HOUR</b>
S9123*	<b>REGISTERED NURSE (RN) SERVICES, PER VISIT (UP TO 2 HOURS)</b> [equal to two Per Unit Payments] * The code and fee for a skilled nursing visit is subject to the Centers for Medicare and Medicaid Services (CMS) releasing a HIPAA compliant code for a 2-hour visit. In the event CMS does not release such a code, Ancillary Provider shall continue to use S9123 until such time CMS prevents the use of it. S9123 represents one Per Unit Payment - Ancillary Provider should identify a skilled nursing visit in hourly increments using two (2) Per Unit Payments (ie, list S9123 twice).	<b>\$ 160.00 PER VISIT</b>
<b>NURSING – LICENSED PRACTICAL NURSE</b> Licensed practical nursing services consist of a visit by a Licensed Practical Nurse (LPN), wherein the LPN observes and continues the implementation of the home care plan for an established Covered Person under the supervision of a Registered Nurse. In most cases, the Covered Person is stable recovering and/ or improving. However, the Covered Person may be responding inadequately to the therapy regimen or may have developed a minor complication. <b>Included in the Payment Rates for Licensed Practical Nursing Services:</b> All ancillary medical supplies, professional services associated with licensed practical nursing services, educational materials, Covered Person education, clinical management (i.e., monitoring, on-call, record keeping, etc.), and mileage associated with the care rendered by the Ancillary Provider during an encounter wherein the authorized Health Services are rendered by Ancillary Provider.		
S9124	<b>LICENSED PRACTICAL NURSE (LPN) SERVICES, PER HOUR</b> [equal to one Per Unit Payment]	<b>\$80.00</b>
S9124*	<b>LICENSED PRACTICAL NURSE (LPN) SERVICES, PER VISIT (UP TO 2 HOURS)</b> [equal to two Per Unit Payments] * The code and fee for an LPN nursing visit is subject to the Centers for Medicare and Medicaid Services (CMS) releasing a HIPAA compliant code for a 2-hour visit. In the event CMS does not release such a code, Ancillary Provider shall continue to use the above code until such time CMS prevents the use of it. S9124 represents a Per Unit Payment - Ancillary Provider should identify LPN nursing visit in hourly increments using two (2) Per Unit Payments (ie, list S9124 twice).	<b>\$160.00</b>
<b>MEDICAL SOCIAL SERVICES</b> Medical social services consist of a licensed medical social worker providing information, assistance and support in accessing and obtaining community services to assist the Covered Person and his or her family to better cope with the stresses of illness and/or disability. <b>Included in the Payment Rate for Medical Social Services:</b> All ancillary medical supplies, professional services associated with medical social services, educational materials, Covered Person education, clinical management (i.e. monitoring, on-call, record keeping, etc.), and mileage associated with the care rendered by the Ancillary Provider during each day the authorized Health Services are rendered by Ancillary Provider in accordance with the treatment plan requested or recommended by the Covered Person's Physician.		
S9127	<b>MEDICAL SOCIAL SERVICES, PER DIEM</b>	<b>\$ 110.00 PER DIEM</b>

# COMPENSATION EXHIBIT 418

## Ancillary Home Care Services Provider Payment

<b>OCCUPATIONAL THERAPY</b>		
<i>Included in the Per Diem Rate for Occupational Therapy:</i>		
All ancillary medical supplies, professional services associated with occupational therapy, educational materials, Covered Person education, clinical management (i.e., monitoring, on-call, record keeping, etc.), and mileage associated with the care rendered by the Ancillary Provider during each day the authorized Health Services are rendered by Ancillary Provider in accordance with the treatment plan requested or recommended by the Covered Person's Physician.		
97003	<b>OCCUPATIONAL THERAPY EVALUATION</b> Evaluation code to be billed on initial visit only and only if the Occupational Therapist is the home care professional who is opening the case for services.	\$ 110.00
S9129	<b>OCCUPATIONAL THERAPY, PER DIEM</b>	\$ 110.00 PER DIEM
<b>PHYSICAL THERAPY</b>		
<i>Included in the Per Diem Rate for Physical Therapy:</i>		
All ancillary medical supplies, professional services associated with physical therapy, educational materials, Covered Person education, clinical management (i.e., monitoring, on-call, record keeping, etc.), and mileage associated with the care rendered by the Ancillary Provider during each day the authorized Health Services are rendered by Ancillary Provider in accordance with the treatment plan requested or recommended by the Covered Person's Physician.		
97001	<b>PHYSICAL THERAPY EVALUATION</b> Evaluation code to be billed on initial visit only.	\$ 110.00
S9131	<b>PHYSICAL THERAPY, PER DIEM</b>	\$ 110.00 PER DIEM
<b>SPEECH THERAPY</b>		
<i>Included in the Payment Rate for Speech Therapy:</i>		
All ancillary medical supplies, professional services associated with speech therapy, educational materials, Covered Person education, clinical management (i.e. monitoring, on-call, record keeping, etc.), and mileage associated with the care rendered by the Ancillary Provider during each day the authorized Health Services are rendered by Ancillary Provider in accordance with the treatment plan requested or recommended by the Covered Person's Physician.		
S9128	<b>SPEECH THERAPY, PER DIEM</b>	\$ 120.00 PER DIEM

<b>RESPIRATORY THERAPY</b>	<b>PER DIEM</b>
Home Visit for Respiratory Care	99503    \$ 110.00
Home Visit for Mechanical Ventilation Care	99504    \$ 110.00
<i>Included in the Per Diem rates for Respiratory Therapy:</i>	
All ancillary medical supplies, professional services associated with respiratory therapy, educational materials, Customer education, clinical management (i.e. monitoring, on-call, record keeping, etc.), and mileage associated with the care rendered by the Ancillary Provider during each day the authorized Health Services are rendered by Ancillary Provider in accordance with the treatment plan requested or recommended by the Customer's Physician.	
<b>NURSING SERVICES-HIGH TECH-INFUSION ONLY</b>	<b>PAYMENT RATE</b>
Nursing Visit (up to 2 hours)	99601    \$ 160.00 Per Visit
Each additional hour	99602    \$ 80.00 Per Hour
<i>Nursing Services Includes:</i>	
All ancillary medical supplies, nursing services, educational materials, Customer education, clinical management (i.e., monitoring, on-call, record keeping, etc.), and mileage associated with the care rendered by the Ancillary Provider during an encounter wherein the authorized Health Services are rendered by Ancillary Provider. <b>These codes apply to nursing services for the purpose of home administration of infusion/specialty drugs only.</b>	

# COMPENSATION EXHIBIT 418

## Ancillary Home Care Services Provider Payment

	PER DIEM	
<b>ENTEROSTOMAL THERAPY</b>	<b>S9474</b>	<b>\$ 110.00</b>
<i>Included in the Per Diem rates for Enterostomal Therapy:</i> All ancillary medical supplies, professional services associated with enterostomal therapy, educational materials, Customer education, clinical management (i.e. monitoring, on-call, record keeping, etc.), and mileage associated with the care rendered by the Ancillary Provider during each day the authorized Health Services are rendered by Ancillary Provider in accordance with the treatment plan requested or recommended by the Customer's Physician.		

	RATE	
<b>ZOSTER VACCINE AND ADMINISTRATION</b>		
<b>Zoster Vaccine-Zoster (shingles) vaccine, live, for subcutaneous injection. Supplies and materials provided by the physician over and above those usually included with the procedure(s) rendered are reported separately</b>	<b>90736</b>	<b>\$172.46</b>
<b>Administration Fee-Immunization administration (includes percutaneous, intradermal, subcutaneous, or intramuscular injections); one vaccine (single or combination vaccine/toxoid)</b>	<b>90471</b>	<b>\$10.00</b>

**2.3 Default Payment.** In the event that a fee has not been established for a particular covered service or item, payment will be made at 60% of Ancillary Provider's Customary Charge, less any applicable Covered Person Expenses.

**2.4 Prior Notification Requirements.** *Prior notification to Plan is required for all home care services provided.* Notification for all initial and concurrent requests for services is made during normal business hours (Monday through Friday, 8:00am – 4:30pm EST) by calling the Care Coordination Unit toll-free at 1-877-7NYSHIP (1-877-769-7447); select United HealthCare from the menu of Empire Plan carriers/vendors, then the option for the Home Care Advocacy Program. If additional hours are required beyond the notification for the initial services, notification will need to be made to the Plan prior to rendering additional home services. Failure to obtain prior notification will result in non-payment for services rendered, except in the case of emergency. In case of emergency services rendered without prior notification, Ancillary Provider must provide notification the next business day or as soon as reasonably possible. In no event shall the Covered Person be billed for any portion of otherwise covered services not reimbursed by United HealthCare due to failure to notify.

**2.5 Inclusive Rates.** The following services related to home care performed by the Ancillary Provider are included in the rates established by section 2.2 of this Exhibit and shall not, in any case, be billed to a Covered Person, nor shall there be any separate billing of these services allowed:

- Costs incurred when Ancillary Provider is unable to locate Covered Person or Covered Person is not present at location determined for visit;
- Costs incurred for all mileage associated with care rendered;
- Costs in connection with consultation with family of Covered Person;

# COMPENSATION EXHIBIT 418

## Ancillary Home Care Services Provider Payment

- Costs incurred for “escort” services for professionals to location of Covered Person.

**2.6 Extraordinary Sterile Medical Supplies.** If required, Ancillary Provider shall refer Covered Person to an Empire Plan contracted medical supply provider. Payment to Ancillary Provider for extraordinary sterile medical supplies will be considered on an individual basis subject to Default Payment as outlined in section 2.3 where appropriate.

### SECTION 3

#### Miscellaneous Provisions

**3.1 Medical Treatment Plan.** Home care services must be provided pursuant to a medical treatment plan by and under the supervision of a Physician. Such medical treatment plan must be pursuant to the Covered Person’s benefit contract.

**3.2 Daily Nursing Documentation.** Ancillary Provider must maintain daily nursing documentation of care rendered to Covered Person. Copies of daily nursing documentation must be sent to Plan upon request.

**3.3 Payment Code Updates.** United shall have the right to update any codes, ICD-9-CM Code, HCPCS Code and/or CPT Code from time to time according to changes in the industry, including among other things (a) the latest edition of the Current Procedural Terminology (CPT) manual which is revised by the American Medical Association, (b) the latest edition of the HCPCS manual which is revised by the Centers for Medicare and Medicaid Services (CMS), (c) the latest edition of the ICD-9-CM which is issued by the U.S. Department of Health and Human Services; and (d) the latest guidelines from the National Uniform Billing Committee. Ordinarily, rates are updated using similar methodologies for similar services. We will not generally attempt to communicate routine maintenance of this nature. However, for non-routine rate changes which are intended to substantially alter the overall methodology or reimbursement level of the rate schedule, we will give you 60 days written or electronic notice of the changes.

**3.3 Confidentiality.** We are both prohibited from disclosing to third parties any fee schedule or rate information. There are three exceptions:

- You can disclose to a patient information relating to our payment methodology for a service the patient is considering (eg, global fee, fee for service), but not specific rates.
- We and the participating entities may use this information to administer your patients’ benefit contracts and to pay your claims. We also may permit auditors and other consultants who need the information to perform their duties, all who are subject to a confidentiality agreement, to have access to this information.
- We both may produce this information in response to a court order, subpoena or regulatory requirement to do so, provided that we use reasonable efforts to seek to maintain confidential treatment for the information.

**3.4 Maximums Listed.** Rate amounts listed in Table 1 of section 2.2 are gross amounts. Any copayment, deductible, or coinsurance that the Covered Person is responsible to pay under the benefit plan will be subtracted from the amount listed in determining the amount to be paid by the Payor. The actual payment amount is also subject to matters described in our Agreement, such as the Payment Policies.

**3.5 Level of Care Required.** Ancillary Provider shall monitor level of care rendered to Covered Person and ensure that the professional(s) rendering such care is(are) commensurate with the Covered Person’s required care and bill based on the level of care required regardless of the status of the professional actually performing services. For example, If an RN renders services that could have been supplied in their entirety by a Home Health Aide, Ancillary Provider will identify and bill those services using the Home Health Aide code(s) and rate(s).

**3.6 Laboratory Work.** Ancillary Provider shall have all laboratory work done by one of Participating Plan’s nationally, regionally, or locally contracted reference laboratories and billed by the laboratory. Failure to utilize a contracted laboratory shall result in disapproval of reimbursement for the difference between the actual costs incurred and the rates which would have been realized under the laboratory agreements.

**3.7 Unable to Provide Service.** In the event that Ancillary Provider is unable to provide Health Services to a Covered Person, Ancillary Provider shall arrange and pay for services rendered by another health care provider, upon approval by Participating Plan. Ancillary Provider shall bill Payor, and Payor shall reimburse Ancillary Provider for

**COMPENSATION EXHIBIT 418**  
**Ancillary Home Care Services Provider Payment**

such services rendered by another health care provider, but only up to the amount and under the Protocols stated in this Compensation Exhibit.

# COVERED SERVICE AREA EXHIBIT

1. Warren County Health Services agrees to apply all terms and conditions of this Agreement consistently in all parts of its covered service area.
2. Warren County Health Services agrees to provide all contracted services stated in the Compensation Exhibit in all parts of its covered service area.
3. Covered service area includes:

State	County(ies)
NY	Warren

# CREDENTIALLED HOME CARE SERVICE PROVIDERS

## List of Contracted Home Care Service Providers

1. For purposes of this Agreement, Covered Services shall be limited to such services provided by home care service providers that have been credentialed by United HealthCare Insurance Company of New York.
2. For purposes of this Agreement, only the below outlined home care service providers have been credentialed by United HealthCare Insurance Company of New York. Therefore, only those home care service providers are allowed to provide Covered Services under the terms of this Agreement. The list of home care service providers will be periodically amended in conjunction with paragraph three below.
3. Warren County Health Services will initiate and complete the credentialing process with United HealthCare Insurance Company of New York for any new home care service provider prior to those home care service providers providing services under this Agreement.

Home Care Service Provider	Tax ID#	Associated Exhibit(s)	Effective Date	Cancel Date
Warren County Health Services	14-6002576	Compensation Exhibit 418		

## Home Care Service Standards

Service Area Service/Staffing	Service Expectations
Access	<ul style="list-style-type: none"> <li>◆ Ancillary Provider will accept all case referrals for services within their licensure, scope of practice and geographic service area. Less than 2% of all home care cases referred to Ancillary Provider are declined.</li> </ul>
24 hour/7 day availability	<ul style="list-style-type: none"> <li>◆ RNs and other Ancillary Provider staff are available 24/7 and Customers are given documentation on after hours numbers.</li> </ul>
Staffing Compliment and Credentials	<ul style="list-style-type: none"> <li>◆ There is a compliment of RNs available that are certified in their applicable specialty or who have a level of certification, licensure, education and/or experience acceptable to United or who are under the supervision of an RN who meets certification, licensure, education and/or experience acceptable to United.</li> </ul>
Staff Orientation and Ongoing Training	<ul style="list-style-type: none"> <li>◆ There is a written orientation plan with documented skill demonstrations.</li> <li>◆ Minimum skill demonstration requirements identified/met before staff go "solo".</li> <li>◆ There is dedicated training staff.</li> <li>◆ There is documentation of initial and ongoing training programs including polices and procedures.</li> </ul>
Continuing Education	<ul style="list-style-type: none"> <li>◆ <math>\geq 6</math> programs per year related to new technology or documented areas needing improvement are presented to Ancillary Provider staff.</li> <li>◆ <math>\geq 3</math> programs are designed and presented to referring Physicians and Participating Plan care coordinators upon request</li> </ul>
Sub-Contracted Providers	<ul style="list-style-type: none"> <li>◆ Ancillary Provider will conduct audits every two years of their sub-contractors to ensure that staffing credentials, response time, incidents and satisfaction meet the same standards as Ancillary Provider.</li> <li>◆ Ancillary Provider will provide Ancillary Program Contract Manager, upon request, a current listing of all sub-contracted providers.</li> <li>◆ There are complaints registered on <math>&lt; 2\%</math> of Sub-Contracted Provider cases.</li> </ul>
First Visit Response	<ul style="list-style-type: none"> <li>◆ 100% same day or first day requested limited only by patient availability.</li> </ul>

<b>Quality</b>	
Professional Accreditation	<ul style="list-style-type: none"> <li>◆ Ancillary Provider must be accredited by JCAHO in all provider sites serving United.</li> <li>◆ Ancillary Provider will have Medicare and Medicaid provider numbers in all geographic areas in which Health Services are administered.</li> </ul>
Consistency	<ul style="list-style-type: none"> <li>◆ There is documentation of consistent training programs including policies and procedures in all Ancillary Provider sites.</li> </ul>
Continuous Quality Improvement (CQI)	<ul style="list-style-type: none"> <li>◆ There is a documented CQI program identifying (through data) opportunities for real time, measured improvement in areas of core competencies in all Service categories.</li> <li>◆ There are demonstrated ties between CQI findings and staff orientation, training, policies and procedures.</li> <li>◆ There is a quarterly report submitted by Ancillary Provider to the Ancillary Programs Contract Manager ("APCM") regarding above CQI process, upon request.</li> </ul>
Customer Complaints	<ul style="list-style-type: none"> <li>◆ Complaints are logged by category and type, with specific corrective action plans for any patterns</li> <li>◆ There are complaints registered on &lt; 2 % of cases.</li> </ul>
Vendor Alert Process	<ul style="list-style-type: none"> <li>◆ Ancillary Provider shall participate in the Care Coordination Unit vendor alert<sup>1</sup> process.</li> <li>◆ Ancillary Provider will respond to documented issue within 24 hours of complaint, resolving issue, as appropriate and within a reasonable time frame, and provide Ancillary Program Contract Manager a written response within 5 business days to include specific corrective action plan.</li> <li>◆ Written response shall be sent via facsimile to 845-382-7930 during normal Care Coordination Unit business hours, Monday through Friday, 8:00 a.m. – 4:30 p.m. Eastern Time.</li> </ul>
Referring Physician Complaints	<ul style="list-style-type: none"> <li>◆ Complaints are logged by category and type, with specific corrective action plans for any patterns</li> <li>◆ There are complaints registered on &lt; 2 % of cases.</li> </ul>
<b>Data Reporting and Measurement</b>	
Survey Results	<ul style="list-style-type: none"> <li>◆ Ancillary Provider shall have available and where applicable, upon Participating Plan request, JCAHO accreditation status, Customer and Physician satisfaction surveys, Medicare/Medicaid surveys and any other documents referenced in this Agreement, subject to rules and regulations governing Customer confidentiality.</li> </ul>
Utilization	<ul style="list-style-type: none"> <li>◆ Ancillary Provider will submit to Ancillary Program Contract Manager, upon request, separate quarterly reports on volume of services by type of service.</li> <li>◆ Reports will include but not be limited to the following: average number of nursing visits per case, number of readmits to the hospital, percent of cases Ancillary Provider filled during the reporting period, average time Ancillary Provider took to respond to requests for services, number of no shows, types of cases Ancillary Provider was not able to fill during the reporting period, and utilization by referring Physician.</li> </ul>
Incidents	<ul style="list-style-type: none"> <li>◆ Error rate is &lt; 2%.</li> </ul>

<sup>1</sup> Care Coordination Unit documents patient, family, physician, or discharge planner complaints and grievances and forwards to Ancillary Provider via facsimile

<b>Billing and Reimbursement</b>	
Electronic Billing	<ul style="list-style-type: none"> <li>◆ Working towards 95% of all claims are submitted electronically.</li> </ul>
Complete/Clean Claim Submission	<ul style="list-style-type: none"> <li>◆ 95% of all claims submitted contain accurate and all information necessary to process the claim as defined in the Additional Protocols and Service Standards in each of the respective Services and Payment Appendices.</li> </ul>
Coding Methodology	<ul style="list-style-type: none"> <li>◆ Standard coding methodology is used in billing United</li> </ul>
Accounts Receivable Reconciliation	<ul style="list-style-type: none"> <li>◆ Monthly AR reconciliation is done with results reported to Ancillary Program Contract Manager quarterly, as requested.</li> <li>◆ Corrective action plan is developed to resolve outstanding AR issues.</li> </ul>
<b>Training and Communication</b>	
Participating Plan Administrative Communications	<ul style="list-style-type: none"> <li>◆ There are standard, quarterly meetings, as requested, with Participating Plan to review data reports, quality issues, and address any administration issues.</li> </ul>
Staff Training	<ul style="list-style-type: none"> <li>◆ All Ancillary Provider staff members having direct contact with Customer shall be fully educated in the Empire Plan, the home health care benefit and Care Coordination Unit policy and procedure and have access to the Empire Plan Home Health Care Provider Manual.</li> </ul>
Account Support	<ul style="list-style-type: none"> <li>◆ There is a documented plan and adequate staffing to conduct initial education and ongoing interface with United staff.</li> <li>◆ Ancillary Provider shall appoint a coordinator who will assume the day-to-day responsibilities with regard to Ancillary Provider performance under this agreement and serve as the primary liaison with United. The coordinator will also assist United in resolving Customer issues.</li> <li>◆ Ancillary Provider shall participate in regularly scheduled ongoing contract management meetings with the Ancillary Program Contract Manager, as requested.</li> </ul>

## RESOLUTION REQUEST FORM NO. 4

### Request for Extending, Rescinding or Amending Resolution

DEPARTMENT NAME: Health Services

DATE: February 26, 2010

- (a) Purpose of Contract Change: To amend contract to include \$75.00/hour for on-site medical consultation services for travel clinic
- (b) Resolution Number, or Numbers if Amended, which Authorized the Original Contract: 142/2008 see attached
- (c) Name of Contractor: Richard Leach MD
- (d) Address of Contractor: 28 Sherman Avenue, Glens Falls, NY 12801
- (e) Contractor's Contact Person and Telephone Number: Richard Leach MD, 793-6619
- (f) Commencement Date of Amendment: 3/22/2010
- (g) Termination Date of Extension: 30 day by either party, same as current contract
- (h) Payment Provisions: 75.00/hour, quarterly
  - i) lump sum amount
  - ii) hourly rate amount
  - iii) total amount not to exceed
  - iv) how will payments be made (i.e. monthly, quarterly, upon completion of the project, etc.
- (i) Where are the Funds for this Contract ? List Budget Code, (with title), Object Code (with title), and Amount OR Capital Project OR Capital Reserve Project Number and Title and Amount: A4018.0030.437 Consulting

*Dr Leach*  
**Warren County Board of Supervisors**

RESOLUTION NO. 142 OF 2008

Resolution introduced by Supervisors Sokol, Sheehan, Haskell, Thomas, Tessier, Champagne and O'Connor

**AMENDING RESOLUTION NO. 84 OF 2004 - INCREASE RATES  
PAID TO RICHARD LEACH, M.D., AS MEDICAL DIRECTOR  
FOR TUBERCULOSIS AND ALL OTHER INFECTIOUS DISEASE  
RELATED ILLNESSES WITH THE HEALTH SERVICES DEPARTMENT  
- HEALTH SERVICES**

WHEREAS, Resolution No. 84 of 2004 continued the agreement with Richard Leach, M.D., to provide medical direction services for Tuberculosis Program and all other infectious disease related illnesses within the Warren County Health Services Department, and

WHEREAS, the Director of the Health Services Department desires to increase the rates paid to Richard Leach, M.D., for the medical direction services for an amount of One Thousand Five Hundred Dollars (\$1,500) with additional reimbursements for the following circumstances: Two Hundred Twenty-Three Dollars (\$223) for the initial consultation patient visits and Eighty-Five Dollars (\$85) for revisits to patients for any patient referred for treatment by the Director of Public Health/Patient Services or her designee and One Hundred Seventy-Five Dollars (\$175) per hour for any public health related meeting attended at the request of the Director of Public Health/Patient Services, for a term commencing January 1, 2008 and terminating upon thirty (30) days written notice, now, therefore, be it

RESOLVED, that the Chairman of the Board of Supervisors be, and hereby is, authorized to execute an amendment agreement with Richard Leach, M.D., 28 Sherman Avenue, Glens Falls, New York 12801 to provide medical direction services for Tuberculosis Program and all other infectious disease related illnesses within the Warren County Health Services Department for the amounts as outlined within the preambles of this resolution, for a term commencing January 1, 2008 and terminating upon thirty (30) days written notice, in a form approved by the County Attorney.

## AMENDMENT AGREEMENT

THIS AMENDMENT OF AGREEMENT, amending the agreement between the COUNTY OF WARREN, a municipal corporation and political subdivision established under the Laws of the State of New York, having its offices and place of business located at the Warren County Municipal Center with a mailing address of 1340 State Route 9, Lake George, New York 12845 (the "County"), and

RICHARD P. LEACH, M.D., with an office located at 28 Sherman Avenue, Glens Falls, New York 12801, (the "Contractor").

WHEREAS, the County and Contractor previously entered into an agreement dated February 9, 2000 and most recently renewed by Resolution No. 162 of 2006, wherein the Contractor is providing medical direction services relative to the Tuberculosis and other Infectious Diseases Program within the Warren County Health Services Department, and

WHEREAS, the County and Contractor have agreed to increase the rates paid to Contractor,

NOW, THEREFORE, it is agreed by and between the parties as follows:

1. Paragraph "4" shall be amended to read:

"4. It is further agreed that the Contractor shall be compensated at the rate of One Thousand Five Hundred Dollars (\$1,500) with additional reimbursements for the following circumstances: Two Hundred Twenty-Three Dollars (\$223) for the initial consultation patient visits and Eighty-Five Dollars (\$85) for revisits to patients for any patient referred for treatment by the Director of Public Health/Patient Services or her designee and One Hundred Seventy-Five Dollars (\$175) per hour for any public health related meeting attended at the request of the Director of Public Health/Patient Services."

2. Other than as set forth above, the parties do not intend to change any other term, condition or provision of the original agreement and renewal agreement. The agreement dated February 9, 2000, and the amendment agreements dated January 24, 2001, February 6, 2002, January 8, 2003, February 4, 2004 and January 3, 2005 shall continue to remain in full force and

effect between the parties as amended hereby.

3. This agreement constitutes the full understanding of the parties as to the amendment of the aforesaid agreement. This amendment of agreement may not be modified except by further written agreement executed by the parties.

IN WITNESS WHEREOF, this amendment agreement has been executed by the duly authorized officers of the respective parties.

Approved as to Form:

*R. Manning*  
Assistant Warren County Attorney

COUNTY OF WARREN

By: *Frederick H. Monroe*  
FREDERICK H. MONROE, CHAIRMAN  
Board of Supervisors

Date: *2/1/08*

RICHARD P. LEACH, M.D.

By: *Richard P. Leach*

Date: *4/7/2008*

STATE OF NEW YORK )  
 ) ss.:  
COUNTY OF WARREN )

On the *7<sup>th</sup>* day of *April*, in the year 2008, before me, the undersigned, a Notary Public in and for said state, personally appeared *Richard P. Leach*, personally known to me or proved to me on the basis of satisfactory evidence to be the individual(s) whose name(s) is (are) subscribed to the within instrument and acknowledged to me that he/she/they executed the same in his/her/their capacity(ies), and that by his/her/their signature(s) on the instrument, the individual(s), or person upon behalf of which the individual(s) acted, executed the instrument.

*Sandra G. Vey*  
Notary Public

SANDRA G. VEY  
Notary Public, State of New York  
Registration # 01VE4956206  
Qualified in Warren County  
Commission Expires Sept. 18, 2009

**WARREN COUNTY ATTORNEY'S OFFICE**

Warren County Municipal Center  
1340 State Route 9  
Lake George, New York 12845

Telephone 518 - 761 - 6463  
Fax 518 - 761 - 6377

LAW DEPARTMENT

**DATE:** April 9, 2008  
**TO:** Patricia Auer, Director  
Health Services Department  
**FROM:** Patricia C. Nenninger, Assistant County Attorney  
**RE:** 2008 AGREEMENT

Enclosed please find a copy of the following fully executed Agreement for your records:

Contracting Agency:

RICHARD P. LEACH, M.D.

Authorizing Resolution:

142 of 2008

PCN:svn  
Enclosure

cc: Judith Harris, Auditor (w/enc.)

Dr Leach

Reso  
84/2004

## RENEWAL AGREEMENT

THIS RENEWAL AGREEMENT (hereinafter referred to as the "Agreement"), made by and between the COUNTY OF WARREN, a municipal corporation and political subdivision established under the Laws of the State of New York, having its principal offices and place of business located at the Warren County Municipal Center with a mailing address of 1340 State Route 9, Lake George, New York 12845-3484, (the "County"), and

RICHARD P. LEACH, M.D. , with an office located at 28 Sherman Avenue, Glens Falls, New York 12801 (the "Contractor").

WITNESSETH, that the parties hereto mutually agree as follows:

1. That the Agreement previously entered into by the parties dated February 9, 2000 and providing for medical direction services relative to the Tuberculosis and other Infectious Diseases Program within the Warren County Health Services Department (hereinafter referred to as the "Previous Agreement"), is hereby renewed for the period commencing January 1, 2005 and terminating upon thirty (30) days written notice by either party, under the same terms and conditions as set forth in said Previous Agreement except to the extent amended or changed as follows:

(a) Paragraph "3" is amended to read:

"3. This Agreement shall be for a term commencing January 1, 2005 and terminating upon thirty (30) days written notice to the party."

(b) Paragraph "4" is amended to read:

"4. It is further agreed that the Contractor shall be compensated at the rate of Four Thousand One Hundred Twenty Dollars (\$4,120) with additional reimbursements for the following circumstances: One Hundred Seventy-Five Dollars (\$175) per hour in the event of an unanticipated emergency requiring the presence of the Medical Director for Infectious Diseases; and Seventy-Five Dollars (\$75) for any public health related meeting attended at the request of the Director of Public Health/Patient Services with advance notice of at least one (1) week."

(c) Paragraph "15" is added as follows:

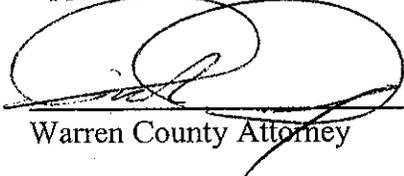
and if contradictory or in addition to any paragraph in the Previous Agreement the same shall be considered amended and/or superseded for the purposes of this Agreement:

2. That the abbreviated description in Paragraph "1" hereof of the Previous Agreement entered into by the parties, is intended for reference and convenience purposes only and shall not be deemed to fully describe the Previous Agreement or any terms or conditions thereof.

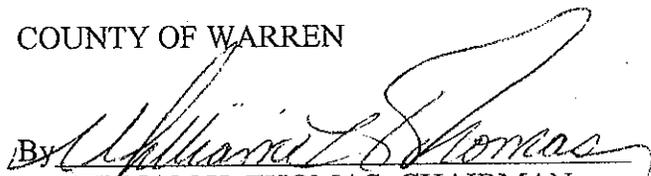
3. The parties shall rely upon the full text of the Previous Agreement and the specific amendment or changes set forth in this Agreement for all understandings, terms, conditions, obligations and/or requirements of performance during the extended term provided by this Agreement.

IN WITNESS WHEREOF, this Agreement has been executed by the duly authorized officers of the respective parties.

Approved as to Form:

  
Warren County Attorney

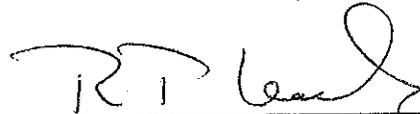
COUNTY OF WARREN

By   
WILLIAM H. THOMAS, CHAIRMAN  
Board of Supervisors

Date

12/29/04

RICHARD P. LEACH, M.D.

  
Richard P. Leach, M.D.

Date

1/3/05

## RESOLUTION REQUEST FORM NO. 4

### Request for Extending, Rescinding or Amending Resolution

DEPARTMENT NAME: Health Services

DATE: February 26, 2010

- (a) Purpose of Contract Change: To amend 2008 Personal Care Aide rates for North Country Home Aides Inc. for PCA level I: \$21.56/hour and PCA level II: \$21.93/hour and to authorize retroactive payment of 2009 rates to January 1, 2009 and continue to pay 2009 rates until 2010 rates are approved.
- (b) Resolution Number, or Numbers if Amended, which Authorized the Original Contract: 446/2009 see attached
- (c) Name of Contractor: North Country Home Services Inc.
- (d) Address of Contractor: 25 Church Street, Saranac Lake, NY 12983
- (e) Contractor's Contact Person and Telephone Number: Rebecca Leahy, 891-2641
- (f) Commencement Date of Amendment: 1/1/2009
- (g) Termination Date of Extension: When 2010 rates are approved by Medicaid and contract is amended to pay new rates
- (h) Payment Provisions: Upon receipt of documentation for each patient visit provided
- i) lump sum amount see (a) above
  - ii) hourly rate amount
  - iii) total amount not to exceed
  - iv) how will payments be made (i.e. monthly, quarterly, upon completion of the project, etc.
- (i) Where are the Funds for this Contract ? List Budget Code, (with title), Object Code (with title), and Amount **OR** Capital Project **OR** Capital Reserve Project Number and Title and Amount: A4010.470 CHHA contract; A4016.470 Long Term Home Health Care Program contract

Warren Co

New York State Department of Health  
Bureau of Long Term Care Reimbursement  
Medicaid Personal Care Rates 2009

Agency: NORTH COUNTRY HOME SERVICES, INC.  
25 Church Street

DCN Number: 82471531

Saranac Lake, NY 12983

County: WARREN

Region: RURAL

Service: Level I  
Actual

Effective Date: Jan 1, 2009

	PC Program Cost	Trended Cost	Regional Ceiling	Rate Calculation
<b>Administration</b>				
<hr/>				
Admin Reported Total	6.660			
Less:				
Capital Cost	0.356	0.373		0.373
Background & Fingerprinting	0.000			
Admin Subject to Ceiling	6.304			
Admin Ceiling	6.255			
Lower Of:				
Admin Cost or Ceiling	6.255	6.558		6.558
Total Admin				6.931
<hr/>				
<b>Direct Care and Training</b>				
<hr/>				
Care & Training Rep Total	15.680			
Less:				
Capital Cost	0.000	0.000		0.000
Background & Fingerprinting	0.028			
Direct Care & Training Subject To Regional Ceiling	15.652	16.410	14.360	14.360
Total				21.291
<hr/>				
Profit / Surplus Component			1.252%	0.267
Total Cost Based Rate				21.56
Public Charge Rate				22.00
Rate (Lower of Cost or Public Charge)				21.56
2009 Worker Recruitment & Retention Add-on - (SSL 367 Q)				1.59
Homecare Provision, A Q, & E Adjustment - PHL 3614(11)				0.34
Final Rate:				
One Client				23.49
Two Clients				11.75
One Client 1/4 Hour				5.87
Two Clients 1/4 Hour				2.94

RECEIVED

JAN 22 2010

WARREN COUNTY  
HEALTH SERVICES

New York State Department of Health  
 Bureau of Long Term Care Reimbursement  
 Medicaid Personal Care Rates 2009

Agency: NORTH COUNTRY HOME SERVICES, INC.  
 25 Church Street  
 Saranac Lake, NY 12983

DCN Number: 82471531

County: WARREN

Region: RURAL

Service: Level II  
 Actual

Effective Date: Jan 1, 2009

	PC Program Cost	Trended Cost	Regional Ceiling	Rate Calculation
<u>Administration</u>				
Admin Reported Total	6.809			
Less:				
Capital Cost	0.364	0.382		0.382
Background & Fingerprinting	0.000			
Admin Subject to Ceiling	6.445			
Admin Ceiling	6.308			
Lower Of:				
Admin Cost or Ceiling	6.308	6.613		6.613
Total Admin				<u>6.995</u>
<u>Direct Care and Training</u>				
Care & Training Rep Total	15.720			
Less:				
Capital Cost	0.000	0.000		0.000
Background & Fingerprinting	0.028			
Direct Care & Training Subject To Regional Ceiling	15.692	16.451	14.660	14.660
Total				<u>21.655</u>
Profit / Surplus Component			1.252%	0.271
Total Cost Based Rate				21.93
Public Charge Rate				22.00
Rate (Lower of Cost or Public Charge)				21.93
2009 Worker Recruitment & Retention Add-on - (SSL 367 Q)				1.62
Homecare Provision, A Q, & E Adjustment - PHL 3614(11)				0.35
Final Rate:				
One Client				23.90
Two Clients				11.95
One Client 1/4 Hour				5.98
Two Clients 1/4 Hour				2.99

# Home Health Aide Rates 2005-2010

	<u>2005</u>	<u>2006</u>	<u>2007</u>	<u>2008</u>	<u>2009</u>	<u>2010</u>
<b>Greater Adk :</b>	\$23.60	\$24.31				
HHA			\$25.04	\$25.54	\$25.54	\$25.54
PCA			\$24.79	\$25.28	\$25.28	\$25.28
<b>Interim:</b>						
HHA	\$17.85	\$18.15	\$18.70	\$19.00	\$19.00	
PCA	\$17.25	\$17.70	\$18.60	\$18.75	\$18.75	
Housekeeping		\$17.00	\$17.85	\$18.20	\$18.20	
<b>North Country:</b>						
HHA	\$22.34	\$22.66	\$23.00	\$23.68	\$24.39	
PCA Level I	\$18.48	\$19.62	\$20.35	\$20.91	\$21.56	
PCA Level II		\$19.96	\$20.65	\$21.24	\$21.93	
<b>Visiting Nurses:</b>						
HHA	\$18.55	\$19.30	\$19.98	\$20.68	\$20.68	
PCA	\$18.05	\$18.80	19.46	\$20.14	\$20.14	

.65 increase per hour  
.69 increase per hour

\* North Country PCA level I & II rates have not been approved yet for 2009 from the State.

Pat is working on an amended resolution to allow us to pay No Ctry the PCA 2008 rates until such time the 2009 rates are established. I will than submit a retro bill for the difference.

Reso 446/2009 amends 2008 PCA rate of \$21.24 to pay for 2009 visits until such time a 2009 rate is approved.

2009 approved rates were rec'd 1/22/10. The LT PCA II rate is \$21.93 & LT PCA I rate is \$21.56. We need a resolution to pay retro from 1/1/09 the difference between the 08 and 09 rates. We also need approval to continue to pay the 2009 rates for 2010 visits until such time the 2010 rates are approved by the State.

# Warren County Board of Supervisors

Copy

RESOLUTION NO. 446 OF 2009

Resolution introduced by Supervisors Sokol, Sheehan, Thomas, Champagne, O'Connor, Strainer and Pitkin

**AMENDING RESOLUTION NO. 121 OF 2009 TO REFLECT  
CORRECT RATE FOR PERSONAL CARE AIDE IN THE AGREEMENT  
WITH NORTH COUNTRY HOME SERVICES - HEALTH SERVICES DEPARTMENT**

WHEREAS, Resolution No. 121 of 2009, among other things, authorized a rate increase for North Country Home Services, Inc. for Personal Care Aide at Twenty-One Dollars and Thirteen Cents (\$21.13) per hour, and

WHEREAS, the Director of Public Health/Patient Services has advised that the correct rate is Twenty-One Dollars and Twenty-Four Cents (\$21.24) per hour, now, therefore, be it

RESOLVED, that Resolution No. 121 of 2009 is hereby amended to reflect the Personal Care Aide rate paid to North Country Home Services, Inc. to be Twenty-One Dollars and Twenty-Four Cents (\$21.24) per hour, and be it further

RESOLVED, that other than the above amendment, Resolution No. 121 of 2009 shall remain in full force and effect.

## RESOLUTION REQUEST FORM NO. 4

### Request for Extending, Rescinding or Amending Resolution

DEPARTMENT NAME: Health Services

DATE: February 26, 2010

- (a) Purpose of Contract Change: To amend contract with Upper Hudson Primary Care Consortium that provides medical director services for both division of Public Health and Home Care to reflect name change to Hudson Headwaters Health Network
- (b) Resolution Number, or Numbers if Amended, which Authorized the Original Contract: On file
- (c) Name of Contractor: Hudson Headwaters Health Network
- (d) Address of Contractor: 5 Carey Road, Queensbury, NY 12804
- (e) Contractor's Contact Person and Telephone Number: Kathy Homkey, 761-0300
- (f) Commencement Date of Amendment: 3/22/10
- (g) Termination Date of Extension: No change
- (h) Payment Provisions: No change
  - i) lump sum amount
  - ii) hourly rate amount
  - iii) total amount not to exceed
  - iv) how will payments be made (i.e. monthly, quarterly, upon completion of the project, etc.
- (i) Where are the Funds for this Contract ? List Budget Code, (with title), Object Code (with title), and Amount **OR** Capital Project **OR** Capital Reserve Project Number and Title and Amount: n/a

## RESOLUTION REQUEST FORM NO. 4

### Request for Extending, Rescinding or Amending Resolution

DEPARTMENT NAME: Health Services

DATE: February 26, 2010

- (a) Purpose of Contract Change: To amend contracts with business associates physical therapists and occupational therapists to include the provision to allow them the ability to sign out the department's ultrasound equipment in a form approved by county attorney for use with specific patient treatments
- (b) Resolution Number, or Numbers if Amended, which Authorized the Original Contract: On file with current contracts of Business Associates
- (c) Name of Contractor: See attached list of business associates - information on file in county attorney's office
- (d) Address of Contractor: See (c)
- (e) Contractor's Contact Person and Telephone Number: See (c)
- (f) Commencement Date of Amendment: 3/22/10
- (g) Termination Date of Extension: Same as current contract
- (h) Payment Provisions: No change from current contract
  - i) lump sum amount
  - ii) hourly rate amount
  - iii) total amount not to exceed
  - iv) how will payments be made (i.e. monthly, quarterly, upon completion of the project, etc.
- (i) Where are the Funds for this Contract ? List Budget Code, (with title), Object Code (with title), and Amount **OR** Capital Project **OR** Capital Reserve Project Number and Title and Amount: No additional funding involved for this contract amendment

**Auer, Pat**

---

**From:** Godfrey, Mary Lee  
**Sent:** Tuesday, February 16, 2010 10:03 AM  
**To:** Auer, Pat  
**Subject:** ultrasound

Pat,

This is the list of people who will use us machine.

Physical Therapist  
Steve Bassin, Theresa Dicroce and Denise Jackson  
Adam Willis and Jen Whalen  
Rob Gautreau  
Kelly Huntley  
Rebecca Compson  
Karin Ash  
Natalie Barber- Adirondack Physical Therapy and Fitness  
Diana Burns  
Kathy Fraser  
Dorothy Grover  
Anne Paolano  
Ed Reed  
Kathleen Ryan  
Nicole Willis

Occupational Therapist- They do not use this often but it is in the scope of practice to us for hand therapy.

Dawn Bazan  
Theresa Costin  
Gary Endal  
Stacey Frasier  
Laura Walter

## RESOLUTION REQUEST FORM NO. 3

### Request for New Contract

DEPARTMENT NAME: Health Services

DATE: February 26, 2010

- (a) Is this a Result of a Bid or Request for Proposal? No
- (b) Purpose of Contract: To authorize agreement with Sammon Preston Inc. (V2017) to calibrate and repair ultrasound equipment
- (c) Name of Contractor: Sammon Preston Inc.
- (d) Address of Contractor: PO Box 93040, Chicago, ILL 60673
- (e) Contractor's Contact Person and Telephone Number: Bob Grignon, 518-800-6020, Vanessa 630-378-6169
- (f) Has or will the Contract be provided, if so, please attach: No
- (g) Commencement Date of Contract: 3/22/10
- (h) Termination Date of Contract: 30 day written notice by either party
- (i) Payment Provisions: \$35.00 service/visit to agency , \$22.50 calibration/visit, \$80.00/hour for repairs - time preapproved by DPH/DPS
  - i) lump sum amount
  - ii) hourly rate amount
  - iii) total amount not to exceed
  - iv) how will payments be made (i.e. monthly, quarterly, upon completion of the project, etc.
- (j) Where are the Funds for this Contract ? List Budget Code, (with title), Object Code (with title), and Amount: OR Capital Project OR Capital Reserve Project Number, and Title, and Amount: A4010.422 CHHA Repair and Maintenance of Equipment

Note: Westmount uses this company as a vendor.

**Auer, Pat**

**From:** Driscoll, Tawn  
**Sent:** Thursday, February 18, 2010 9:21 AM  
**To:** Auer, Pat; Schaldone, Sharon  
**Cc:** Godfrey, Mary Lee  
**Subject:** FW: ultra sound machines

*Tawn Driscoll*

Fiscal Manager  
Warren County Health Services  
Phone(518) 761-6415 ext 8730  
Fax (518) 761-6418  
email: driscollt@co.warren.ny.us

**From:** Robert.Grignon@patterson-medical.com [mailto:Robert.Grignon@patterson-medical.com]  
**Sent:** Thursday, February 18, 2010 7:20 AM  
**To:** Driscoll, Tawn  
**Subject:** Re: ultra sound machines

Good Morning Tawn,

I apologize for not getting back to you sooner, I have been very busy. The pricing structure for calibrations is as follows.

Service Call:           \$35.00  
Calibrations:           \$22.50 each unit

We verify ultrasound output and correct it if it is out specification

We also perform Electrical safety on each piece to verify it is within standards.

Any addition work, such as repair of a unit during Calibration is billed @ \$80.00/hr in quarter hour increments. eg:15 min. = \$20.00

Hopefully this information is what you were looking for. If you have any further questions, please don't hesitate to ask.

Sincerely,

Bob Grignon  
Remote Service Tech.  
Upstate NY  
Sammons Preston  
518-810-6020  
robert.grignon@patterson-medical.com

"Driscoll, Tawn" <driscollt@co.warren.ny.us>

<robert.grignon@patterson-medical.com>

02/11/2010 12:50 PM

ultra sound machines

2/18/2010

## RESOLUTION REQUEST FORM NO. 3

### Request for New Contract

**DEPARTMENT NAME:** Health Services

**DATE:** 02/26/2010

- (a) Is this a Result of a Bid or Request for Proposal? NO
- (b) Purpose of Contract: To enter an agreement with Strategic Healthcare Programs, LLC (SHP) to provide Benchmarking and CAHPS Survey Administration as required by CMS Regulation.
- (c) Name of Contractor: Strategic Healthcare Programs, LLC (SHP)
- (d) Address of Contractor: 121 East Mason Street, Suite B  
Santa Barbara, California 93101
- (e) Contractor's Contact Person and Telephone Number: Mark Richardson, Senior Regional Manager (503) 914-6575
- (f) Has or will the Contract be provided, if so, please attach: Yes
- (g) Commencement Date of Contract: 06/01/2010
- (h) Termination Date of Contract: 30 day written notice
- (i) Payment Provisions:
  - i) lump sum amount \$6,995/year, \$1.95 per CAHPS survey
  - ii) hourly rate amount
  - iii) total amount not to exceed
  - iv) how will payments be made (i.e. monthly, quarterly, upon completion of the project, etc. License paid annually, CAHPS Survey billed Quarterly based upon count of surveys mailed
- (j) Where are the Funds for this Contract ? List Budget Code, (with title), Object Code (with title), and Amount: OR Capital Project OR Capital Reserve Project Number, and Title, and Amount: A.4010.428 Data Processing

## Client Agreement for SHP Data Services

This Agreement is between Strategic Healthcare Programs, LLC (SHP) and

**Warren County Health Services  
1340 State Rt 9  
Lake George NY 12845**

(hereinafter "Client"), an authorized Client of SHP, and governs the terms and conditions of Client's use of SHP data services. By signing this Agreement, or using SHP services, Client agrees to be bound by the terms of this Agreement.

**Program(s): SHP for Agencies™ (hereinafter "Program")**

**Fee(s): \$6,995 per year, per branch/location**

**Software Vendor (Please fill in blank):**  

1) Services Provided. SHP will provide web-based data, outcomes and benchmarking services to Client for the purpose of monitoring and comparing various performance and quality measures. SHP will provide interfaces to the Client's software vendor, if applicable. SHP will provide updates and changes to the Program as needed.

Specifically, SHP will provide Client with: web-based access to reports and ad-hoc queries; real-time data analysis and benchmarks; software interfaces; program updates and notices; education and training by web-conference, electronic newsletter and teleconferences; technical support to promptly implement access to the SHP service; data management and telephone support during Pacific Standard Time business hours.

Upon execution of this Agreement, SHP will grant Client access to the Services. SHP shall at all times retain legal title to and ownership of the Programs. Client agrees not to loan, rent, reproduce, attempt to modify or transfer or allow use of the Programs or their content to or by another party.

2) Privacy and Protection of Data. SHP will not disclose identifying information except as expressly permitted by Client or as required by law. To provide Client and other SHP clients with comprehensive comparative and benchmark data, SHP does and reserves the perpetual right to aggregate and disclose aggregate data from all SHP clients in its database. Client's data will not be attributed to Client or its organization.

Client hereby acknowledges that SHP owns all processes, designs, programs, software, technologies, data, trademarks, trade names, inventions and materials comprising the SHP service. Client agrees to use SHP related materials only in accordance with this Agreement and will not reproduce, resell or reverse engineer any contents of SHP services or the Program.

3) Client Responsibilities.

Internet Access: Client will obtain, maintain and pay for all equipment and third-party services (e.g., Internet access and email service) required for Client to access the SHP web-based services. Client will be responsible for safeguarding and administering user name and password information for its organization, restricting Program passwords to authorized staff, maintaining single user passwords, and making passwords inactive when employment is terminated. Client agrees to add or remove users, retrieve passwords, and manage its account only through the secure SHP Web site.

**Participation and Timely Transmission:** Client agrees to employ its best efforts to implement the SHP service and begin transmitting data within twenty (20) days from execution of this Agreement, and to transmit data used for benchmarking purposes on a timely basis.

**Data Quality:** Client agrees to submit accurate and complete data to the best of its ability and to report to SHP any anomalies discovered in the data during the course of collection, entry or analysis. Client agrees to employ its best efforts to submit corrected or revised data within ten (10) days from the date of discovery.

**Communication:** Client agrees to designate in writing a qualified individual to be the primary contact for coordination of the service immediately upon execution of this Agreement. All communication regarding data collection and time schedules will be directed to the primary contact or the alternate contact designated in writing to SHP by the primary contact. Client expressly agrees to receive communication from SHP via phone, email, fax and mail for informational or promotional purposes. Client will notify SHP in writing of any important changes in management or ownership.

**Business Associate Agreement:** The Health Insurance Portability and Accountability Act (HIPAA) requires that all entities involved in the delivery of patient care (Covered Entities) comply with certain requirements of HIPAA, relating to privacy and security of identifiable patient information, also known as protected health information (PHI). SHP is acting as a "Business Associate" to the Client. Attached as Exhibit A to this Agreement is a copy of an executed Business Associate Agreement between the parties.

**Fees and Payment:** Client agrees to pay all fees at the rate stated above. If the parties have agreed on a term of one (1) year as provided in Paragraph 4) below, payment of the above stated Fees must be received by SHP in full prior to implementation of SHP services. If the parties have agreed on a term of more than one (1) year as provided in Paragraph 4) below, payment for the first year of the term is due immediately upon execution of this Agreement and must be received by SHP in full prior to implementation of SHP services. Thereafter, payment of the above fee for successive years is due on or before the Anniversary date. If payments are not received on or before each Anniversary Date, access to SHP services will be discontinued. In addition, Client hereby agrees to pay a late fee in the amount of three per cent (3%) of the amount outstanding after each Anniversary Date compounded monthly for each month that payment is late. Provided, however, that if the parties have agreed on a term of more than one (1) year as provided in Paragraph 4) below, Client may elect to pay fees at the above rate for the entire term of the Agreement upon execution of this Agreement. If payment for the entire term of the Agreement is paid upon execution of this Agreement, Client will receive a discount of five per cent (5%) of the above stated rate per year.

Requests for customized education, presentations, reports, or other services not included in this Agreement will be conducted at the expense of the Client and will be billed at SHP's then prevailing rate per hour.

**4) Commencement and Termination of Agreement.** This Agreement commences on the date of its execution by both parties (the "Anniversary Date") and shall remain in effect for One (1) year(s). Either party may terminate this agreement by providing advance written notice thirty (30) days prior to the Anniversary Date. Written termination of this Agreement must be signed by the Administrator or CEO of Client organization. In the event Client terminates this Agreement before the end of the initial term or any renewal term, payments received from Client will not be refunded. SHP may terminate this

Agreement immediately if Client fails to pay on a timely basis or violates Paragraphs 1) or 2) above.

5) Governing Law and Jurisdiction. The Agreement will be interpreted and enforced in accordance with the laws of the State of California.

6) Disputes/Mediation/Arbitration. The parties hereby agree to mediate any disputes that may arise under this Agreement. In the event of such disputes, the party claiming breach shall notify the other party in writing of such alleged breach. Within five (5) working days of receipt of such notice in accordance with this Paragraph, the parties may mutually agree in writing on a mediator. If the parties cannot agree in writing on a mediator, each party shall immediately designate a mediator and give notice in writing of such designation to the other party in accordance with this Paragraph. The two (2) mediators selected by the parties shall immediately select a third mediator who shall mediate the dispute. Mediation shall be conducted no later than fifteen (15) working days from initial receipt of notice of a dispute by either party. If mediation fails, the parties hereby agree to binding arbitration. The arbitrator shall be selected using the above procedure. The arbitrator selected by the parties shall establish rules that shall govern arbitration.

7) Indemnification.

**SHP Indemnification:** SHP agrees to indemnify and hold Client harmless against all claims, losses, liabilities, damages, injuries, and expenses (including reasonable attorney fees) resulting from or arising in connection with (i) any breach by SHP, or the employees of SHP, of its obligations and acts under this Agreement, or (ii) any claim made by a third party based upon negligence or willful act or omission by SHP, or its employees, or contractors, in connection with SHP's obligations under this Agreement. SHP's obligations under this paragraph shall survive the termination of the Agreement.

**Client Indemnification:** Client agrees to indemnify and hold SHP harmless against all claims, losses, liabilities, damages, injuries, and expenses (including reasonable attorney fees) resulting from or arising in connection with (i.) any breach by Client, or the employees of Client, of its obligations and acts under this Agreement, or (ii.) if any claim made by a third party based upon negligence or willful act or omission by Client, or its employees, or contractors, in connection with Client's obligations under this Agreement. Client's obligations under this paragraph shall survive the termination of the Agreement.

8) Disclaimer or Warranties and Limitation of Liability. SHP and all SHP software and services are provided "as is", and neither SHP nor any service providers make any express or implied representations or warranties to Client regarding the usability or condition of operation thereof. SHP does not warrant that access to or use of services will be error-free or uninterrupted, or that SHP will meet any particular criteria of performance. SHP expressly disclaims all implied warranties including without limitation, warranties of merchantability, title, and fitness for a particular purpose, non-infringement, compatibility, security, or accuracy.

Under no circumstance shall SHP be held liable for any delay or failure in performance resulting directly or indirectly from acts of nature, forces, or causes beyond its reasonable control, including, without limitation, internet failure, computer equipment failures, telecommunication equipment failures, other electrical power failures, acts of god, war or governmental actions. Under no circumstances shall SHP be held liable for

any reasonable delay or failure in providing Client with access to the web site and/or the services or for termination of Client's access.

9) Notices. All notices given pursuant to this Agreement shall be sent to the addresses below by overnight delivery service or certified mail, postage prepaid, return receipt requested. Notice shall be deemed to be given upon receipt. The parties will give notice of any changes in the addresses that appear below to the other party consistent with the requirements of this Paragraph.

10) Waiver. No failure on the part of either party to exercise, and no delay by either party in exercising any right, power or remedy hereunder shall operate as a waiver thereof, nor shall any single or partial exercise of any right, power or remedy by either party preclude any other or further exercise thereof or the exercise of any other right, power or remedy. No express waiver or assent by either party to any breach of or default in any term or condition of this Agreement shall constitute a waiver of or an assent to any succeeding breach of or default in the same or any other term or condition hereof.

11) Headings. The headings describing the contents of particular sections are inserted only for convenience and shall not be construed as a part of this Agreement or as a limitation on or enlargement of the scope of any of the terms or provisions of this Agreement.

12) Severability. All rights and restrictions contained herein may be exercised and shall be applicable and binding only to the extent that they do not violate any applicable laws and are intended to be limited to the extent necessary so that they will not render this Agreement illegal, invalid or unenforceable. If any term of this Agreement shall be held to be illegal, invalid or unenforceable by a court of competent jurisdiction, it is the intention of the parties that the remaining terms hereof shall constitute their agreement with respect to the subject matter hereof, and all such remaining terms shall remain in full force and effect.

13) No Third Party Beneficiaries. The parties hereto do not intend to, and do not, by executing this Agreement, confer any benefit upon any person other than the parties hereto and their permitted successors and assigns.

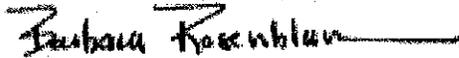
14) Successors and Assigns. This Agreement shall inure to the benefit of and be binding upon the parties hereto and their respective successors. This Agreement may not be assigned by Client except with the advance written permission of SHP.

15) Entire Agreement; Exhibits. This Agreement supersedes all prior discussions and agreements between the parties with respect to the subject matter hereof, and this Agreement contains the sole and entire agreement between the parties with respect to the matters covered hereby. This Agreement may not be modified or amended except by an instrument in writing signed by the parties or their duly authorized representatives. Each of the Exhibits to this Agreement is hereby incorporated by reference in this Agreement for all purposes.

IN WITNESS WHEREOF, the parties have caused this Agreement to be executed under seal as of the day and year first above written.

---

Authorized Client Signature  
Warren County Health Services  
1340 State Rt 9  
Lake George NY 12845



---

Date

22 December 2009

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SHP Signature  
Strategic Healthcare Programs, LLC  
121 East Mason Street, Suite B  
Santa Barbara, California 93101

---

Date

*The proposed contract is valid only if executed by client within 30 days of signature by SHP*

## **BUSINESS ASSOCIATE/CHAIN OF TRUST AGREEMENT**

THIS BUSINESS ASSOCIATE/CHAIN OF TRUST AGREEMENT (the "Agreement") is effective the last date of execution shown below (the "Effective Date") by and between;

**Warren County Health Services  
1340 State Rt 9  
Lake George NY 12845**

(hereinafter "COVERED ENTITY"), and STRATEGIC HEALTHCARE PROGRAMS, a limited liability corporation with its operating office at 121 East Mason Street, Santa Barbara, California 93101, hereinafter referred to as the "BUSINESS ASSOCIATE".

### **RECITALS**

WHEREAS, COVERED ENTITY and Business Associate are parties to an agreement (the "Underlying Agreement") pursuant to which Business Associate provides certain services to COVERED ENTITY and, in connection with those services, COVERED ENTITY discloses to Business Associate certain individually identifiable protected health information ("PHI") that is subject to protection under the Health Insurance Portability and Accountability Act of 1996, as amended from time to time ("HIPAA");

WHEREAS, the parties desire to comply with the HIPAA standards for the privacy of PHI of patients of COVERED ENTITY;

NOW THEREFORE, for and in consideration of the recitals above and the mutual covenants and conditions herein contained, COVERED ENTITY and Business Associate enter into this Agreement to provide a full statement of their respective responsibilities.

### **ARTICLE I – DEFINITIONS**

1.1 Definitions. Unless otherwise provided herein or on Exhibit 1.1 attached hereto, capitalized terms shall have the same meaning as set forth in the HIPAA regulations, 45 CFR parts 142 and 160-164.

### **ARTICLE II – SCOPE OF USE OF PHI**

2.1 Performance of Agreement. Business Associate, its agents and employees (collectively referred to as "Business Associate") may use PHI solely to perform its duties under the Underlying Agreement and only as allowed by the terms of the Underlying Agreement and this Agreement. Business Associate agrees that it will not use or disclose PHI in a manner that violates or would violate the HIPAA regulations.

2.2 Safeguards for the protection of PHI. Business Associate agrees that it (a) will protect and safeguard from any oral and written disclosure all confidential information regardless of the type of media on which it is stored (e.g., paper, fiche, etc.) with which it may come into contact in accordance with applicable statutes and regulations, including, but not limited to HIPAA; (b) implement and maintain appropriate policies and procedures to protect and safeguard the PHI; and (c) use appropriate safeguards to prevent use or disclosure of PHI other than as permitted by this Agreement or required by law. Business Associate acknowledges that COVERED ENTITY is relying on the security safeguards of Business Associate in selecting Business Associate as a business partner. Business Associate shall promptly notify COVERED ENTITY of any material change to any aspect of its security safeguards.

2.3 Reporting of Unauthorized Use. Business Associate will promptly report to COVERED ENTITY any unauthorized use or disclosure immediately upon becoming

aware of it; and will indemnify and hold COVERED ENTITY harmless from all liabilities, costs and damages arising out of or in any manner connected with the disclosure by Business Associate of any PHI. Business Associate shall permit COVERED ENTITY to investigate any such report and to examine Business Associate's premises, records and practices.

2.4 Use of Subcontractors. To the extent Business Associate uses one or more sub contractors to provide services under the Underlying Agreement, and such subcontractors or agents receive or have access to PHI, Business Associate agrees that it will ensure that each such subcontractor or agent shall agree to all of the same restrictions and conditions to which Business Associate is bound. Each such subcontractor or agent shall sign an agreement with Vendor containing substantially the same provisions as this Agreement.

2.5 Breach or Misuse of PHI. Business Associate recognizes that any breach of confidentiality or misuse of information found in and/or obtained from records may result the termination of this Agreement and/or legal action. Unauthorized disclosure may give rise to irreparable injury to the patient or to the owner of such information and accordingly the patient or owner of such information may seek legal remedies against Business Associate.

### **SECTION III – AMENDMENT OF PHI**

3.1 Amendments by Business Associate. Business Associate acknowledges that the HIPAA regulations require COVERED ENTITY to provide access to PHI to the subject of that information, if and when Business Associate makes any Material Alteration to such information. Business Associate shall provide COVERED ENTITY with notice of each Material Alteration in any PHI and shall cooperate promptly with COVERED ENTITY in responding to any request made by any subject of such information to COVERED ENTITY to inspect and/or copy such information. Business Associate may not deny COVERED ENTITY access to any such information if, in COVERED ENTITY' sole discretion, such information must be made available to the subject seeking access to it.

3.2 Amendments Requested by COVERED ENTITY. Business Associate shall promptly incorporate all amendments or corrections to PHI when notified by COVERED ENTITY that such information is inaccurate or incomplete.

### **SECTION IV – AVAILABILITY, AUDITS AND INSPECTIONS**

4.1 Availability of PHI. Business Associate agrees that it will (a) make available PHI in accordance with 45 CFR § 164.254; (b) make available the information required to provide an accounting of disclosures in accordance with 45 CFR § 528. Business Associate will provide such accounting to COVERED ENTITY as soon as possible, but at least twenty (20) days from request by COVERED ENTITY. Each accounting shall provide (i) the date of each disclosure; (ii) the name and address of the organization or person who received the PHI; (iii) a brief description of the information disclosed; and (iv) for disclosures other than those made at the request of the subject, the purpose for which the information was disclosed and a copy of the request or authorization for disclosure. Business Associate shall maintain a process to provide this accounting of disclosures for as long as Business Associate maintains PHI received from or on behalf of COVERED ENTITY.

4.2 Access to DHHS. Business Associate shall make its internal practices, books and records relating to the use and disclosure of PHI received from, or created or received by one party on behalf of the other available to the Secretary of Health and

Human Services, governmental officers and agencies for purposes of determining compliance with 45 CFR §§ 164.500 – 534.

4.3 Access to COVERED ENTITY. Upon reasonable notice, Business Associate shall make its facilities, systems and records available to COVERED ENTITY to monitor compliance with this Agreement.

## SECTION V – TERM/TERMINATION

5.1 Term and Termination. This Agreement is on the Effective Date and remain effective for the entire term of the Underlying Agreement, or until terminated as set forth herein.

5.2 Termination for Improper Use. COVERED ENTITY may terminate this Agreement and the Underlying Agreement if COVERED ENTITY, in its sole discretion, reasonably suspects that the Business Associate has improperly used or disclosed PHI in breach of this Agreement.

5.3 Termination for Inadequate Safeguards. COVERED ENTITY may terminate this Agreement without penalty if it determines, in its sole discretion, that any such changes or any diminution of Business Associate's reported security procedures or safeguards render any or all of Business Associate's safeguards unsatisfactory to COVERED ENTITY.

5.4 Termination After Repeated Violations. COVERED ENTITY may terminate the Underlying Agreement without penalty if Business Associate repeatedly violates this Agreement or any provision hereof, irrespective of whether, or how promptly, Business Associate may remedy such violation after being notified of the same. In the event of such termination, COVERED ENTITY shall not be liable for the payment of any services performed by Business Associate after the effective date of termination.

5.5 Return/Destruction of PHI. Business Associate agrees that, upon termination of the Underlying Agreement, for whatever reason, it will return or destroy all PHI, if feasible, received from, or created or received by it on behalf of COVERED ENTITY which Business Associate maintains in any form, and retain no copies of such information. An authorized representative of Business Associate shall certify in writing to COVERED ENTITY, within five (5) days from the date of termination or other expiration of the Underlying Agreement, that all PHI has been returned or disposed of as provided above and that Business Associate no longer retains any such PHI in any form.

5.6 No Feasible Return/Destruction of PHI. To the extent such return or destruction of PHI is not feasible, Business Associate shall extend the precautions of this Agreement to the information and limit further uses and disclosures to those purposes that make the return or destruction of the information unfeasible. Business Associate shall remain bound by the provisions of this Agreement, even after termination of the Underlying Agreement, until such time as all PHI has returned or otherwise destroyed as provided in this section.

5.7 Effect of Termination. All rights, duties and obligations established in this Agreement shall survive termination of this Agreement.

## SECTION VI – INDEMNIFICATION/INSURANCE

6.1 Indemnification. Business Associate shall indemnify and hold COVERED ENTITY harmless from and against all claims, liabilities, judgments, fines, assessments, penalties, awards or other expenses, of any kind or nature whatsoever, including,

without limitation, attorney's fees, expert witness fees, and costs of investigation, litigation or dispute resolution, relating to or arising out of any breach or alleged breach of this Agreement by Business Associate.

6.2 Insurance. If COVERED ENTITY requires, Business Associate shall obtain and maintain insurance coverage against improper uses and disclosures of PHI by Business Associate, naming COVERED ENTITY as an additional named insured. Promptly following a request by COVERED ENTITY for the maintenance of such insurance coverage, Business Associate shall provide a certificate evidencing such insurance coverage.

#### **SECTION VII – DISCLAIMER**

7.1 Disclaimer. COVERED ENTITY MAKES NO WARRANTY OR REPRESENTATION THAT COMPLIANCE BY BUSINESS ASSOCIATE WITH THIS AGREEMENT OR THE HIPAA REGULATIONS WILL BE ADEQUATE OR SATISFACTORY FOR BUSINESS ASSOCIATE'S OWN PURPOSES OR THAT ANY INFORMATION IN THE POSSESSION OF BUSINESS ASSOCIATE OR CONTROL, OR TRANSMITTED OR RECEIVED BY BUSINESS ASSOCIATE, IS OR WILL BE SECURE FROM UNAUTHORIZED USE OR DISCLOSURE, NOR SHALL COVERED ENTITY BE LIABLE TO BUSINESS ASSOCIATE FOR ANY CLAIM, LOSS OR DAMAGE RELATING TO THE UNAUTHORIZED USE OR DISCLOSURE OF ANY INFORMATION RECEIVED BY BUSINESS ASSOCIATE FROM HOSPITAL OR FROM ANY OTHER SOURCE. BUSINESS ASSOCIATE IS SOLELY RESPONSIBLE FOR ALL DECISIONS MADE BY BUSINESS ASSOCIATE REGARDING THE SAFEGUARD OF PHI.

#### **SECTION VIII – MISCELLANEOUS**

8.1 Construction. This Agreement shall be construed as broadly as necessary to implement and comply with HIPAA and the HIPAA regulations. The parties agree that any ambiguity in this Agreement shall be resolved in favor of a meaning that complies and is consistent with HIPAA and the HIPAA regulations.

8.2 Notice. All notices and other communications required or permitted pursuant to this Agreement shall be in writing, addressed to the party at the address set forth at the end of this Agreement, or to such other address as either party may designate from time to time. All notices and other communications shall be mailed by registered or certified mail, return receipt requested, postage pre-paid, or transmitted by hand delivery or telegram. All notices shall be effective as of the date of delivery of personal notice or on the date of receipt, whichever is applicable.

8.3 Modification of Agreement. The parties recognize that this agreement may need to be modified from time to time to ensure consistence with amendments to and changes in applicable federal and state laws and regulations, including, but not limited to, HIPAA. This Agreement shall not be waived or altered, in whole or in part, except in writing signed by the parties.

8.4 Transferability. COVERED ENTITY has entered into this Agreement is specific reliance on the expertise and qualifications of Business Associate. Consequently, Business Associate's interest under this Agreement may not be transferred or assigned or assumed by any other person, in whole or in part, without the prior written consent of COVERED ENTITY.

8.5 Governing Law and Venue. This Agreement shall be governed by, and interpreted in accordance with, the internal laws of the State of California, without giving effect to its conflict of law provisions. Santa Barbara County, California, shall be the sole and exclusive venue for any arbitration, litigation, special proceeding or other proceeding as between the parties that may be brought under, or arise out of this Agreement.

8.6 Binding Effect. This Agreement shall be binding upon, and shall ensure to the benefit of, the parties hereto and their respective permitted successors and assigns.

8.7 Execution. This Agreement may be executed in multiple counterparts, each of which shall constitute an original and all of which shall constitute but one Agreement.

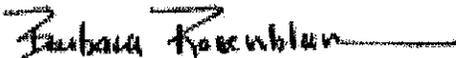
8.8 Gender and Number. The use of the masculine, feminine or neuter genders, and the use of the singular and plural, shall not be given an effect of any exclusion or limitation herein. The use of the word "person" or "party" shall mean and include any individual, trust, corporation, partnership or other entity.

8.9 Priority of Agreement. If any portion of this Agreement is inconsistent with the terms of the Underlying Agreement, the terms of this Amendment shall prevail. Except as set forth above, the remaining provisions of the Underlying Agreement are ratified in their entirety.

IN WITNESS WHEREOF, the parties have hereunto set their hands effective the day and year first above written.

---

Authorized Client Signature  
Warren County Health Services  
1340 State Rt 9  
Lake George NY 12845



---

Date

22 December 2009

---

SHP Signature  
Strategic Healthcare Programs, LLC  
121 East Mason Street, Suite B  
Santa Barbara, California 93101

---

Date

## Amendment to the Client Agreement

### SHP for Patient Satisfaction™ (HH-CAHPS)

The additional provisions set forth below are hereby made a part of the current Agreement on file between Strategic Healthcare Programs, LLC (hereinafter SHP), and the organization below (hereinafter Client).

**Warren County Health Services  
1340 State Rt 9  
Lake George NY 12845**

The Agreement is hereby amended as follows. All other terms and conditions of the Agreement remain in full force and effect.

#### 1) ADDITIONAL SERVICES AND ADDITIONAL SITES

Client wishes to purchase **SHP for Patient Satisfaction™ (HH CAHPS)**, which includes the following:

- I. Data interface to Client's software for automated capture of HH-CAHPS required data (where available)
- II. Complete survey administration program
  - a. Program set-up
  - b. Sample size analysis
  - c. HH-CAHPS survey designed by SHP to encourage higher return rate
  - d. Agency-specific logo insertion on patient cover page
  - e. Mailing with postage paid return envelope
  - f. Response tracking
  - g. Toll-free call line to handle patient inquiries about the survey
  - h. Re-mailing as necessary to achieve CMS-mandated return rate
  - i. Database administration
  - j. Support desk assistance
  - k. Data submission to CMS
- III. Real-time satisfaction reports and queries
  - a. Clinician-specific reports utilizing the SHP Clinician Scorecard™
  - b. Online patient comments
  - c. Benchmarks
  - d. Other reports as developed
  - e. Education - Winning Wednesday Webinars™

Surveys will be processed in accordance with CMS protocols and guidelines:

Activity	Timing
Mail initial questionnaire with cover letter to sampled patients	No later than 3 weeks after the close of the sample month
Mail second questionnaire with cover letter to all sampled patients who do not respond to first questionnaire mailing	Approximately 3 weeks (21 days) after the first questionnaire is mailed
Complete data collection	Six weeks (42 days) after the first questionnaire is mailed

#### 2) COMMENCEMENT AND TERMINATION OF AGREEMENT

This initial term of this Amendment commences when executed by both parties. Thereafter, this Agreement shall renew automatically on an annual basis unless 30-day written cancellation is provided to SHP.



# Warren County Request to Host Meeting or Conference

Name of Department: Health Sciences

Name of Meeting/Conference: Thank you luncheon for

H, N, clinics service

Date: March 18

Location: To be determined depending upon price quotes

from 3 establishments

Purpose: see above

Contact Person: (If other than Department Head) \_\_\_\_\_

Phone No.: 761-6580

Number of People attending:

10 County Employees

0 State Employees

30 Volunteers

\_\_\_\_ Others (specify) \_\_\_\_\_

Cost to County (please include amounts):

Room rental 0

Food/beverage grant will reimburse up to 15<sup>00</sup>/person

Supplies 0

Other (specify) 0

approximately  
Total Cost: 600<sup>00</sup>

100% Reimbursed by  
Emergency Preparedness Grant

Dept Head Approval:

Petersen

Signature

2.26.10

Date:

Committee Chairman Approval:

Matthew

Signature

2/26/10

Date

# Warren County Request to Host Meeting or Conference

Name of Department: Health Sciences

Name of Meeting/Conference: Thank you luncheon for  
H<sub>1</sub>N<sub>1</sub> clinics service

Date: March 18

Location: To be determined depending upon price quotes  
from 3 establishments

Purpose: see above

Contact Person: (If other than Department Head) \_\_\_\_\_

Phone No.: 761-6580

Number of People attending:

10 County Employees

0 State Employees

30 Volunteers

\_\_\_\_ Others (specify) \_\_\_\_\_

Cost to County (please include amounts):

Room rental 0

Food/beverage grant will reimburse up to 15<sup>00</sup>/person

Supplies 0

Other (specify) 0

approximately  
Total Cost: 600<sup>00</sup>  
100% Reimbursed by  
Emergency Preparedness Grant

Dept Head Approval:

Petrocs R. Ryan  
Signature

2-26-10  
Date:

Committee Chairman Approval:

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

## RESOLUTION REQUEST FORM NO. 4

### Request for Extending, Rescinding or Amending Resolution

DEPARTMENT NAME: Health Services

DATE: February 26, 2010

- (a) Purpose of Contract Change: To amend contract with Supplemental Foods to reflect a deficit reduction in amount of \$14,521.00 bringing grant from \$549,953 to \$535,432
- (b) Resolution Number, or Numbers if Amended, which Authorized the Original Contract: 664/2009 see attached
- (c) Name of Contractor: NYS DOH Division of Nutrition, Bureau of Supplemental Foods
- (d) Address of Contractor: Riverview Center, 150 Broadway, 6<sup>th</sup> Floor West, Albany, NY 12204-2719
- (e) Contractor's Contact Person and Telephone Number: Bill Wojcicki, 408-5278
- (f) Commencement Date of Amendment: 3/22/10
- (g) Termination Date of Extension: 9/30/10
- (h) Payment Provisions: Monthly with voucher submission
  - i) lump sum amount
  - ii) hourly rate amount
  - iii) total amount not to exceed
  - iv) how will payments be made (i.e. monthly, quarterly, upon completion of the project, etc.
- (i) Where are the Funds for this Contract ? List Budget Code, (with title), Object Code (with title), and Amount **OR** Capital Project **OR** Capital Reserve Project Number and Title and Amount: A4013.410 WIC expenses, A4013.4403 WIC Federal Grant Revenue

# Warren County Board of Supervisors

RESOLUTION NO. 664 OF 2009

**Resolution introduced by Supervisors Sokol, Sheehan, Thomas, Champagne, O'Connor, Strainer and Pitkin**

**AUTHORIZING AGREEMENT CONTINUING CONTRACTUAL RELATIONSHIP WITH  
NEW YORK STATE DEPARTMENT OF HEALTH FOR SPECIAL SUPPLEMENTAL  
FOOD PROGRAM FOR THE WOMEN, INFANTS AND CHILDREN (WIC) PROGRAM  
- HEALTH SERVICES DEPARTMENT**

RESOLVED, that Warren County continue the contractual relationship (the previous contract being authorized by Resolution No. 566 of 2008) with the New York State Department of Health, Bureau of Supplemental Foods Division of Nutrition, Riverview Center, 180 Broadway, Albany, New York 12204-2719, for participation in the Special Supplemental Food Program for the WIC Program within Warren County, for the first year of a new five year contract cycle in an amount not to exceed Five Hundred Forty-Nine Thousand Nine Hundred Fifty-Three Dollars (\$549,953), for an initial term commencing October 1, 2009 and terminating September 30, 2010, and the Chairman of the Board of Supervisors be, and hereby is, authorized to execute said agreement in the form approved by the County Attorney, and be it further

RESOLVED, that the Chairman of the Board of Supervisors be, and hereby is, authorized to execute any and all documents necessary to accept any Cost of Living Adjustment (COLA) payments that the County may receive and/or any other monies made available to the County under the initial term of the grant in a form approved by the County Attorney.

**Auer, Pat**

**From:** Harriss, Kathy  
**Sent:** Tuesday, February 16, 2010 10:18 AM  
**To:** Auer, Pat  
**Subject:** FW: URGENT: DEFICIT REDUCTION PLAN - CHANGES TO WIC CONTRACT

Good Morning!

I sensed something was going on, but not this drastic!

Kathy

**From:** Joshua J Huggins on behalf of DON-WICBUDGET BML  
**Sent:** Fri 2/12/2010 5:53 PM  
**To:** Harriss, Kathy  
**Cc:** Driscoll, Tawn  
**Subject:** URGENT: DEFICIT REDUCTION PLAN - CHANGES TO WIC CONTRACT

**ACTION REQUIRED**

The New York State Department of Health Division of Nutrition Bureau of Supplemental Food Programs has been directed to amend all contracts that are funded using State funds. Please review and complete the attached documents to amend your contract and return the completed, signed and notarized documents to the address indicated.

Hard copies of these attachments have been mailed to: Fred Monroe.

If you have questions or need assistance in identifying potential savings, please contact your regional office representative.

**IMPORTANT NOTICE:** This e-mail and any attachments may contain confidential or sensitive information.

2/16/2010

Agency ID 201  
 Contract Name Warren County Health Services  
 Contract Number C025807

Original Contract Amount	\$549,953
Required Reduction Amount	\$14,521
New Contract Amount	\$535,432

This worksheet is designed to help you revise your Appendix B. The document will only print a revised Appendix B once your contract has been reduced by the required amount.

Please mail the revised Appendix B (You do not need to include the first page of this worksheet) with the rest of the required contract documents as outlined in your cover letter.

Personal Service	Current Contract Amount	Adjustment	New Contract Amount
Program Support	\$176,851	\$0	\$176,851
Non-Direct Staff	\$0	\$0	\$0
Competent Professional Authority	\$111,323	\$0	\$111,323
Total FTEs and Salary	\$288,174	\$0	\$288,174
Fringe Benefits	\$110,256	\$0	\$110,256
Non-Direct Fringe Benefits	\$0	\$0	\$0
Total Personal Service and Fringe Benefits (a)	\$398,430	\$0	\$398,430
<b>Other Than Personal Service</b>			
Space	\$20,292	\$0	\$20,292
Other Non-Personal Service	\$32,389	\$0	\$32,389
Subtotal Other Than Personal Service (b)	\$52,681	\$0	\$52,681
Total Direct Costs (a+b)	\$451,111	\$0	\$451,111
Indirect Costs (c)	\$34,715	\$0	\$34,715
Subtotal (a+b+c)	\$485,826	\$0	\$485,826
Breast Pumps and Collection Kits	\$1,651	\$0	\$1,651
Enhanced Peer Counseling Grant	\$12,480	\$0	\$12,480
Subtotal Allowable Reimbursement with Breastfeeding Costs	\$499,957	\$0	\$499,957
Unallocated	\$49,996	\$0	\$49,996
Grand Total	\$549,953	\$0	\$549,953



# STATE OF NEW YORK DEPARTMENT OF HEALTH

Riverview Center 150 Broadway Albany, New York 12204-2719

Richard F. Daines, M.D.  
Commissioner

James W. Clyne, Jr.  
Executive Deputy Commissioner

February 12, 2010

Fred Monroe  
Chairman, Board of Supervisors  
Warren County Health Services  
Warren County Municipal Center  
1340 State Route 9  
Lake George, NY 12845

Re: Contract # C025807

Dear Contractor:

The New York State Department of Health recently received several directives that will require modifying the Special Supplemental Nutrition Program for Women, Infants and Children (WIC) contracts. These changes are detailed below.

### **Deficit Reduction Program**

Chapter 502 of the New York State Laws of 2009, commonly known as the Deficit Reduction Program (DRP), reduced several appropriations associated with Department of Health contracts. The DRP is limited to State funded appropriations - because WIC contracts are predominately federally funded, the impact of DRP was minimized, requiring contract values to be reduced by 2.64%. The WIC contract listed above is impacted by these Laws and must be reduced. Please review the enclosed letter regarding DRP for further instructions and actions that are required on your part.

### **Appendix G**

The Director of State Operations, Office of Taxpayer Accountability has required new language related to "notices" be added to all contracts executed after December 4, 2009. This language has been incorporated into a new contract appendix titled "**Appendix G – Notices.**" Agency specific contact information must be completed in the spaces provided on Appendix G and returned to the address below.

**Appendix C**

In an effort to reduce the costs associated with generating and mailing paper reimbursement checks, the Director of State Operations, Office of Taxpayer Accountability is requiring new language be added to **Appendix C – Payment and Reporting Schedule** requiring all contractor payments be made electronically, unless a specific authorization to continue to receive paper checks is obtained from the Commissioner. Please review Section 1.D of the enclosed revised Appendix C for further information. Appendix C Section 1.F has also been revised to update the address for submitting monthly voucher claims and reports of expenditure. Please initial the revised Appendix C in the margin next to Section 1.D and Section 1.F to acknowledge contractor acceptance of these changes and return with the other documents included in this mailing. These changes will be incorporated into each agency's FFY 2010 WIC contract.

When you have completed the modifications to Appendix B and initialed the changes to Appendix C, please sign, date, and notarize the Appendix X provided. Return these documents within 5 business days from the receipt of this letter to:

**NYS Department of Health  
Division of Nutrition/RPOU  
Riverview Center  
150 Broadway, 6<sup>th</sup> Floor West  
Albany, NY 12204-2719**

If you have questions regarding any of the information described in this letter or the enclosures, please contact your regional office representative.

Sincerely,

Timothy Mooney, Director  
Bureau of Supplemental Food Programs

enclosures

cc: Kathy Harriss  
Regional Offices  
Local Agency Fiscal Contacts  
Ginelle Jones



**STATE OF NEW YORK  
DEPARTMENT OF HEALTH**

Riverview Center 150 Broadway Albany, New York 12204-2719

Richard F. Daines, M.D.  
*Commissioner*

James W. Clyne, Jr.  
*Executive Deputy Commissioner*

February 12, 2010

Fred Monroe  
Chairman, Board of Supervisors  
Warren County Health Services  
1340 State Route 9  
Warren County Municipal Center  
Lake George, NY 12845

Re: Contract # C025807

Dear Contractor:

Chapter 502 of the New York State Laws of 2009, commonly known as the Deficit Reduction Program (DRP), reduced several appropriations associated with Department of Health contracts. The contract listed above is among those contracts impacted by these reductions and must be reduced by \$14,521 (2.64%).

In order to implement this reduction, this contract must be amended. Please review the enclosed current contract budget and make the necessary adjustments to the budget to effect the required action. For this reduction exercise, the Unallocated and Enhanced Peer Counseling budget lines **cannot** be reduced. Any budget reductions made should insure that contract savings will begin immediately and be fully realized by March 31, 2010.

When you have completed your modifications, please sign, date, and notarize the Appendix X provided. Please return these documents within 5 business days from the receipt of this letter to:

**NYS Department of Health  
Division of Nutrition/RPOU  
Riverview Center  
150 Broadway, 6<sup>th</sup> Floor West  
Albany, NY 12204-2719**

Should you have questions regarding the application of the Deficit Reduction Program to your contract, please contact your regional office representative.

cc: Kathy Harriss  
Regional Offices  
Local Agency Fiscal Contacts  
Ginelle Jones

Appendix B

Warren County Health Services  
PROJECT #201  
CONTRACT # C025807  
October 1, 2009 - September 30, 2010

	<u>BUDGET AMOUNT</u>
<b><u>Personal Service</u></b>	
Program Support	\$176,851.00
Non-Direct Staff	\$0.00
Competent Professional Authority	\$98,802.00
Total FTEs and Salary	<hr/> \$275,653.00
Fringe Benefits	\$108,256.00
Non-Direct Fringe Benefits	\$0.00
Total Personal Service and Fringe Benefits (a)	<hr/> \$383,909.00
<b><u>Other Than Personal Service</u></b>	
Space	\$20,292.00
Other Non-Personal Service	\$32,389.00
Subtotal Other Than Personal Service (b)	<hr/> \$52,681.00
Total Direct Costs (a+b)	\$436,590.00
Indirect Costs (c)	\$34,715.00
Subtotal (a+b+c)	<hr/> \$471,305.00
Breast Pumps and Collection Kits	\$1,651.00
Enhanced Peer Counseling Grant (funded by separate grant)	\$12,480.00
Subtotal Allowable Reimbursement with Breastfeeding Costs	<hr/> \$485,436.00
Unallocated Funding (see note)	\$49,996.00
<b>Grand Total</b>	<hr/> <b>\$535,432.00</b>

An average caseload monthly service level of 1,685 participants is assigned commensurate with this budget. WIC participation is defined in CFR 246.2 as "pregnant women, breastfeeding women, postpartum women, infants and children who are receiving supplemental foods or food instruments under the Program, and the breastfed infants of participant breastfeeding women." Service to less than the assigned caseload may result in a reassignment of caseload and associated funding in the current and / or subsequent contract years.

**NOTE:** Unallocated Funds are used at the discretion of the NYS DOH.  
No funding in the Unallocated Budget Line can be accessed without prior approval by the NYS DOH.

**Federal funds are being used to support this contract. The Catalog of Federal Domestic Assistance (CFDA) number for these funds is 10.557**

## Appendix G

### NOTICES

All notices permitted or required hereunder shall be in writing and shall be transmitted either:

- (a) via certified or registered United States mail, return receipt requested;
- (b) by facsimile transmission;
- (c) by personal delivery;
- (d) by expedited delivery service; or
- (e) by e-mail.

Such notices shall be addressed as follows or to such different addresses as the parties may from time to time designate:

#### State of New York Department of Health

Name: Michael Rimkunas

Title: Assistant Director, Resource Planning and Operations Unit

Address: Division of Nutrition, Riverview Center, 150 Broadway – FL6 West, Albany, N.Y. 12204-2719

Telephone Number: (518) 402-7099

Facsimile Number: (518) 402-7348

E-Mail Address: [mer16@health.state.ny.us](mailto:mer16@health.state.ny.us)

#### Warren County Health Services

Name: Kathy G. Harriss

Title: WIC Coordinator

Address: Municipal Center, Bldg. 11

Telephone Number: 518-761-6428

Facsimile Number: 518-761-7643

E-Mail Address: [harrissK@co.warren.ny.us](mailto:harrissK@co.warren.ny.us)

Any such notice shall be deemed to have been given either at the time of personal delivery or, in the case of expedited delivery service or certified or registered United States mail, as of the date of first attempted delivery at the address and in the manner provided herein, or in the case of facsimile transmission or email, upon receipt.

The parties may, from time to time, specify any new or different address in the United States as their address for purpose of receiving notice under this AGREEMENT by giving fifteen (15) days written notice to the other party sent in accordance herewith. The parties agree to mutually designate individuals as their respective representative for the purposes of receiving notices under this AGREEMENT. Additional individuals may be designated in writing by the parties for purposes of implementation and administration/billing, resolving issues and problems, and/or for dispute resolution.

PAYMENT AND REPORTING SCHEDULE

I. Payment and Reporting Terms and Conditions

A. The STATE may, at its discretion, make an advance payment to the CONTRACTOR, during the initial or any subsequent PERIOD, in an amount to be determined by the STATE but not to exceed sixteen and two-thirds (16.67) percent of the maximum amount indicated in the budget as set forth in the most recently approved Appendix B. If this payment is to be made, it will be due thirty calendar days, excluding legal holidays, after the later of either:

- ① the first day of the contract term specified in the Initial Contract Period identified on the face page of the AGREEMENT or if renewed, in the PERIOD identified in the Appendix X, OR
- ① if this contract is wholly or partially supported by Federal funds, availability of the federal funds;

provided, however, that a STATE has not determined otherwise in a written notification to the CONTRACTOR suspending a Written Directive associated with this AGREEMENT, and that a proper voucher for such advance has been received in the STATE's designated payment office. If no advance payment is to be made, the initial payment under this AGREEMENT shall be due thirty calendar days, excluding legal holidays, after the later of either:

- ① the end of the first monthly/quarterly period of this AGREEMENT; or
- ① if this contract is wholly or partially supported by federal funds, availability of the federal funds:

provided, however, that the proper voucher for this payment has been received in the STATE's designated payment office.

B. No payment under this AGREEMENT, other than advances as authorized herein, will be made by the STATE to the CONTRACTOR unless proof of performance of required services or accomplishments is provided. If the CONTRACTOR fails to perform the services required under this AGREEMENT the STATE shall, in addition to any remedies available by law or equity, recoup payments made but not earned, by set-off against any other public funds owed to CONTRACTOR.

C. Any optional advance payment(s) shall be applied by the STATE to future payments due to the CONTRACTOR for services provided during initial or subsequent PERIODS. Should funds for subsequent PERIODS not be appropriated or budgeted by the STATE for the purpose herein specified, the STATE shall, in accordance with Section 41 of the State Finance Law, have no liability under this AGREEMENT to the CONTRACTOR, and this AGREEMENT shall be considered terminated and cancelled.

D. The CONTRACTOR will be entitled to receive payments for work, projects, and services rendered as detailed and described in the program workplan, Appendix D.

All payments shall be in conformance with the rules and regulations of the Office of the State Comptroller. CONTRACTOR shall provide complete and accurate billing invoices and/or vouchers to the Agency's designated payment office in order to receive payment. Billing invoices and/or vouchers submitted to the Agency must contain all information and supporting documentation required by the Contract, the Agency and the State Comptroller. Payment for invoices and/or vouchers submitted by the CONTRACTOR shall only be rendered electronically unless payment by paper check is expressly authorized by the Commissioner, in the Commissioner's sole discretion, due to extenuating circumstances. Such electronic payment shall be made in accordance with ordinary State procedures and practices. The CONTRACTOR shall comply with the State Comptroller's procedures to authorize electronic payments. Authorization forms are available at the State Comptroller's website at [www.osc.state.ny.us/epay/index.htm](http://www.osc.state.ny.us/epay/index.htm), by email at [epunit@osc.state.ny.us](mailto:epunit@osc.state.ny.us) or by telephone at 518-474-4032. CONTRACTOR acknowledges that it will not receive payment on any invoices or vouchers submitted under this contract if it does not comply with the State Comptroller's electronic payment procedures, except where the Commissioner has expressly authorized payment by paper check as set forth above.

- E. The CONTRACTOR will provide the STATE with the reports of progress or other specific work products pursuant to this AGREEMENT as described in this Appendix below. All required reports or other work products developed under this AGREEMENT must be completed as provided by the agreed upon work schedule in a manner satisfactory and acceptable to the STATE in order for the CONTRACTOR to be eligible for payment.
- F. The CONTRACTOR shall submit to the STATE monthly voucher claims and reports of expenditures on such forms and in such detail as the STATE shall require. The CONTRACTOR shall submit vouchers to the State's designated payment office located at the address below:

**NYS Department of Health  
Division of Nutrition/BSFP-RPOU  
Riverview Center  
150 Broadway – FL 6 West  
Albany, N.Y. 12204-2719**

All vouchers submitted by the CONTRACTOR pursuant to this AGREEMENT shall be submitted to the STATE no later than forty-five (45) days after the end date of the period for which reimbursement is being claimed. In no event shall the amount received by the CONTRACTOR exceed the budget amount approved by the STATE, and, if actual expenditures by the CONTRACTOR are less than such sum, the amount payable by the STATE to the CONTRACTOR shall not exceed the amount of actual expenditures. All contract advances in excess of actual expenditures will be recouped by the STATE prior to the end of the applicable budget period.

- G. If the CONTRACTOR is eligible for an annual cost of living adjustment (COLA), enacted in New York State Law, that is associated with this grant AGREEMENT, payment of such COLA shall be made separate from payments under this AGREEMENT and shall not be applied toward or amend amounts payable under Appendix B of this AGREEMENT.

Before payment of a COLA can be made, the STATE shall notify the CONTRACTOR, in writing, of eligibility for any COLA. The CONTRACTOR shall be required to submit a written certification attesting that all COLA funding will be used to promote the recruitment and retention of staff or respond to other critical non-personal service costs during the State fiscal year for which the cost of living adjustment was allocated, or provide any other such certification as may be required in the enacted legislation authorizing the COLA.

## II. PROGRESS AND FINAL REPORTS

### Specific Deliverables

The local agency will have responsibility for the following required deliverables and all associated tasks. These deliverables must be submitted in accordance with specified WIC Program requirements and timeframes to the Regional Office, unless otherwise indicated.

#### A. Monthly Reports

Deliverable 1: **Monthly Budget Statement and Report of Expenditure (BSROE) and Voucher** – due close of business 45 days after the end of the reporting period.

Deliverable 2: **Breastfeeding Progress Report** – due to central and regional office 45 days after the end of the month being reported.

Deliverable 3: **Monthly Personnel Vacancy Report** - due concurrent with the monthly voucher.

#### B. Annual Reports or Plans

##### *Nutrition Services:*

Deliverable 4: **Annual Nutrition Services Management Plan (NSMP) and Biennial Self Assessment** for the next fiscal year – due close of business (1<sup>st</sup> of July).

Deliverable 5: **Nutrition Services and Administration Local Agency Time Effort Study data and Nutrition Services and Administration Expenditure Report (NSA)** for the previous year due close of business (1<sup>st</sup> of December).

##### *Administrative Services:*

Deliverable 6: **"Closeout" or supplemental voucher**– due close of business (14<sup>th</sup> of November).

Deliverable 7: **Local Agency Corrective Action Plan (CAP)** – as required by Management Evaluation Report.

Deliverable 8: **A-133 Single Audit Report** – as required by Appendix A-1. Copies must be submitted to the DOH Audit Clearinghouse, the Federal Single Audit Clearinghouse and DOH Division of Nutrition.

Agency Code 12000  
APPENDIX X

Contract Number: C025807  
Contractor: Warren County Health Services

Amendment Number X- 1

This is an AGREEMENT between THE STATE OF NEW YORK, acting by and through NYS Department of Health, having its principal office at Albany, New York, (hereinafter referred to as the STATE), and **Warren County Health Services** (hereinafter referred to as the CONTRACTOR), for amendment of this contract.

This amendment makes the following changes to the contract (check all that apply):

- Modifies the contract period at no additional cost
- Modifies the contract period at additional cost
- Modifies the budget or payment terms
- Modifies the work plan or deliverables
- Replaces appendix(es) C with the attached appendix(es) C
- Adds the attached appendix(es) G
- Other: (describe) \_\_\_\_\_

This amendment is  is not  a contract renewal as allowed for in the existing contract.

All other provisions of said AGREEMENT shall remain in full force and effect.

Prior to this amendment, the contract value and period were:

\$ 549,953 From 10 / 1 / 2009 to 9 / 30 / 2010.  
(Value before amendment) (Initial start date)

This amendment provides the following addition (complete only items being modified):

\$ -14,521 From  / /  to  / / .

This will result in new contract terms of:

\$ 535,432 From 10 / 1 / 2009 to 9 / 30 / 2010.  
(All years thus far combined) (Initial start date) (Amendment end date)



Signature Page for:

Contract Number: C025807

Contractor: Warren County Health Services

Amendment Number: X-1

-----  
IN WITNESS WHEREOF, the parties hereto have executed this AGREEMENT as of the dates appearing under their signatures.

**CONTRACTOR SIGNATURE:**

By: \_\_\_\_\_ Date: \_\_\_\_\_  
(signature)

Printed Name: \_\_\_\_\_

Title: \_\_\_\_\_

STATE OF NEW YORK                    )  
  ) SS:  
County of \_\_\_\_\_                    )

On the \_\_\_\_ day of \_\_\_\_\_ in the year \_\_\_\_\_ before me, the undersigned, personally appeared \_\_\_\_\_, personally known to me or proved to me on the basis of satisfactory evidence to be the individual(s) whose name(s) is(are) subscribed to the within instrument and acknowledged to me that he/she/they executed the same in his/her/their/ capacity(ies), and that by his/her/their signature(s) on the instrument, the individual(s), or the person upon behalf of which the individual(s) acted, executed the instrument.

\_\_\_\_\_  
(Signature and office of the individual taking acknowledgement)

-----  
**STATE AGENCY SIGNATURE**

"In addition to the acceptance of this contract, I also certify that original copies of this signature page will be attached to all other exact copies of this contract."

By: \_\_\_\_\_ Date: \_\_\_\_\_  
(signature)

Printed Name: Barbara S. Devore

Title: Deputy Director, CCH

-----  
**ATTORNEY GENERAL'S SIGNATURE**

By: \_\_\_\_\_ Date: \_\_\_\_\_

**STATE COMPTROLLER'S SIGNATURE**

By: \_\_\_\_\_ Date: \_\_\_\_\_

## RESOLUTION REQUEST FORM NO. 7

### Request to Amend County Budget\*

**\*If this is the result of a grant award, also complete and submit  
Form No. 5 or 6**

**DEPARTMENT NAME:** Health Services

**DATE:** February 26, 2010

- (a) Purpose of Amendment: To amend 2010 WIC Budget to reflect a contract deficit reduction in the amount of \$14,521.00
- (b) Appropriation Code (with title), Object Code (with title) and Amount: A4013.410 WIC Supplies Expense
- (c) Revenue Code (with title), and Amount: A4013.4403 WIC Federal Grant Revenue

**Auer, Pat**

---

**From:** DeLorenzo, Tammie  
**Sent:** Wednesday, February 24, 2010 1:10 PM  
**To:** Auer, Pat  
**Cc:** Schaldone, Sharon  
**Subject:** Reso to request SHP Contract

Hi Pat-

Based upon the following quotes:

**SHP**

- Benchmarking \$6,995
- CAHPS \$3,510 (\$1.95 per survey est 100 per month 50% remail rate)

**OCS**

- Benchmarking \$7,500
- CAHPS \$4,995 flat fee

**Press Ganey**

- Benchmarking \$7,500
- CAHPS \$4,995 flat fee

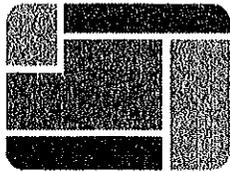
It is recommended that we Cancel our current contracts with OCS (\$11,000 budgeted) and enter into an agreement with SHP for Benchmarking and CAHPS survey Administration.

We are required by CMS Regulation to select an approved CAHPS survey vendor and begin to submit Patient Satisfaction data by 09/01/10. This will replace our current Patient Satisfaction questionnaire for the CHHA. The quote includes complete administration of the questionnaire including mailing to patients, correlating data, reporting data to CMS and benchmark reports so that we can see our outcomes. It is recommended that we test submission prior to that date hence the requested contract start date of 06/01/10.

Thanks

*Tammie DeLorenzo*  
Clinical and Fiscal Informatics Coordinator  
Warren County Health Services  
1340 State Route 9  
Lake George NY 12845  
(518)824-8772

2/24/2010

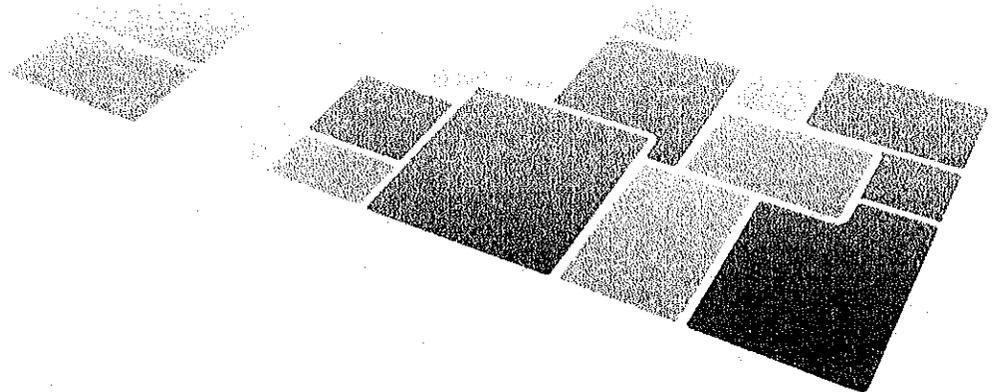


# County Health Rankings

Mobilizing Action Toward Community Health

2010

**New York**



Robert Wood Johnson Foundation



UNIVERSITY OF WISCONSIN

**Population Health Institute**

*Translating Research into Policy and Practice*

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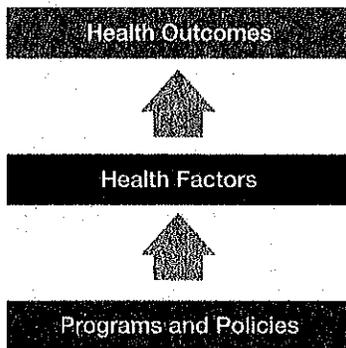
## Introduction

Where we live matters to our health. The health of a community depends on many different factors, including quality of health care, individual behavior, education and jobs, and the environment. We can improve a community's health through programs and policies. For example, people who live in communities with ample park and recreation space are more likely to exercise, which reduces heart disease risk. People who live in communities with smoke-free laws are less likely to smoke or to be exposed to second-hand smoke, which reduces lung cancer risk.

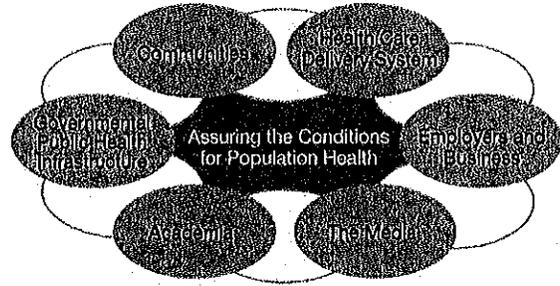
The problem is that there are big differences in health across communities, with some places being much healthier than others. And up to now, it has been hard to get a standard way to measure how healthy a county is and see where they can improve.

The Robert Wood Johnson Foundation and the University of Wisconsin Population Health Institute are pleased to present the 2010 *County Health Rankings*, a collection of 50 reports that reflect the overall health of counties in every state across the country. For the first time, counties can get a snapshot of how healthy their residents are by comparing their overall health and the factors that influence their health, with other counties in their state. This will allow them to see county-to-county where they are doing well and where they need to improve. Everyone has a stake in community health. We all need to work together to find solutions. The *County Health Rankings* serve as both a call to action and a needed tool in this effort.

All of the *County Health Rankings* are based upon this model of population health improvement:



In this model, health outcomes are measures that describe the current health status of a county. These health outcomes are influenced by a set of health factors. These health factors and their outcomes may also be affected by community-based programs and policies designed to alter their distribution in the community. Counties can improve health outcomes by addressing all health factors with effective, evidence-based programs and policies.



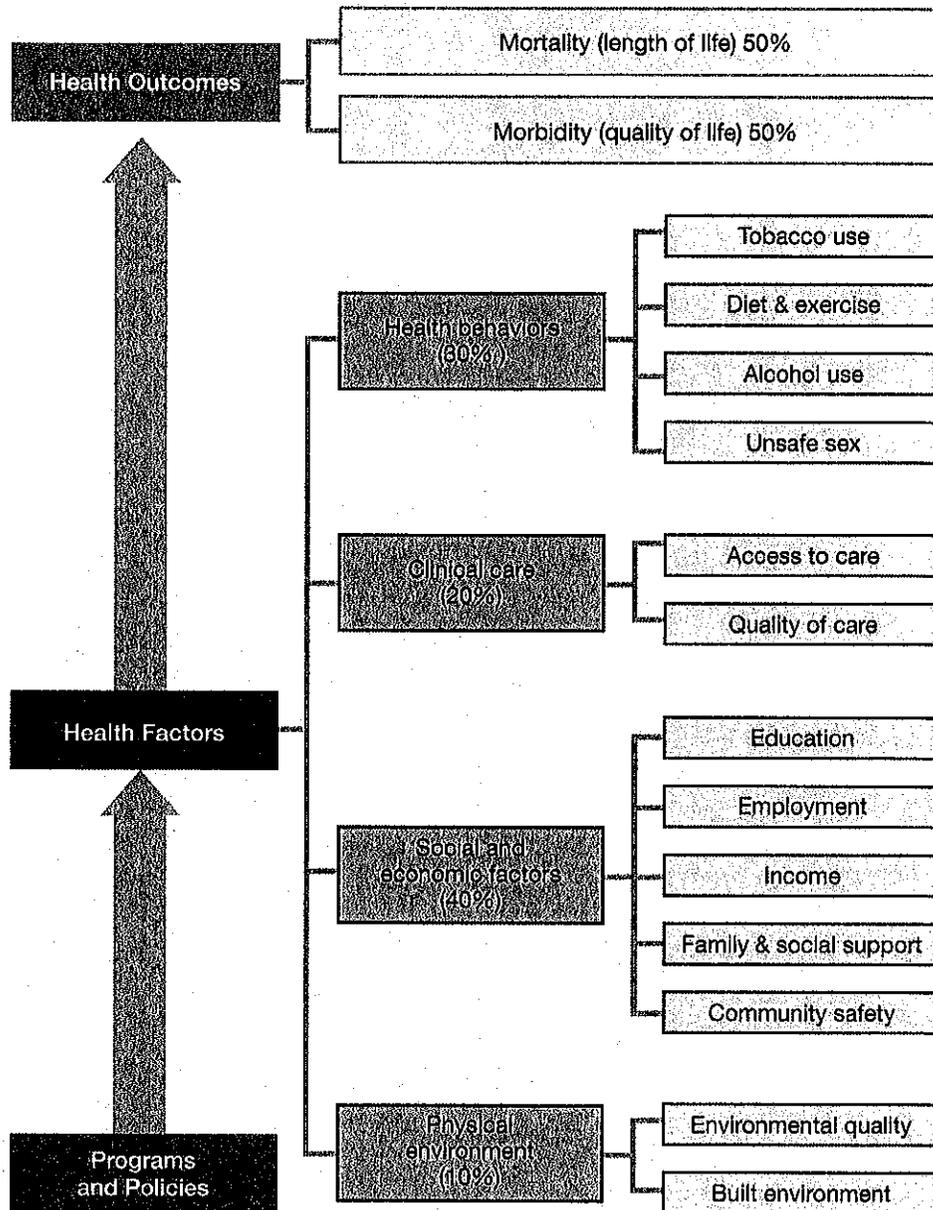
Institute of Medicine, 2002

To compile the *Rankings*, we built on our prior work in Wisconsin, worked closely with staff from the Centers for Disease Control and Prevention and Dartmouth College, and obtained input from a team of expert advisors. Together we selected a number of population health measures based on scientific relevance, importance, and availability of data at the county level. For a more detailed explanation of the choice of measures, see [www.countyhealthrankings.org](http://www.countyhealthrankings.org).

## The Rankings

This report ranks New York counties according to their summary measures of health outcomes and health factors, as well as the components used to create each summary measure. The figure below depicts the structure of the *Rankings* model. Counties receive a rank for each population health component; those having high ranks (e.g., 1 or 2) are estimated to be the "healthiest."

Our summary health outcomes rankings are based on an equal weighting of mortality and morbidity measures. The summary health factors rankings are based on weighted scores of four types of factors: behavioral, clinical, social and economic, and environmental. The weights for the factors (shown in parentheses in the figure) are based upon a review of the literature and expert input, but represent just one way of combining these factors.

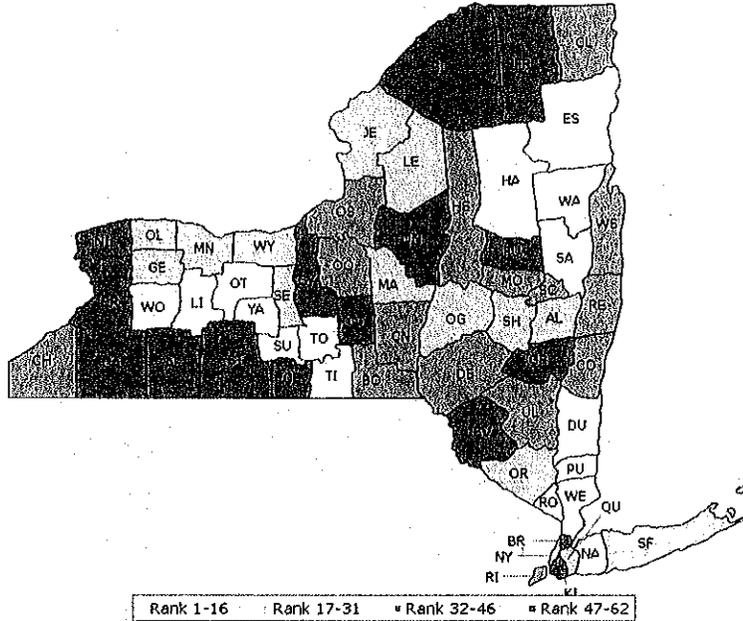


County Health Rankings model ©2010 UWPHI

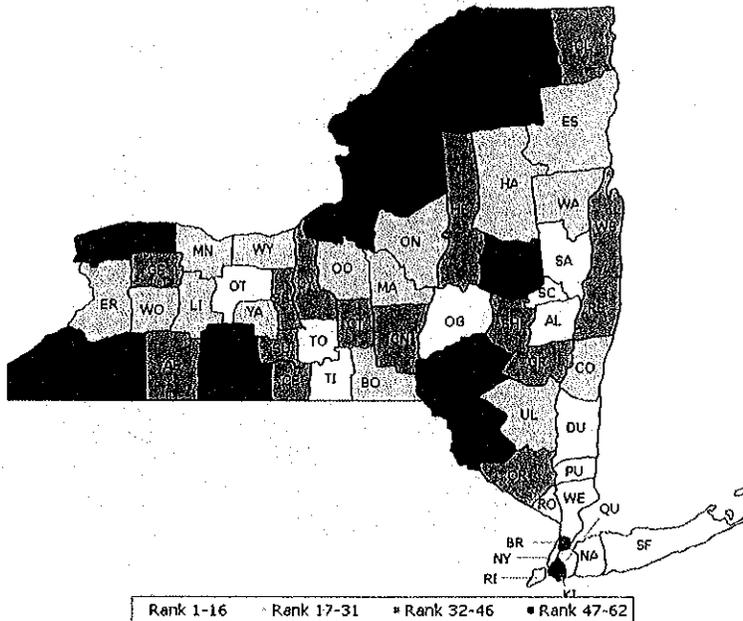
The maps on this page display New York's counties divided into groups by health rank. The lighter colors indicate better performance in the respective summary rankings. The green map shows the distribution of summary health outcomes. The blue displays the distribution of the summary rank for health factors.

Maps help locate the healthiest and least healthy counties in the state. The health factors map appears similar to the health outcomes map, showing how health factors and health outcomes are closely related.

### HEALTH OUTCOMES



### HEALTH FACTORS



## Summary Health Outcomes & Health Factors Rankings

Counties receive two summary ranks:

- Health Outcomes
- Health Factors

Each of these ranks represents a weighted summary of a number of measures.

Health outcomes represent how healthy a county is while health factors are what influences the health of the county.

Rank	Health Outcomes	Rank	Health Factors
1	Putnam	1	Nassau
2	Saratoga	2	Westchester
3	Tompkins	3	Tompkins
4	Livingston	4	Rockland
5	Ontario	5	Saratoga
6	Nassau	6	Putnam
7	Schuyler	7	Ontario
8	Rockland	8	Suffolk
9	Westchester	9	New York
10	Yates	10	Dutchess
11	Dutchess	11	Schenectady
12	Wyoming	12	Albany
13	Essex	13	Richmond
14	Warren	14	Tioga
15	Tioga	15	Otsego
16	Hamilton	16	Queens
17	Orleans	17	Monroe
18	Suffolk	18	Hamilton
19	Lewis	19	Warren
20	Schoharie	20	Livingston
21	Orange	21	Onondaga
22	Queens	22	Yates
23	Madison	23	Columbia
24	Otsego	24	Wyoming
25	Genesee	25	Madison
26	Seneca	26	Broome
27	Albany	27	Wayne
28	Wayne	28	Erie
29	Jefferson	29	Oneida
30	New York	30	Ulster
31	Monroe	31	Essex
32	Montgomery	32	Rensselaer
33	Ulster	33	Orange
34	Richmond	34	Schoharie
35	Rensselaer	35	Genesee
36	Clinton	36	Washington
37	Schenectady	37	Clinton
38	Onondaga	38	Chenango
39	Delaware	39	Greene
40	Broome	40	Schuyler

Rank	Health Outcomes	Rank	Health Factors
41	Herkimer	41	Cortland
42	Chautauqua	42	Seneca
43	Chenango	43	Herkimer
44	Washington	44	Cayuga
45	Columbia	45	Chemung
46	Oswego	46	Allegany
47	Fulton	47	Lewis
48	Steuben	48	Delaware
49	Cayuga	49	Chautauqua
50	Franklin	50	Franklin
51	St. Lawrence	51	Kings
52	Allegany	52	Steuben
53	Cortland	53	Orleans
54	Oneida	54	Niagara
55	Erie	55	Fulton
56	Cattaraugus	56	Cattaraugus
57	Niagara	57	Montgomery
58	Kings	58	Sullivan
59	Greene	59	St. Lawrence
60	Chemung	60	Oswego
61	Sullivan	61	Jefferson
62	Bronx	62	Bronx

## Health Outcomes Rankings

The summary health outcomes ranking is based on measures of mortality and morbidity. Each county's ranks for mortality and morbidity are displayed here. The mortality rank, representing length of life, is based on a measure of premature death: the years of potential life lost prior to age 75.

The morbidity rank is based on measures that represent health-related quality of life and birth outcomes. We combine four morbidity measures: self-reported fair or poor health, poor physical health days, poor mental health days, and the percent of births with low birthweight.

Rank	Mortality	Rank	Morbidity
1	Nassau	1	Ontario
2	Tompkins	2	Livingston
3	Putnam	3	Wyoming
3	Westchester	4	Essex
5	Rockland	5	Yates
6	Saratoga	6	Putnam
7	Schuyler	7	Warren
8	Queens	8	Lewis
9	Tioga	9	Saratoga
10	Hamilton	10	Schoharie
11	Orleans	11	Dutchess
12	Livingston	12	Montgomery
13	New York	13	Schuyler
14	Ontario	14	Tompkins
15	Dutchess	15	Rockland
16	Yates	16	Columbia
17	Suffolk	17	Nassau
18	Otsego	18	Albany
19	Madison	19	Delaware
20	Orange	20	Wayne
21	Warren	21	Seneca
22	Essex	22	Genesee
23	Richmond	23	Schenectady
24	Wyoming	24	Orange
25	Genesee	25	Suffolk
26	Monroe	26	Jefferson
27	Seneca	27	Herkimer
28	Clinton	28	Westchester
29	Schoharie	29	Greene
30	Onondaga	30	Hamilton
31	Rensselaer	31	Tioga
32	Ulster	32	Washington
33	Jefferson	33	Ulster
34	Wayne	34	Madison
35	Chautauqua	35	Chenango
36	Albany	36	Broome
37	Chemung	37	Otsego
38	Lewis	38	Orleans
39	Cayuga	39	Rensselaer
40	Franklin	40	St. Lawrence

Rank	Mortality	Rank	Morbidity
41	Broome	41	Cattaraugus
42	Steuben	42	Monroe
43	Chenango	43	Oswego
44	Schenectady	44	Allegany
45	Delaware	45	Clinton
46	Washington	46	Fulton
47	Oneida	47	Onondaga
48	Fulton	48	Cortland
49	Herkimer	49	Sullivan
50	Oswego	50	Chautauqua
51	Montgomery	51	Richmond
52	Kings	52	Steuben
53	Cortland	53	Queens
54	Allegany	54	Erie
55	Niagara	55	Franklin
56	Erie	56	Cayuga
57	St. Lawrence	57	New York
58	Columbia	58	Oneida
59	Cattaraugus	59	Niagara
60	Greene	60	Kings
61	Bronx	61	Chemung
62	Sullivan	62	Bronx

## Health Factors Rankings

The summary health factors ranking is based on four factors: health behaviors, clinical care, social and economic, and physical environment factors. In turn, each of these factors is based on several measures. Health behaviors include measures of smoking, diet and exercise, alcohol use, and risky sex behavior. Clinical

care includes measures of access to care and quality of care. Social and economic factors include measures of education, employment, income, family and social support, and community safety. The physical environment includes measures of environmental quality and the built environment.

Rank	Health Behaviors	Clinical Care	Social & Economic Factors	Physical Environment
1	Westchester	Monroe	Putnam	Wayne
2	New York	Onondaga	Nassau	Chenango
3	Nassau	Schenectady	Saratoga	Herkimer
4	Rockland	Albany	Tompkins	Steuben
5	Tompkins	Erie	Suffolk	Tioga
6	Queens	Saratoga	Rockland	Tompkins
7	Putnam	Nassau	Westchester	Ontario
8	Essex	Westchester	Ontario	Cayuga
9	Suffolk	New York	Dutchess	Allegany
10	Dutchess	Broome	Hamilton	Chemung
11	Ontario	Rockland	Tioga	Madison
12	Kings	Warren	Livingston	Lewis
13	Otsego	Richmond	Ulster	Broome
14	Saratoga	Ontario	Madison	Otsego
15	Yates	Chautauqua	Orange	Cattaraugus
16	Schoharie	Seneca	Albany	Seneca
17	Richmond	Tioga	Columbia	Genesee
18	Wyoming	Montgomery	Otsego	Onondaga
19	Hamilton	Chemung	Yates	Cortland
20	Oneida	Greene	Genesee	Oswego
21	Schuyler	Madison	Wyoming	Washington
22	Albany	Dutchess	Warren	Wyoming
23	Schenectady	Livingston	Richmond	St. Lawrence
24	Franklin	Suffolk	Schenectady	Dutchess
25	Herkimer	Wayne	Washington	Oneida
26	Erie	Rensselaer	Rensselaer	Montgomery
27	Columbia	Chenango	Broome	Livingston
28	Greene	Ulster	Wayne	Fulton
29	Clinton	Oneida	Monroe	Rockland
30	Warren	Yates	Seneca	Schuyler
31	Delaware	Columbia	Queens	Orleans
32	Cortland	Lewis	Essex	Nassau
33	Onondaga	Tompkins	Onondaga	Schenectady
34	Livingston	Niagara	Chautauqua	Schoharie
35	Chenango	Steuben	Cayuga	Kings
36	Monroe	Fulton	Delaware	Queens
37	Tioga	Jefferson	Clinton	Bronx
38	Orange	Washington	Allegany	Clinton
39	Bronx	Franklin	New York	Greene
40	Rensselaer	Otsego	Herkimer	Westchester

Rank	Health Behaviors	Clinical Care	Social & Economic Factors	Physical Environment
41	Chemung	Clinton	Steuben	Saratoga
42	Broome	Cortland	Schoharie	Delaware
43	Genesee	Cayuga	Oneida	Rensselaer
44	Ulster	Putnam	Erie	Hamilton
45	Allegany	Hamilton	Cortland	Warren
46	Wayne	Allegany	Schuyler	Richmond
47	Madison	Schoharie	Lewis	Jefferson
48	Cayuga	Queens	Orleans	Columbia
49	Lewis	Kings	Niagara	Monroe
50	Sullivan	Orange	Cattaraugus	Franklin
51	Orleans	Schuyler	Greene	Sullivan
52	Niagara	Essex	Chemung	Orange
53	Washington	Wyoming	Chenango	Ulster
54	Fulton	Genesee	Oswego	Putnam
55	Chautauqua	Cattaraugus	Jefferson	Chautauqua
56	St. Lawrence	Sullivan	St. Lawrence	Erie
57	Seneca	Orleans	Fulton	Albany
58	Cattaraugus	Delaware	Franklin	Suffolk
59	Montgomery	Bronx	Sullivan	New York
60	Steuben	St. Lawrence	Montgomery	Yates
61	Oswego	Oswego	Kings	Niagara
62	Jefferson	Herkimer	Bronx	Essex

## 2010 County Health Rankings: Measures, Data Sources, and Years of Data

	Measure	Data Source	Years of Data
<b>HEALTH OUTCOMES</b>			
<b>Mortality</b>	Premature death (Years of Potential Life Lost)	National Center for Health Statistics	2004-2006
<b>Morbidity</b>	Self-reported health status	Behavioral Risk Factor Surveillance System	2002-2008
	Poor physical health days	Behavioral Risk Factor Surveillance System	2002-2008
	Poor mental health days	Behavioral Risk Factor Surveillance System	2002-2008
	Low birthweight	National Center for Health Statistics	2000-2006
<b>HEALTH FACTORS</b>			
<b>HEALTH BEHAVIORS</b>			
<b>Tobacco</b>	Adult smoking	Behavioral Risk Factor Surveillance System	2002-2008
<b>Diet and Exercise</b>	Adult obesity	National Center for Chronic Disease Prevention and Health Promotion	2006-2008
<b>Alcohol Use</b>	Binge drinking	Behavioral Risk Factor Surveillance System	2002-2008
	Motor vehicle death rate	National Center for Health Statistics	2000-2006
<b>High Risk Sexual Behavior</b>	Teen births	National Center for Health Statistics	2000-2006
	Chlamydia rate	National Center for Health Statistics	2006
<b>CLINICAL CARE</b>			
<b>Access to Care</b>	Uninsured adults	Small Area Health Insurance Estimates, U.S. Census	2005
	Primary care providers	Health Resources & Services Administration	2006
<b>Quality of Care</b>	Preventable hospital stays	Medicare/Dartmouth Institute	2005-2006
	Diabetic screening	Medicare/Dartmouth Institute	2003-2006
	Hospice use	Medicare/Dartmouth Institute	2001-2005
<b>SOCIOECONOMIC FACTORS</b>			
<b>Education</b>	High school graduation	National Center for Education Statistics <sup>1</sup>	2005-2006
	College graduates	U.S. Census/American Community Survey	2000/2005-2007
<b>Employment</b>	Unemployment rate	Bureau of Labor Statistics	2008
<b>Income</b>	Children in poverty	Small Area Income and Poverty Estimates, U.S. Census	2007
	Income inequality	U.S. Census/American Community Survey <sup>2</sup>	2000/2005-2007
<b>Family and Social Support</b>	Social/emotional support	Behavioral Risk Factor Surveillance System	2005-2008
	Single-parent households	U.S. Census/American Community Survey	2000/2005-2007
<b>Community Safety</b>	Violent crime <sup>3</sup>	Uniform Crime Reporting, Federal Bureau of Investigation	2005-2007
<b>PHYSICAL ENVIRONMENT</b>			
<b>Air Quality<sup>4</sup></b>	Unhealthy air due to ozone	U.S. Environmental Protection Agency / Centers for Disease Control and Prevention	2005
	Unhealthy air due to particulate matter	U.S. Environmental Protection Agency / Centers for Disease Control and Prevention	2005
<b>Built Environment</b>	Access to healthy foods	Census Zip Code Business Patterns	2006
	Liquor stores	Census County Business Patterns	2006

<sup>1</sup> State data sources for KY, NH, NC, PA, SC, and UT (2007-2008).

<sup>2</sup> Income inequality estimates for 2000 were calculated by Mark L. Burkey, North Carolina Agricultural & Technical State University, [www.ncat.edu/~burkeym/Gini.htm](http://www.ncat.edu/~burkeym/Gini.htm).

<sup>3</sup> Homicide rate (2000-2006) from National Center for Health Statistics for AK, AZ, AR, CO, CT, GA, ID, IN, IA, KS, KY, LA, MN, MS, MT, NE, NH, NM, NC, ND, OH, SD, UT, and WV. State data source for IL.

<sup>4</sup> Not available for AK and HI.

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Suggested citation: University of Wisconsin Population Health Institute. *County Health Rankings 2010*.



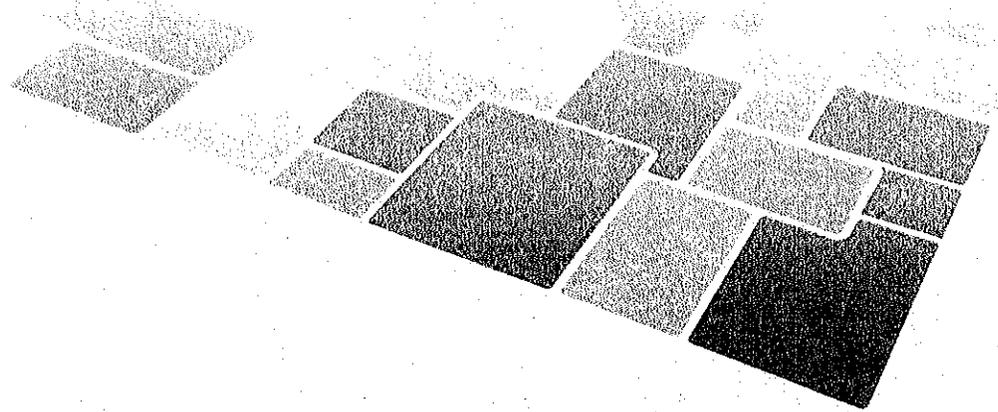
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# County Health Rankings

Mobilizing Action Toward Community Health

[countyhealthrankings.org](http://countyhealthrankings.org)



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