Warren County Health Services
Health Services Committee Meeting
March 28, 2014
Information Submitted By: Patricia Auer, DPH/DPS

Action Agenda/New Business

Request Resolution:
To amend the contract with United Healthcare Empire Plan provider to reflect agreement changes and updated schedule of maximum allowable fees as specified in the revised agreement in a form approved by the County Attorney.
Rationale:
Under usual circumstances it is not necessary to request an updated resolution if it is just a matter of updating reimbursement, but in this case there are minor language changes to the contract. After consultation with the County Attorney, he feels the updated resolution is necessary.

Request Resolution:
To authorize a Memorandum of Understanding with Hudson Headwaters Health Network Ryan White Program to enable staff from HHHN to provide HIV Testing at Warren County Health Services Sexually Transmitted Disease Clinic at no cost to Warren County in a form approved by the County Attorney.
Rationale:
This is advantageous to Warren County Health Services as our staff has been providing this service utilizing Ryan White Grant funds that are no longer available as the Ryan White Grant funds must now cover only services provided by HHHN. Ginelle Jones, ADPH, has met with the Ryan White Program coordinator and they have staff trained and available to provide the service. The amount of time involved is about two hours per week.

Request Resolution:
Budget Transfer:
Please see **Attachment #5,** which will be distributed at the meeting.
Rationale:
The explanation is noted on the Attachment, and Tawn Driscoll, Fiscal Manager will be present at the meeting to answer any questions.

Request Resolution:
To develop a Memorandum of Understanding between Warren County Health Services and Warren County Information Technology Department relative to the proper disposal of computer equipment to assure that all patient privacy information is protected and all HIPAA (Health Insurance Portability Accountability Act) regulations are followed in a form approved by the County Attorney.
Rationale:
This memorandum has been suggested by the Warren County Administrator to strengthen the policy for disposal of technology equipment that includes private health information of patients. Should this information be breeched in any way, it could lead to a costly situation for the county as well as compromising an individual's confidentiality with regard to private health information.

Request Committee Approval:
To authorize Sharon Schaldone, Assistant Director of Patient Services, and Tammie DeLorenzo, Clinical and Informatics Coordinator to attend the Home Care Association of New York State Educational Program "Engage, Collaborate and Partner." In Albany on April 23, 2014 at a cost of $329.00 per person. Lunch is included in the conference fee.
Rationale:
The new health care market place, prompted by federal and state policy changes, is encouraging the development of new models of service delivery, care provision and payment. Home care providers are well positioned in this new marketplace to offer hospitals, health systems, physician practices and health plans a value proposition for expertise and service delivery. It is important we are present to hear what is said. Dr. John Rugge is one of the speakers and will discuss Patient Centered Homes.

Pending Items

Update on Referral Numbers and Impact of Other Certified Agencies
Please see **Attachment #4.**

Information for Discussion

Emergency Response and Preparedness Activities: Please see **Attachment #1** for the monthly report.

Report of New York State Department of Health Survey of the Certified Home Health Agency
Our Corrective Action Report has been reviewed and accepted. We have provided a copy of the report for the minutes, and will have a copy available at the meeting for any members who wish to review it. Sharon Schaldone, Assistant Director of Patient Services will be present at the meeting to provide a brief summary of the report.

Laptop Computer Issues
The laptop computers we purchased in 2008 as part of our Electronic Medical Records Project are now causing a number of issues that are impacting our visit productivity, staff morale, and are not able to keep pace with the current technology. Although we knew at last year's budget planning process that replacement would be needed, we made some modifications by adding memory capacity that we hoped would carry up through another year. That plan has not proven to be the case, and on March 13, we met with County Administrator, Paul Dusek, Information Technology Director, Michael Colvin, and Assistant to the Administrator, JoAnn McKinstry to discuss the issues and propose a plan for replacement. Although Warren County has a replacement plan for computer equipment, our laptops were slated to be upgraded as opposed to needing replacement . The Administrator and County IT Director concur that the replacement needs to happen and state there are funds available to cover the cost. Tammie DeLorenzo, Fiscal and Informatics Coordinator will be present at the meeting to review the specific issues and answer any questions.

Reports of Expenditures, Revenues, Overtime and Per Diem Use: Please see **Attachment #2.**
Revenue and Expense Comparison Report for 2013 vs 2014: Please see **Attachment #3.**
Tawn Driscoll, Fiscal Manager, will be present at the meeting to review the reports and answer any questions.
Attachments:
#1 Emergency Response and Preparedness Activities Report
#2 Reports of Expenditures, Revenues, Overtime, and Per Diem Use
#3 Revenue and Expense Comparison Report for 2013 vs 2014
#4 Referral Numbers Comparisons
#5 Budget Transfer Request

BT ACTIVITY SHEET
BP2 - 7/1/13 - 6/30/14
Page 1
Topic Color Codes
Red/Chempack; Green/SNS; Blue/Mass Fatality; Black/Training;
Purple/Special Needs; Orange/Drill; Black/Pan Flu

Attachment 1

3rd QUARTER ACTIVITIES (January 1, 2014 – March 31, 2014) ***►= added to appropriate deliverable information***

Date	Type	Subject/Comments	Attendees	Topic (i.e. Chempack, Drill, Mass Fatality, SNS, Training, Pan Flu, Special Needs)
3/4/14	Meeting	►L-1 EPR Plan Review by Key BT Staff	Dan Durkee, Ginelle Jones, Pat Belden, Angela Meade	
3/6/14	Fit Testing	School Nurses (6)	Ginelle Jones, Pat Belden	
3/11/14	Meeting	BT Coordinators in Ballston Spa	Dan Durkee	
3/12/14	Meeting	►L-1 EPR Plan	Dan Durkee, Angela Meade	
3/17/14	Meeting	►M-1 County Emergency Preparedness Assessment (CEPA)	Ginelle Jones, Dan Durkee, et al	
3/18/14	Training	►L-4 & M-8 HSEEP	Dan Durkee	Training
3/19/14	Tabletop	►GFH "Evacuation of Behavioral Health (special needs population)	Dan Durkee	
3/19/14	Webinar	►M-5 ClinOps "Legal Issues"	Angela Meade, Amy Bartlett	
3/19/14	Meeting	►L-1 EPR Plan	Dan Durkee, Angela Meade	
3/20/14	Meeting	►L-1 EPR Plan Review by Key BT Staff	Dan Durkee, Ginelle Jones, Pat Belden, Patty Myhrberg, Angela Meade	
3/27/14	Meeting	►M-19 Closed PODS/Legal Issues	Dan Durkee, Martin Affredou, CA	
3/31/14	Webinar	►M-4 ServNY – Build 56 Updates	Angela Meade	

WARREN COUNTY HEALTH SERVICES BUDGET ANALYSIS

REVENUE AND EXPENDITURES FOR 2014 AS OF 3/25/2014 10:35:44 AM

FUND(S): A, CL, D, DM, EF, GI, MS, SD, V

CODE(S): 4010, 4011, 4013, 4016, 4018, 4046, 4054, 4189, 4025

EXPENSES	2014 BUDGETED	2014 YTD ACTUAL	2013 Prior Year Totals
Salaries - Regular	$2,846,807.00	$520,275.23	$2,808,026.17
Salaries - Overtime	$137,500.00	$26,746.53	$159,087.21
Salaries - Part Time	$270,918.00	$56,346.01	$246,611.85
Salaries - Sick Leave Incentive			
100's PERSONAL SERVICES	$3,255,225.00	$603,367.77	$3,213,725.23
200's EQUIPMENT	$35,802.87	$2,494.65	$214,683.50
400's CONTRACTUAL	$7,451,793.00	$403,020.19	$5,282,006.02
800's EMPLOYEE BENEFITS	$1,829,495.00	$458,498.45	$1,750,798.31
TOTALS	**$12,572,315.87**	**$1,467,381.06**	**$10,461,213.06**

REVENUES	2014 BUDGETED	2014 YTD ACTUAL	2013 Prior Year Totals
	$10,267,332.00	$468,539.01	$7,988,649.29

Notes: Within Revenue, we have accrued the January billilng for CHHA, LTC and MCH of $349,030.75 and for WIC January, February and COLA funds of $76,823.58. We currently are working on February billings for CHHA, LTC and MCH. Our payroll is 18.54% of current budget while was19.16% of 2013 budget.(see below)

Warren County Health Services

Salaries Comparison

2013 vs 2014

as of 3/9/14 Payroll date ending

Total of All Depts	YTD 2014	YTD 2013	YTD 13v14	% Change	Total Budget 2014	Total Actual 2013
Regular Salaries	$520,275.23	$538,928.95	-$18,653.72	-3.46%	$2,846,807.00	$2,808,026.1
Overtime Salaries	$26,746.53	$37,728.46	-$10,981.93	-29.11%	$137,500.00	$159,087.2
Part Time Salaries	$56,346.01	$39,007.65	$17,338.36	44.45%	$270,918.00	$246,611.8
Sick Leave Incentive	$0.00	$0.00	$0.00	0.00%	$0.00	$0.0
TOTALS	$603,367.77	$615,665.06	-$12,297.29	-2.00%	$3,255,225.00	$3,213,725.2
% current YTD Salary to Total Budget	18.54%	19.16%				

*Source: Detail G/L report for all Salary Category from 1/1/XX-3/9/XX

Note: Regular salaries are below last year due to a nursing position that is currently open. Overtime is also below last year,due to the fact that Per Diem staff have been utilized to cover staff shortages. YTD 2014 (18.54% of budget) is below 2013 YTD (19.16% 0f budget) by $12,297.29. We have built up a list of experienced Per Diem nurses which has helped with both staffing shortage and increase in patient referrals. Also to note, part time salaries overall are high due to an employee retirement cash out in January which is 65% of the YTD overage in this line.

Revenue and Expense Comparison 2014 vs 2013
as of 3/28/14 meeting

EXPENSES	3/28/14 Meeting 2014 YTD Actual as of 3/25/14 G/L	3/25/2013 2013 YTD Actual as of 3/25/13	Variance
Salaries - Regular	$520,275.23	$538,928.95	($18,653.72)
Salaries - Overtime	$26,746.53	$37,411.19	($10,664.66)
Salaries - Part Time	$56,346.01	$39,324.92	$17,021.09
Salaries - Sick Leave Incentive	$0.00	$0.00	$0.00
100's PERSONAL SERVICES	$603,367.77	$615,665.06	($12,297.29)
200's EQUIPMENT	$2,494.65	$7,758.50	($5,263.85)
400's CONTRACTUAL	$403,020.19	$1,024,400.73	($621,380.54)
800's EMPLOYEE BENEFITS	$458,498.45	$456,458.55	$2,039.90
TOTALS	**$1,467,381.06**	**$2,104,282.84**	**($636,901.78)**

REVENUES	2014 YTD ACTUAL	2013 Prior Year Totals	
	$468,539.01	**$563,363.46**	**($94,824.45)**

Note: The committee meeting was held on March 22,2013, compared to our current meeting date of 3/28/14, therefore source was Budget Performance Report as of 3/25/13 for comparison above and reflects the one payroll in March YTD.

Salaries:
As noted on financial page, Salary differences are due to open positions within the CHHA department. Per Diem staff have been utilized to assist in nursing services. Part time salaries, however also reflects an employee's cash out (65%) due to a retirement in January.

Contractual Services:
To note, in comparing the Preschool, Early Intervention, CHHA and LTC contractual accounts, they are at this time 78.47% of the variance in Contractual expenss.One large reason within Preschool, is that Prospect school still has not been approved for rates from the state and therefore nothing has been paid for 2014. Also our EI Program is paid through the Escrow account which is much slower in paying invoices to vendors than we were in paying vouchers. Contractual services seem skewed because of timing of payments being made.
We currently are in the middle of a check run, and those expenses are not seen above until the batches have been paid and posted, which will not be until month end.

Attachment #3

Warren County Health Services
Patient Evaluations
CHHA Division

CATEGORY	01/2013	02/2013	03/2013	04/2013	05/2013	06/2013	07/2013	08/2013	09/2013	10/2013	11/2013	12/2013
SN eval	156	115					151	135	126	141	113	145
SN IV eval	9	4					4	6	7	5	7	10
CDPAP	11	8					7	11	7	6	12	16
PRI	13	4					13	14	8	14	7	2
SN Evals per month	**189**	**131**					**175**	**166**	**148.00**	**166.00**	**139.00**	**163.00**
PT evals	103	88					96	95	83	104	76	80
PT only	22	7	20	23			37	28	21	30	18	19
PT only evals per mo	**22**	7					37	28	21	30	18	19
Total Evals per month	**211**	**138**					**212**	**194**	**169**	**134**	94	99

CATEGORY	01/2014	02/2014	03/2014	04/2014	05/2014	06/2014	07/2014	08/2014	09/2014	10/2014	11/2014	12/2014
SN eval	127	110										
SN IV eval	7	4										
CDPAP	7	2										
PRI	3	2										
UASNY	15	11										
SN Evals per month	**159**	**125**										
PT evals	88	82										
PT only	33	32										
PT only evals per mo	**33**	**32**										
Total Evals per month	**192**	**157**										
	-9%	14%										

ANNUAL

CATEGORY	2012	2013
SN eval	1965	2131
SN Evals per Year		
PT evals	1057	1063
PT only	275	294
Total Evals per Year	3297	3488

Total # of Visits for	2012	2013
ALL SERVICES	50,693.00	49,333.00

Attachment #4

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-Family Health /Disease Program

DATE: March 28, 2014

(a) **Purpose of Amendment**: To amend the 2014 budget to transfer the revenue related to the Lead Grant from the Family Health Program to the Disease Program to more accurately reflect the expense related to the grant ($24,202.00).

(b) Revenue Code (with title), and Amount:
A.4018.0020.4457 Family Health –Lead Revenue ($24,202.00)

Revenue Code (with title), and Amount:
A.4018.0030.4457 Disease Program –Lead Revenue $24,202.00

RESOLUTION REQUEST FORM NO. 4

Request for Extending, Rescinding or **Amending** Resolution

DEPARTMENT NAME: Health Services

DATE: 03/28/2014

(a) Purpose of Contract Change: To amend the contract with United Healthcare Empire Plan Provider to reflect agreement changes and schedule of maximum allowable fees as specified in the revised agreement in a form approved by the county attorney.

(b) Resolution Number, or Numbers if Amended, which Authorized the Original Contract: R. 192/2010 (see attached)

(c) Name of Contractor: Empire Plan Network Management United Healthcare

(d) Address of Contractor: 505 Boices Lane, Kingston, NY 12401

(e) Contractor's Contact Person and Telephone Number: Geraldine Fairley, 1-877-769-7447 ext. 27975

(f) Commencement Date of Amendment: 06/01/2014

(g) Termination Date of Extension: per terms of current agreement

(h) Payment Provisions: per terms and amounts specified in 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:

A 4010.1610 – CHHA Health Services Revenue
A 4018.0020.1612 Family Health Revenue
A 4054.0060.1604 Early Intervention Revenue

Warren County Board of Supervisors

RESOLUTION NO. 192 OF 2010

Resolution introduced by Supervisors Sokol, Thomas, Champagne, Taylor, Pitkin, Loeb and McDevitt

RATIFYING THE ACTIONS OF THE CHAIRMAN OF THE BOARD OF SUPERVISORS IN EXECUTING AN AGREEMENT WITH UNITED HEALTH CARE EMPIRE PLAN TO ALLOW RECEIPT OF REIMBURSEMENT OF NURSING AND OTHER HEALTH RELATED THERAPEUTICAL SERVICES - HEALTH SERVICES DEPARTMENT

WHEREAS, the Director of Public Health/Patient Services negotiated new rates with United Health Care Empire Plan, which the Director has prior authority to do pursuant to Resolution Nos. 449 of 2006 and 485 of 2006, and

WHEREAS, upon receipt of the agreement with the new rates it was determined that the terms of the agreement had been revised and in order to obtain the new rates beginning April 1, 2010, the Chairman of the Board needed to sign the agreement prior to the March 19, 2010 Board meeting, now, therefore, be it

RESOLVED, that the actions of the Chairman of the Board of Supervisors with respect to the execution of the agreement with United Health Care Empire Plan relating to new rates and a revised agreement, are hereby ratified.

The NYS Empire Plan
UnitedHealthcare Insurance Company of New York
PO Box 2300 Kingston NY 12402-2300

3/1/2014

WARREN COUNTY HEALTH SVCS
1340 STATE ROUTE 9
LAKE GEORGE, NY 12845-3434

Re UnitedHealthcare Empire Plan Provider Agreement Changes Including Updated Schedule of Maximum Allowable Fees

Dear Empire Plan Network Provider:

Enclosed please find the following updates to your UnitedHealthcare Empire Plan Provider Agreement:

Compensation Exhibit
In accordance with recently enacted NYS law, non-routine fee schedule changes must be made with 90 days written or electronic notice. Therefore, **effective 6/1/2014**, we are replacing the existing Compensation Exhibit with the enclosed version dated February 2014.

Base Agreement
In accordance with Section 12.8 of your current agreement, the changes made to the base agreement require your signature and will become **effective upon execution of the updated agreement by both parties**. Language clarifications and minor updates, including removal of references to HMOs or the NYDOH, have been made throughout, and key updates can be found in the following sections:

- Section I – 1.1
- Section II – 2.4, 2.7
- Section III – 3.3
- Section IV – 4.4
- Section V – 5.0, 5.1
- Section VI – 6.0
- Section VII – 7.0
- Section IX
- Section X – 10.1
- Section XI – 11.1
- Section XII – 12.3, 12.8, 12.11
- Signature Section

Updated versions of all contract documents/exhibits have also been included here. Two copies of the full agreement are enclosed. Both copies must be signed and returned. Photocopies or rubber-stamped signatures are not acceptable. When received, both agreements will be executed by UnitedHealthcare Insurance Company of New York. We will retain one, and the other will be returned to you along with a notice informing you of the effective date. ***Return both signed/validated agreement(s) to Geraldine Fairley at: Empire Plan Network Management, 505 Boices Ln, Kingston, NY 12401.***

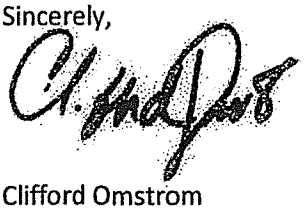
Home Care Provider Manual

Updates to this document have been made to support the above-referenced changes to the base agreement and will become **effective upon execution of the updated base agreement**. Again, language clarifications, minor updates and vendor changes have been made throughout, and key updates can be found in the following sections:

- How to Reach Us – Providing Official Written Notice, Disputes & Arbitration
- Billing & Payments – COB/Fee Schedule
- Claims Overview – Appeals

Should you have any questions concerning this letter or your participation in general, please feel free to write to us at the above address or contact your Empire Plan network account manager, Geraldine Fairley, by calling 1-877-7NYSHIP (1-877-769-7447). Select the Medical Program from the main menu of Empire Plan carriers/vendors, then the option for Medical Services Provider and leave a message for your network account manager via extension 27975.

Sincerely,



Clifford Omstrom
Executive Director
The NYS Empire Plan

Enclosures

The UnitedHealthcare Empire Plan Provider Agreement
- ALLIED / ANCILLARY -

I. INTRODUCTION

1.0 The words "we," "us," "our," and "UnitedHealthcare" in the Agreement means UnitedHealthcare Insurance Company of New York and/or UnitedHealthcare Service LLC. The words "you" and "your" refer to the undersigned Provider.

1.1 This Agreement applies to you and the services you provide in all of your practice arrangements and for all of your tax identification numbers for which you have ownership and control.

II. DEFINITIONS

2.0 **UnitedHealthcare** – UnitedHealthcare Insurance Company of New York and/or UnitedHealthcare Service LLC.

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 **Payment Policies** - The guidelines adopted by United for calculating payment of claims under this Agreement. The Payment Policies may change from time to time as discussed in section 4.4 of this Agreement.

2.5 **Payor** - The party financially responsible for payment for Covered Services, which are: (i) for insured Products, the applicable UnitedHealthcare licensed insurer; or (ii) for Administrative Services Only ("ASO") business, the applicable self-funded Plan

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

2.7 **Protocols** - The programs and administrative procedures adopted by United or a Payor to be followed by 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 management processes, quality improvement, peer review, customer grievance, concurrent review, retrospective review, performance standards, audit programs, and other similar United or Payor programs. The Protocols may change from time to time as discussed in section 3.3 of this Agreement.

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. You will continue to have an independent responsibility to provide appropriate medical care to Covered Persons.

3.2 You will maintain all licenses and certifications required under State and Federal law for 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. You need to be credentialed in accordance with our Credentialing Plan for the duration of this Agreement.

3.3 You will cooperate with and be bound by our Protocols:

3.3.1 You will use reasonable efforts to direct Covered Persons only to other providers that participate in our network.

3.3.2 You will respond to our requests for clinical information, accept and return telephone calls from our staff, as required by us and as described in the Protocols.

The Protocols will be made available to you on-line or upon request. Some or all Protocols also may be disseminated in the form of the applicable provider manual(s) or in other communications.

We may change the Protocols from time to time. We will use reasonable efforts to inform you at least 30 days in advance of any material changes to the Protocols. We may implement changes in the Protocols without your consent if such change is applicable to all or substantially all providers of health care services in our network and that practice the same specialty as you. Otherwise, changes to the Protocols proposed by us are subject to the terms this Agreement that are applicable to amendments.

3.4 You will notify us in writing by certified mail or by overnight courier 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, including Federal Tax ID number;

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.

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 UnitedHealthcare 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 UnitedHealthcare 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/pre-notification of certain services rendered. Failure to notify us of services requiring pre-authorization/pre-notification 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 provider applicants and participating providers to determine whether the 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 notice.

4.4 You will be paid for health care services provided to Covered Persons. You will be paid according to the applicable Compensation Exhibits, and in accordance with our Payment Policies as described in the applicable provider manual(s). You are responsible for collecting from Covered Persons that portion of any payment which constitutes a copayment, coinsurance or deductible, if any. You agree that we may obtain reimbursement for overpayments by off-setting against future payments.

You will be paid for Medically Necessary Covered Services only. Payment may be denied for not following Protocols, for not filing timely, for services not covered under the Covered Person's Benefit Plan, or for lack of medical necessity as follows:

4.4.1 Payment may be denied in whole or in part if you do not comply with a Protocol or do not file a timely claim as required under this Agreement.

In the event payment is denied under this subsection for failure to comply with a Protocol you may appeal the denial as set forth in the applicable provider manual(s).

A claim denied under this subsection (4.4.1) is also subject to denial for other reasons permitted under the Agreement; reversal of a denial under this subsection (4.4.1) does not preclude us from upholding a denial for one of these other reasons.

4.4.2 Services not covered under the applicable Benefit Plan are not subject to the rates or discounts of this Agreement. You may seek and collect payment from a Covered Person for such services (provided that you obtained the Covered Person's written consent), as outlined in the applicable provider manual(s).

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.

V. BILLING

5.0 You will not charge Covered Persons anything for the services you provide, if those services are Covered Services under their Coverage Document, other than the applicable copayment, coinsurance, or deductible amount. If the Covered Services you provide are denied or otherwise not paid due to your failure to file a timely claim, to submit a complete claim, or based on our Payment Policies and methodologies, you may not charge the Covered Person. If the services you provide are not covered under our customers' Coverage Document, you may, bill the Covered Person directly. 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, if the services you provide are denied for reason of not being medically necessary, you may not charge the Covered Person unless they have, with knowledge of our determination of a lack of medical necessity, agreed in writing to be responsible for payment of those charges.

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

VI. UNITEDHEALTHCARE 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 ninety (90) days from the date that you receive them. If you are not in agreement with these changes, you can terminate this Agreement in accordance with subsection 9.1.

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.

VII. MAINTAINING RECORDS

7.0 You will maintain adequate medical, financial and administrative records related to Covered Services rendered under this Agreement, including claims records for the longer of six (6) years or the time required by State and Federal law. You will provide copies of such records to Covered Persons, us, or State and Federal agencies, at no cost, as outlined in the applicable provider manual(s).

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 provider directories, rosters, and marketing materials. You may represent yourself as a participating provider in any product governed by the Agreement in which you participate. When this Agreement terminates neither you nor UnitedHealthcare 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 three (3) years, unless terminated by you or us as set forth below. After the Agreement has been in effect for three (3) years, this Agreement will automatically renew for successive one (1) year terms unless terminated by you or us.

9.1 Either party may terminate this Agreement at any time by giving the other party at least sixty (60) days advance written notice.

9.2 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 fully 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, or (iii) we determine that the immediate termination of this Agreement is necessary to protect the health, safety, or welfare of Covered Persons.

9.3 We may not terminate this Agreement solely because of you (1) advocating on behalf of a Covered Person; (2) filing a complaint against us; or (3) appealing a decision made by us.

9.4 Termination notices must be sent by certified mail, return receipt requested, to Empire Plan Network Management, 505 Boices Lane Kingston, NY 12401.

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 provider with us.

10.1 With respect to cancellation of your agreement, the following will apply to all Covered Services rendered for Covered Persons: (1) the reimbursement amount and provisions for payment stipulated in the Agreement will be in effect for services provided prior to and including the effective date of cancellation; and (2) in the event that there are Covered Services planned which will not be rendered prior to the cancellation date, you will advise Covered Persons of the cancellation of your agreement, thereby allowing each to be informed regarding his/her new financial liability prior to the continuation of care.

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 Each of us is responsible for the costs, damages, claims, and liabilities that result from our own acts.

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 You are an independent contractor. This means we do not have an employer-employee, principal-agent, partnership, joint venture, or similar arrangement. It also means that you make independent health care treatment decisions; we do not. We do not reserve any right to control those treatment decisions.

12.4 Except as provided in Paragraph 5.0 and 5.1, 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 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:

Empire Plan Network Management
UnitedHealthcare
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 provider Manual updates, will be considered to have been received three (3) business days after mailing. This provision will survive termination of this Agreement for any reason.

12.8 We may amend this Agreement or any of the appendices or exhibits on ninety (90) days written notice by sending you a copy of the amendment. Your signature is not required to make the amendment effective. 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.

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 We will work together good faith to resolve any disputes between us ("disputes") including but not limited to all questions of arbitrability, the existence, validity, scope or termination of the Agreement or any term thereof.

If one of us does not agree with an action taken by the other, we will resolve all disputes between us by following the dispute procedures set out in the applicable provider manual(s). If we are unable to resolve the dispute within 60 days following the date one of us sends written notice to the other, and if either of us wishes to pursue the dispute beyond those procedures set out in the applicable provider manual(s), they will submit the dispute to binding arbitration in accordance with the Commercial Dispute Procedures of the American Arbitration Association (see http://www.adr.org) within one year.

If the dispute pertains to a matter which is generally administered by our procedures, such as a credentialing or quality improvement plan, the policies and procedures set forth in that plan must be fully exhausted by you before you may invoke any right to arbitration under this Agreement.

We both expressly intend that any dispute between us be resolved on an individual basis so that no other dispute with any third party(ies) may be consolidated or joined with our dispute. We both agree that any arbitration ruling by an arbitrator allowing class action arbitration or requiring consolidated arbitration involving any third party(ies) would be contrary to our intent and would require immediate judicial review of such ruling. The arbitrator will not vary the terms of this Agreement and will be bound by governing law. We both acknowledge that this Agreement involves interstate commerce, and is governed by the Federal Arbitration Act, 9 U.S.C. § 1 *et seq.* The arbitrator will not have the authority to award punitive or exemplary damages against either of us, except in connection with a statutory claim that explicitly provides for such relief. Arbitration will be conducted in Albany, New York. The decision of the arbitrator(s) on the points in dispute will be binding, and judgment on the award may be entered in any court having jurisdiction.

If a court allows any litigation of a dispute to go forward, we both waive rights to a trial by jury with respect to that litigation, and the judge will be the finder of fact. Any provision of this Agreement that is invalid or unenforceable shall not affect the validity or enforceability of the remaining provisions of this Agreement or the validity or enforceability of the offending provision in any other situation or in any other jurisdiction.

In the event a party wishes to terminate this Agreement based on an assertion of uncured material breach, and the other party disputes whether grounds for such a termination exist, the matter will be resolved through arbitration under this Agreement. While such arbitration remains pending, the termination for breach will not take effect. This section of the Agreement governs any dispute between us arising before or after execution of this Agreement and this section shall survive and govern any termination of this Agreement.

THIS AGREEMENT CONTAINS A BINDING ARBITRATION PROVISION THAT MAY BE ENFORCED BY THE PARTIES.

With your signature, you confirm you understand the contract, including the dispute resolution procedures and all appendices and exhibits referenced in the attached Appendix 1.

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

UnitedHealthcare Insurance Company of New York and UnitedHealthcare Service LLC

By: _____
(Signature)

Name: Clifford Omstrom

Title: Executive Director

Effective Date: _____

Provider
Please print or type the following information:

By: _____
(Signature)

Name: _____

Title: _____

Date: _____

WARREN COUNTY HEALTH SVCS
(Provider Name)

1340 STATE ROUTE 9
(Street Address)

LAKE GEORGE (City) NY (State) 12845-3434 (Zip)

APPENDIX 1
Home Care Services Provider

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

Product Description Exhibit	Defines "participating entities" and lists the type of benefit contracts offered to our customers.
Compensation Exhibit 418 – Ancillary Home Care Services Provider Payment	Provides definitions and stipulations regarding payment for services.
Credentialed Home Care Services Provider Exhibit	Outlines the Home Care Services Providers covered by this Agreement
Service Standards Exhibit - Home Care Services	Outlines level and quality of services expected from Ancillary Provider in regard to both Covered Persons and Plan.
Home Care Provider Manual	Clarifies the mechanics of our relationship.

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); and
- 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.

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 **Covered Person Expenses:** Copayments, deductibles, or coinsurance that are the financial responsibility of the Covered Person according to the Covered Person's Plan.

1.2 **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.

1.3 **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.

1.4 **Eligible Charges:** The Customary Charge for Covered Services that are eligible for reimbursement to the Ancillary Provider.

1.5 **Ancillary Home Care Services Provider:** Ancillary Provider who renders home care Covered Services.

1.6 **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.

1.7 **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.

1.8 **Per Hour Rate:** Consists of one Per Unit Payment made to Ancillary Provider for additional time beyond the initial consecutive two-hour visit.

1.9 **Per Diem:** The payment rate made to Ancillary Provider for all authorized services rendered to a Covered Person by Ancillary Provider during one day.

1.10 **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.

1.11 **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 Payer the lesser of (1) Ancillary Provider's Eligible Charges, less any applicable Covered Person Expenses and subject to the Payment Policies, or (2) the contract rates set forth in Section 2.4, 2.5, and 2.6 of this Exhibit, less any applicable Covered Person Expenses and subject to the Payment Policies.

2.2 **Timely Submission / Complete Claims.** Payment under this Exhibit is subject to the requirements set forth in the Agreement regarding timely submission of a complete claim and in compliance with applicable Protocols such as quality of service. 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.

2.3 Interest / Penalties. 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.

2.4 Default Payment. In the event that a fee has not been established for a particular covered service or item, no payment will be made.

2.5 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

Fee Schedule ID:	07465	
SERVICE CODE	**DESCRIPTION**	**RATE**
HOME HEALTH AIDE 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. ***Included in the Payment Rates for Home Health Aide:*** 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	**HOME HEALTH AIDE, PER HOUR** **[equal to one Per Unit Payment]**	**$ 50.00 PER HOUR**
S9122*	**HOME HEALTH AIDE, PER VISIT(UP TO 2 HOURS)** **[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 identify a home health aide visit in hourly increments using two (2) Per Unit Payments (ie, list S9122 twice).	**$ 100.00 PER VISIT**
NURSING – SKILLED (REGISTERED NURSE) 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. ***Included in the Payment Rates for Skilled Nursing Services:*** 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	**REGISTERED NURSE (RN) SERVICES, PER HOUR** **[equal to one Per Unit Payment]**	**$ 80.00 PER HOUR**
S9123*	**REGISTERED NURSE (RN) SERVICES, PER VISIT (UP TO 2 HOURS)** **[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).	**$ 160.00 PER VISIT**

COMPENSATION EXHIBIT 418
Ancillary Home Care Services Provider Payment

NURSING – LICENSED PRACTICAL NURSE

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.

Included in the Payment Rates for Licensed Practical Nursing Services:

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	**LICENSED PRACTICAL NURSE (LPN) SERVICES, PER HOUR [equal to one Per Unit Payment]**	**$ 80.00 PER HOUR**
S9124*	**LICENSED PRACTICAL NURSE (LPN) SERVICES, PER VISIT (UP TO 2 HOURS) [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).	**$ 160.00 PER VISIT**

NURSING – HIGH TECH – INFUSION ONLY

These codes apply to nursing services for the purpose of home administration of infusion/specialty drugs only.

Included in the Payment Rates for HighTech Nursing Services:

All ancillary medical supplies, 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.

99601	**HIGH TECH NURSING SERVICES, PER VISIT (UP TO 2 HOURS)**	**$ 160.00 PER VISIT**
99602	**HIGH TECH NURSING SERVICES, EACH ADDITIONAL HOUR**	**$ 80.00 PER HOUR**

MEDICAL SOCIAL SERVICES

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.

Included in the Payment Rate for Medical Social Services:

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	**MEDICAL SOCIAL SERVICES, PER DIEM**	**$ 110.00 PER DIEM**

OCCUPATIONAL THERAPY

Included in the Per Diem Rate for Occupational Therapy:

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	**OCCUPATIONAL THERAPY EVALUATION** 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	**OCCUPATIONAL THERAPY, PER DIEM**	**$ 110.00 PER DIEM**

PHYSICAL THERAPY

Included in the Per Diem Rate for Physical Therapy:

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	**PHYSICAL THERAPY EVALUATION** Evaluation code to be billed on initial visit only.	**$ 110.00**
S9131	**PHYSICAL THERAPY, PER DIEM**	**$ 110.00 PER DIEM**

COMPENSATION EXHIBIT 418
Ancillary Home Care Services Provider Payment

RESPIRATORY THERAPY ***Included in the Payment Rates for Respiratory Therapy:*** All ancillary medical supplies, professional services associated with respiratory 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.		
99503	**HOME VISIT FOR RESPIRATORY CARE, PER DIEM**	**$ 110.00 PER DIEM**
99504	**HOME VISIT FOR MECHANICAL VENTILATION CARE, PER DIEM**	**$ 110.00 PER DIEM**
SPEECH THERAPY ***Included in the Payment Rate for Speech Therapy:*** 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	**SPEECH THERAPY, PER DIEM**	**$ 120.00 PER DIEM**
ENTEROSTOMAL THERAPY ***Included in the Payment Rate for Enterostomal Therapy:*** All ancillary medical supplies, professional services associated with enterostomal 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.		
S9474	**ENTEROSTOMAL THERAPY, PER DIEM**	**$ 110.00 PER DIEM**
NUTRITIONAL COUNSELING, DIETITIAN VISIT ***Included in the Payment Rate for Nutritional Counseling, Dietitian Visit:*** All ancillary medical supplies, professional services associated with nutritional counseling/dietitian 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 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.		
S9470	**NUTRITIONAL COUNSELING, DIETITIAN VISIT, PER DIEM**	**$ 110.00 PER DIEM**
DIABETIC MANAGEMENT PROGRAM, DIETITIAN VISIT ***Included in the Payment Rate for Diabetic Management Program, Dietitian Visit:*** All ancillary medical supplies, professional services associated with nutritional counseling/dietitian 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 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.		
S9465	**DIABETIC MANAGEMENT PROGRAM, DIETITIAN VISIT, PER DIEM**	**$ 110.00 PER DIEM**

2.6 Maximum Hours. No more than 16 hours of private duty nursing services by an individual nurse will be reimbursed in any 24-hour period, and there must be a minimum of 8 hours between any 16-hour shifts. Emergency situations will be reviewed on an individual basis.

2.7 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 UnitedHealthcare 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 UnitedHealthcare due to failure to notify.

2.8 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 Routine Updates. Routine updates occur when United mechanically incorporates revised information created by the Fee Source, and as described below, to update the Fee Amounts calculated in accordance with this Fee Information Document. United routinely updates its fee schedule: (1) to stay current with applicable coding practices; (2) in response to price changes for immunizations and injectable medications; and (3) to remain in compliance with HIPAA requirements. United will not generally attempt to communicate routine updates of this nature. The types of routine updates, and their respective effective dates, are described below.

- **Annual Changes to Relative Value Units, Conversion Factors, or Flat Rate Fees:**
  This fee schedule follows a "stated year" construction methodology. The RVU, the Conversion Factor, and the flat rate fees (non-RVU based fees such as DME fees) will be locked in as the basis for deriving Fee Amounts. Therefore, the annual publication of RVUs and Conversion Factors by CMS may affect this fee schedule. Generally, any RVU, Conversion Factor, or flat rate fee changes published in subsequent years by the Primary Fee Sources will not be reflected in this fee schedule except, for example, to add Fee Amounts for new codes or to replace alternate Fee Basis amounts.

  United shall have the right to update any codes such as ICD-9-CM, HCPCS Code, CPT Code and/or ASA 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, (d) the latest edition of the Relative Value Guide which is revised by the American Society of Anesthesiologists and (e) the latest guidelines from the Centers for Medicare and Medicaid Services (CMS). Additionally, as codes are updated, United may update the code or code ranges within this Exhibit, or within the Representative Schedule of Maximum Allowable Fees to be consistent with the services indicated in the table or section. United will make best efforts to update and implement any new or revised Basic Value Units by April 1 of each year or within 90 days following publication by and availability from the ASA, whichever occurs later. Updated Basic Value Units for the current year will be utilized for claims payment as indicated in the Payment Policies.

  UnitedHealthcare routinely updates its Empire Plan fee schedule in response to additions, deletions, and changes to CPT codes by the American Medical Association, and in response to similar changes to other service coding and reporting conventions that are widely used in the health care industry, such as those maintained by the Centers for Medicaid and Medicare Services (ie, HCPCS, etc.). Ordinarily, the fee schedule is updated using similar methodologies for similar services. We will not generally attempt to communicate routine maintenance of this nature. However, for non-routine fee schedule changes which are intended to substantially alter the overall methodology or reimbursement level of the fee schedule, we will give you 90 days written or electronic notice of the changes.

  Claims already processed prior to the change being implemented by United will not be reprocessed unless otherwise required by law. In the event that CMS does not publish a complete set of Fee Basis amounts for a specific code (for example: Global, -TC, and -26 fees) and the code contains a status code of "C" (indicating the code is carrier priced), United will use reasonable commercial efforts to establish Fee Amounts for all modifiers associated with the code based on fee information available and published by the local fiscal intermediary and by fiscal intermediaries from other locations.

- **Updates in Response to Changes Published by Primary Fee Sources:**
  United updates its fee schedule in response to changes published by Primary Fee Sources as a result of additions, deletions, and changes to CPT codes by the AMA or HCPCS codes by CMS and any subsequent changes to CMS' annual update. United updates its fee schedules for new CPT/HCPCS codes using the applicable Conversion Factor and Pricing Level of the original construction methodology along with the then-current RVU of the published CPT/HCPCS code.

- **Price Changes for Immunizations and Injectables:**
  United annually updates the Fee Amounts in response to price changes for immunizations and injectables published by the Fee Sources. In addition, United's Executive Drug Pricing Forum (EDPF) meets on a regular basis to review and evaluate the drug prices that will be used in each update. The EDPF may address topics including pricing for emerging drugs, anticipated manufacturer price changes, and special circumstances (for example, H1N1 vaccine). Based on supporting information provided by the drug manufacturer or the Fee Source, United's EDPF may elect to establish a Fee Amount or override a Fee Amount, as published by the Fee Source, in favor of a Fee Amount that is more appropriate and reasonable for a particular vaccine or drug. These Fee Amount updates will be effective January 1 of each year for immunizations and October 1 of each year for injectables.

- **Other Updates:**
  United reserves the right, but not the obligation, to perform other updates as may be necessary to remain consistent with a Primary Fee Source. United also will perform other updates as may be required by applicable law from time to time. Claims already processed prior to the change being implemented by United will not be reprocessed unless otherwise required by law.

3.2 Maximums Listed. Fee Amounts listed in the fee schedule are all-inclusive, including without limitation any applicable taxes. Unless specifically indicated otherwise, Fee Amounts represent global fees and may be subject to reductions based on appropriate Modifier (for example, professional and technical modifiers). As used in the previous sentence, "global fees" refers to services billed without a Modifier, for which the Fee Amount includes both the professional component and the technical component. Any co-payment, deductible or coinsurance that the customer is responsible to pay under the customer's benefit contract will be subtracted from the listed Fee Amount in determining the amount to be paid by the payer. The actual payment amount is also subject to matters described in this agreement, such as the Payment Policies. No payments will be made for any CMS additional compensation programs, including without limitation incentive or bonus payment programs. Please remember that this information is subject to the confidentiality provisions of this agreement.

3.3 Included/Excluded Codes. The inclusion or exclusion of any code in the fee schedule does not ensure or preclude coverage or benefits for a particular service, item, or procedure. It simply means that a value has or has not been assigned to that code. Coverage and benefit amounts are determined in accordance with plan provisions and the Payment Policies.

3.4 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

3.5 Inclusive Rates. The following services related to home care performed by the Ancillary Provider are included in the rates established by section 2.5 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;
- Costs incurred for "escort" services for professionals to location of Covered Person.

3.6 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.

3.7 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.

3.8 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).

3.9 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.

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

CREDENTIALED HOME CARE SERVICES PROVIDERS

List of Contracted Home Care Services Providers

1. For purposes of this Agreement, Covered Services shall be limited to such services provided by Home Care Services Providers that are covered by this Agreement and have been credentialed by UnitedHealthcare.
2. As of 3/1/2014, the below outlined Home Care Services Providers are covered by this Agreement.
3. This list will be amended as needed when Home Care Services Providers are added to or removed from the Agreement.

Home Care Services Provider:	Tax ID#:	Fee Schedule ID:	Effective Date:	Cancel Date:
WARREN COUNTY HEALTH SVCS	146002576	07465		

SERVICE STANDARDS EXHIBIT
Home Care Services

Service/Staffing	
Access	▪ 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.
24 hour/7 day availability	▪ RNs and other Ancillary Provider staff are available 24/7 and Customers are given documentation on after hours numbers.
Staffing Compliment and Credentials	▪ 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 UnitedHealthcare or who are under the supervision of an RN who meets certification, licensure, education and/or experience acceptable to UnitedHealthcare.
Staff Orientation and Ongoing Training	▪ There is a written orientation plan with documented skill demonstrations. ▪ Minimum skill demonstration requirements identified/met before staff go "solo". ▪ There is dedicated training staff. ▪ There is documentation of initial and ongoing training programs including polices and procedures.
Continuing Education	▪ ≥ 6 programs per year related to new technology or documented areas needing improvement are presented to Ancillary Provider staff. ▪ ≥ 3 programs are designed and presented to referring Physicians and Participating Plan care coordinators upon request
Sub-Contracted Providers	▪ 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. ▪ Ancillary Provider will provide Ancillary Program Contract Manager, upon request, a current listing of all sub-contracted providers. ▪ There are complaints registered on < 2 % of Sub-Contracted Provider cases.
First Visit Response	▪ 100% same day or first day requested limited only by patient availability.
Quality	
Professional Accreditation	▪ Ancillary Provider must be accredited by JCAHO in all provider sites serving UnitedHealthcare. ▪ Ancillary Provider will have Medicare and Medicaid provider numbers in all geographic areas in which Health Services are administered.
Consistency	▪ There is documentation of consistent training programs including policies and procedures in all Ancillary Provider sites.
Continuous Quality Improvement (CQI)	▪ There is a documented CQI program identifying (through data) opportunities for real time, measured improvement in areas of core competencies in all Service categories. ▪ There are demonstrated ties between CQI findings and staff orientation, training, policies and procedures. ▪ There is a quarterly report submitted by Ancillary Provider to the Ancillary Program Contract Manager ("APCM") regarding above CQI process, upon request.
Customer Complaints	▪ Complaints are logged by category and type, with specific corrective action plans for any patterns ▪ There are complaints registered on < 2 % of cases.
Plan Participant Grievances	▪ Ancillary Provider shall participate in the Plan Participant Grievance resolution process as noted in the Home Care Provider Manual. ▪ 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 with a written response within 5 business days to include specific corrective action plan. ▪ Written response shall be sent via facsimile to the fax number indicated in the How to Reach Us section of the Home Care Provider Manual.
Referring Physician Complaints	▪ Complaints are logged by category and type, with specific corrective action plans for any patterns. ▪ There are complaints registered on < 2 % of cases.

SERVICE STANDARDS EXHIBIT
Home Care Services

Data Reporting and Measurement	
Survey Results	▪ 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.
Utilization	▪ Ancillary Provider will submit to Ancillary Program Contract Manager, upon request, separate quarterly reports on volume of services by type of service. ▪ 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.
Incidents	▪ Error rate is < 2%.
Billing and Reimbursement	
Electronic Billing	▪ 95% of all claims are submitted electronically.
Complete/Clean Claim Submission	▪ 95% of all claims submitted are accurate and contain all information necessary to process the claim as defined in the applicable Compensation Exhibit and Provider Manual.
Coding Methodology	▪ Standard coding methodology is used in billing UnitedHealthcare.
Accounts Receivable Reconciliation	▪ Monthly AR reconciliation is done with results reported to Ancillary Program Contract Manager quarterly. ▪ Corrective action plan is developed to resolve outstanding AR issues.
Training and Communication	
Participating Plan Administrative Communications	▪ There are standard, quarterly meetings with Participating Plan to review data reports, quality issues, and address any administration issues.
Staff Training	▪ 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.
Account Support	▪ There is a documented plan and adequate staffing to conduct initial education and ongoing interface with UnitedHealthcare staff. ▪ 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 UnitedHealthcare. The coordinator will also assist UnitedHealthcare in resolving Customer issues. ▪ Ancillary Provider shall participate in regularly scheduled ongoing contract management meetings with the Ancillary Program Contract Manager.

RESOLUTION REQUEST FORM NO. 3

Request for *New* Memorandum of Agreement

DEPARTMENT NAME: Health Services

DATE: 03/28/2014

(a) Is this a Result of a Bid or Request for Proposal? **No**

(b) Purpose of Contract: To authorize a Memorandum of Agreement with Hudson Headwaters Health Network Ryan White Program to provide HIV testing services at Warren County Health Services sexually transmitted disease clinics at no cost to Warren County in a form approved by the county attorney.

(c) Name of Contractor: Hudson Headwaters Health Network

(d) Address of Contractor: 9 Carey Road, Queensbury, NY 12804

(e) Contractor's Contact Person and Telephone Number: Erika Walker, 761-0300 ext. 31850, email: ewalker@hhhn.org

(f) Has or will the Contract be provided, if so, please attach: Yes

(g) Commencement Date of Contract: 05/01/2014

(h) Termination Date of Contract: per terms in memorandum of understanding

(i) Payment Provisions: Not applicable

- 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:

Not applicable no finances exchanged between Warren County and Hudson Headwaters Health Network for this initiative.

MEMORANDUM OF AGREEMENT
BETWEEN
HUDSON HEADWATERS HEALTH NETWORK
RYAN WHITE PROGRAM
AND
WARREN COUNTY PUBLIC HEALTH

Hudson Headwaters Health Network (hereinafter "HHHN") is a grantee and recipient of federal funding pursuant to the Ryan White Part C Treatment Extension Act (hereinafter the "Act"), which is administered by the Health Resources and Services Administration (hereinafter "HRSA") of the United States Department of Health and Human Services (hereinafter "HHS"); and

The goal of the Act is to promote Early Intervention Services (hereinafter "EIS") with respect to HIV disease, and the provision of quality, client-centered primary health care and other related services for individuals living with HIV/AIDS in rural and underserved communities; and

Requires recipients of funding to work to identify individuals who test HIV positive, and link such individuals into care and support services; and

Warren County Public Health has an interest in identifying and facilitating the provision of health care services for individuals who test HIV positive;

HHHN and Warren County Public Health, agree as follows:

1. Purpose of Agreement.

The purpose of this Agreement is to coordinate and integrate HIV testing at Warren County STD Clinic for the purpose of early intervention and identification of individuals who test HIV positive – as a way to link such individuals into care and support services in response to the National HIV/AIDS Strategy of 2009.

2. Responsibilities of HHHN:

HHHN shall coordinate and manage a HIV/AIDS Early Intervention Services program within Warren County Public Health STD Clinic, including any grant applications and reporting requirements. Specifically, HHHN shall:

A. Develop and coordinate relationships with other appropriate agencies.

B. Manage all financial aspects of the EIS Program, including relationships with any grantee agency and other service agencies;

C. Provide rapid oral swab testing at Warren County Public Health STD Clinic at designated times mutually agreed upon by the Parties.

3. Responsibilities of Warren County Public Health

Warren County Public Health agrees to facilitate and ensure the safety of participants at the Warren County Public Health STD Clinic EIS Program. Warren County Public Health obligations shall include:

a. Disseminating, in a coordinated effort with HHHN, information to individuals at the Warren County Health Office regarding the availability of HIV testing at the Warren County Public Health STD Clinic

b. Providing adequate training and assistance to HHHN employees regarding facility procedures and rules;

c. Providing adequate facilities for HHHN to conduct HIV testing and adequate facilities for the transmission of results by HHHN to individuals;

d. Instituting appropriate procedures at the facility in order to protect the confidentiality of individuals who undergo testing and/or who receive positive results after testing.

4. Testing Protocol and Limitations.

It is expressly understood by the Parties that:

a. Testing shall be performed by employees of HHHN pursuant to HHHN's established protocols and procedures;

b. Testing shall be conducted on a completely voluntary basis and upon written consent of the individuals;

c. HHHN shall be solely responsible for providing test results to individuals. The provision of such results by HHHN shall be in accordance with established HHHN protocols and procedures;

d. HHHN shall provide only on-site rapid oral swab HIV testing. In the event of a positive test, a secondary off-site lab draw will be required. Such secondary testing would be facilitated by HHHN.

e. HHHN shall be responsible for referring newly diagnosed individuals into the care and services offered by the Ryan White Program of HHHN in accordance with the program's policy and procedures.

5. Program Administration.

Warren County Public Health EIS Program at Warren County Public Health STD Clinic shall be administered by the HHHN director, who shall retain responsibility for the deliverables of this project to HRSA. Any changes in the scope of work must be approved before proposed changes shall take effect. HHHN reserves the right to assign or re-assign its personnel or their respective responsibilities under the grant and/or this Agreement.

6. Other Considerations.

a. In order to preserve the confidentiality of individuals tested, the Parties agree that results of HIV testing performed pursuant to this Agreement shall not become part of the individual's medical record.

b. HHHN and Warren County Public Health shall participate in quality improvement activities, as needed, in order to assure the quality of this Agreement.

c. Each Party to this Agreement shall review and approve all marketing and public communications activities concerning this project prior to their release.

7. Performance Period.

This agreement shall be effective January 1, 2014 with an automatic annual renewal. This agreement supersedes any earlier agreement, and is conditional based on continued funding from HRSA.

8. Termination.

Either Party may terminate this Agreement at any time by providing written notice to the other Party with 30 days' notice. Upon termination of the Agreement, the Parties shall have no further obligation under this Agreement. The addresses for providing notice of termination are as follows:

Hudson Headwaters Health Network
9 Carey Road
Queensbury, New York 12804

Warren County Public Health
Attn: Ginelle Jones
1340 State Rt. 9
Lake George, NY 12845

Hudson Headwaters Health Network

By: _____

Name: George Purdue

Title: Chief Administrative Officer

Date: 3/26/14

Warren County Public Health

By: _____

Name: _____

Title: _____

Date: _____

Client#: 13883 HUDSOHEADW

ACORD™ CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY) 3/26/2014

THIS CERTIFICATE IS ISSUED AS A MATTER OF INFORMATION ONLY AND CONFERS NO RIGHTS UPON THE CERTIFICATE HOLDER. THIS CERTIFICATE DOES NOT AFFIRMATIVELY OR NEGATIVELY AMEND, EXTEND OR ALTER THE COVERAGE AFFORDED BY THE POLICIES BELOW. THIS CERTIFICATE OF INSURANCE DOES NOT CONSTITUTE A CONTRACT BETWEEN THE ISSUING INSURER(S), AUTHORIZED REPRESENTATIVE OR PRODUCER, AND THE CERTIFICATE HOLDER.

IMPORTANT: If the certificate holder is an ADDITIONAL INSURED, the policy(ies) must be endorsed. If SUBROGATION IS WAIVED, subject to the terms and conditions of the policy, certain policies may require an endorsement. A statement on this certificate does not confer rights to the certificate holder in lieu of such endorsement(s).

PRODUCER	CONTACT NAME:	
Cool Insuring Agency Inc CL 784 Troy Schenectady Road Latham, NY 12110 518 783-2665	PHONE (A/C, No, Ext): 518 783-2665	FAX (A/C, No): 5187838754
	E-MAIL ADDRESS:	

INSURER(S) AFFORDING COVERAGE	NAIC #
INSURER A : National Fire Ins Co of Hartfor	02129
INSURER B : Continental Casualty Company	20443
INSURER C :	
INSURER D :	
INSURER E :	
INSURER F :	

INSURED
Hudson Headwaters Health Network
9 Carey Rd.
Queensbury, NY 12804

COVERAGES **CERTIFICATE NUMBER:** **REVISION NUMBER:**

THIS IS TO CERTIFY THAT THE POLICIES OF INSURANCE LISTED BELOW HAVE BEEN ISSUED TO THE INSURED NAMED ABOVE FOR THE POLICY PERIOD INDICATED. NOTWITHSTANDING ANY REQUIREMENT, TERM OR CONDITION OF ANY CONTRACT OR OTHER DOCUMENT WITH RESPECT TO WHICH THIS CERTIFICATE MAY BE ISSUED OR MAY PERTAIN, THE INSURANCE AFFORDED BY THE POLICIES DESCRIBED HEREIN IS SUBJECT TO ALL THE TERMS, EXCLUSIONS AND CONDITIONS OF SUCH POLICIES. LIMITS SHOWN MAY HAVE BEEN REDUCED BY PAID CLAIMS.

INSR LTR	TYPE OF INSURANCE	ADDL INSR	SUBR WVD	POLICY NUMBER	POLICY EFF (MM/DD/YYYY)	POLICY EXP (MM/DD/YYYY)	LIMITS	
A	GENERAL LIABILITY			5086288840	09/01/2013	09/01/2014	EACH OCCURRENCE	$1,000,000
	[X] COMMERCIAL GENERAL LIABILITY						DAMAGE TO RENTED PREMISES (Ea occurrence)	$300,000
	[ ] CLAIMS-MADE [X] OCCUR						MED EXP (Any one person)	$15,000
							PERSONAL & ADV INJURY	$1,000,000
	GEN'L AGGREGATE LIMIT APPLIES PER:						GENERAL AGGREGATE	$2,000,000
	[ ] POLICY [ ] PRO-JECT [X] LOC						PRODUCTS - COMP/OP AGG	$2,000,000
								$
A	AUTOMOBILE LIABILITY			5086288885	09/01/2013	09/01/2014	COMBINED SINGLE LIMIT (Ea accident)	$1,000,000
	[X] ANY AUTO						BODILY INJURY (Per person)	$
	[ ] ALL OWNED AUTOS [ ] SCHEDULED AUTOS						BODILY INJURY (Per accident)	$
	[X] HIRED AUTOS [X] NON-OWNED AUTOS						PROPERTY DAMAGE (Per accident)	$
	[X] Drive Oth Car							$
B	[X] UMBRELLA LIAB [X] OCCUR			5086288868	09/01/2013	09/01/2014	EACH OCCURRENCE	$5,000,000
	[ ] EXCESS LIAB [ ] CLAIMS-MADE						AGGREGATE	$5,000,000
	[ ] DED [X] RETENTION $10000							$
	WORKERS COMPENSATION AND EMPLOYERS' LIABILITY Y/N						[ ] WC STATU-TORY LIMITS [ ] OTH-ER	
	ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? [ ]	N/A					E.L. EACH ACCIDENT	$
	(Mandatory in NH)						E.L. DISEASE - EA EMPLOYEE	$
	If yes, describe under DESCRIPTION OF OPERATIONS below						E.L. DISEASE - POLICY LIMIT	$

DESCRIPTION OF OPERATIONS / LOCATIONS / VEHICLES (Attach ACORD 101, Additional Remarks Schedule, If more space is required)

CERTIFICATE HOLDER

Warren County Public Health
1340 State Route 9
Municipal Building
Lake George, NY 12845

CANCELLATION

SHOULD ANY OF THE ABOVE DESCRIBED POLICIES BE CANCELLED BEFORE THE EXPIRATION DATE THEREOF, NOTICE WILL BE DELIVERED IN ACCORDANCE WITH THE POLICY PROVISIONS.

AUTHORIZED REPRESENTATIVE

Anthony J. Manchuta

KAW

RESOLUTION REQUEST FORM NO. 10

Request for Transfer of Funds

TO: JOAN SADY, CLERK, WARREN COUNTY BOARD OF SUPERVISORS

SIGNED: _____ DATE: 3/28/13

	FROM CODE	TITLE	TO CODE	TITLE	AMOUNT
1.	A.4010.110	Health Services-Full time Salaries	A.4010.130	Health Services-Part time Salary	$7,000.00
2.	A.4013.469	WIC-Other Payments/Contributions Expenses	A.4013.861	WIC-Retiree Hospitalzation	$6,380.00
3.	A.4013.469	WIC-Other Payments/Contributions Expenses	A.4013.210	WIC-Furniture Expense	$1,000.00

Total Transfers **$14,380.00**

1. To transfer funds to cover part time salary (per diem) coverage for Health Services(CHHA) for 2014 due to nursing staffing shortage & FMLA utilization.
2. To transfer funds to cover Retiree Hospitalization for 11 months due to a recent January retirement. Fully covered by the WIC Grant.
3. To transfer funds for the anticipated purchase of office furniture needed. Fully covered by WIC Grant.

CONTINGENT FUND TRANSFER REQUESTS

FROM CODE	TITLE	TO CODE	TITLE	AMOUNT
A.1990 469	Contingent Fund			

Please state reason for transfer request: Total

Please file original request with Clerk of the Board and retain copy for your records

Attachment #5

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: 03/28/2014

(a) Purpose of Request: To develop a Memorandum of Understanding between Warren County Health Services and Warren County Information Technology Department relative to the proper disposal of computer equipment to assure that all patient privacy information is protected and all HIPAA (Health Insurance Portability Accountability Act) regulations are followed in a form approved by the County Attorney.

(b) Details: This memorandum has been suggested by the Warren County Administrator to strengthen the policy for disposal of technology equipment that includes private health information of patients. Should this information be breeched in any way, it could lead to a costly situation for the county.

(c) Previous Resolution Number: Not applicable.

SCHEDULE "A"

AUTHORIZATION TO ATTEND MEETING OR CONVENTION

Check one:

☒ In-State (needs Supervisory Committee authorization)
☐ Out-Of State (needs Board resolution)

The Health Services (Supervisory Committee) hereby authorizes Tammie DeLorenzo and Sharon Schaldone Asst. Director Patient Services (Employee Name) clinical and Information coordinator

to attend Home Care Association of New York State engage, collaborate and Partner Educational Program (Name of meeting or organization)

at Albany Hilton Hotel & Conf Center 40 Lodge St. Albany NY 12207 (Address)

on April 23 2014 (Dates) Mode of transportation to be used Health Services Fleet Vehicle (County Vehicle or Mass Transportation)

If the mode of transportation is not a county vehicle or mass transportation, please explain:

Proper documentation must be attached when submitting for approval.
(Please check documents attached)

☒ Notice of meeting or convention including cost. 329. per person x 2 = 658 total

For Overnight Travel

☐ Room rate $
☐ Meal costs - GSA*per diem rate $ NA- meal included in conference fee GSA* Rate $
*www.gsa.gov

Date: 3/28/14 Patricia [signature] Department Head Signature

Date: 3/28/14 [signature] Committee Chairman Signature

Please refer to the Warren County Travel Policy and County Vehicle Use Regulations for general policy guidelines.

****

Please check to request a fleet vehicle.

☐ **REQUEST FOR USE OF FLEET VEHICLE**

****

Filing Instructions:

1. Original with voucher to Auditor.
2. Copy to Frank Morehouse if fleet vehicle is needed.
3. Copy to Clerk of the Board with Resolution Request form if out-of-state travel.
4. Copy to Purchasing with Purchase Order, if required.
5. Copy to Commissioner of Administrative and Fiscal Services if credit card will be used.

ENGAGE, COLLABORATE AND PARTNER

An Educational Program on Innovative New Models of Service Delivery & Payment

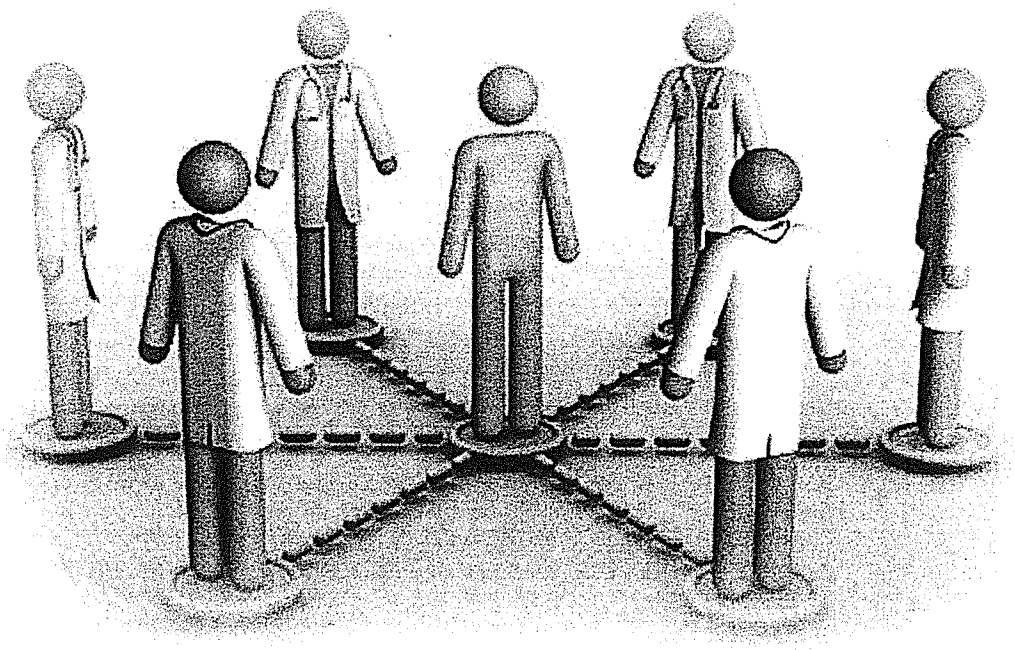
APRIL 23

8:30am to 4:00pm

Albany Hilton Hotel
& Conference Center
40 Lodge Street
Albany, NY 12207

The new health care marketplace, prompted by federal and state policy changes, is encouraging the development of new models of service delivery, care provision and payment. As the provider of high quality services to chronically ill, frail and elderly patients, home care providers are well positioned in this new marketplace to offer hospitals, health systems, physician practices and health plans a value proposition for expertise and service delivery. This new market offers the home care community many new opportunities for partnership and collaboration.

Hear from expert policymakers, consultants and panelists about new models in New York's health care marketplace, as well as how home care providers can successfully position themselves to engage, collaborate and partner with other parts of the health care continuum.



an HCA Education EVENT

HCA PAC Reception

"Nite at the Races"

Thursday, May 8
Saratoga Hilton
5:00pm – 6:30pm

HCA is a voluntary, non-profit, unincorporated association formed solely for political purposes. HCA PAC is not affiliated with any political party, candidate, or organization. The cost of organization, administration and solicitation of contributions for HCA PAC is borne entirely by HCA PAC and the Home Care Association of New York State (HCA). Copies of HCA PAC reports are filed with the New York State Board of Elections in Albany, NY.

What is a PAC?
A **political action committee** (PAC) is a type of political committee organized to elect candidates who share your views and concerns. PACs are used today by thousands of organizations across the nation to distribute funds to political candidates for office.

HCA PAC Background
In 2009 the HCA Board of Directors formed the HCA PAC to offer a means for HCA members and individuals concerned with the challenges confronting home care to support worthy candidates for state elected office.

Government activity at the state level has a direct impact on home care providers and the entire health care system. A strong political action committee is a useful advocacy tool that can help the home care community have a strong voice in public policy efforts. Now in its second year, HCA's PAC will help continue HCA's strong presence in advocating at the State level for your interests, especially during this important election year. Your participation in the HCA PAC will help us to communicate that lawmakers must recognize the true costs of caring for home care patients, make investments in a strong and stable home care safety net and assure that home care's place at the table is well represented.

In today's uncertain political times, a PAC sends a powerful message of unity on behalf of the home care community. It allows those interested in home care to speak with one voice, on behalf of vitally important home care programs and the thousands of patients being served by home care.

Contributing to the HCA PAC
Contributions to the HCA PAC are dedicated to helping elect lawmakers that care about preserving and protecting the home care safety net in New York State. By collectively pooling our resources, home care's message can be clearly heard by policymakers in Albany.

This collective voice communicates that state reimbursement and private sector payment must recognize the true costs of providing care to home care patients, and that home care must be strengthened by providing for resources to address infrastructure, workforce, capital and technology needs.

Supporting the HCA PAC ensures that home care providers have a meaningful voice in the outcome on these and other vital issues that affect the home care community. Interest groups from many disciplines work to have their voice heard, and the home care community's voice also needs to be at the forefront of the debate.

Who Can Contribute to the HCA PAC?
Voluntary contributions may be accepted from any U.S. citizen and for-profit corporations.

Contributions from tax-exempt, not-for-profit corporations **cannot** be accepted. Any eligible corporation is limited by NYS law to contributing no more than $5000 for all political activity during a calendar year; All employees of HCA's member organizations **can** contribute to the HCA PAC.

Participation in the HCA PAC is voluntary and contributions are not tax-deductible.

Does it Make a Difference?
Your participation in the HCA PAC produces real political power. Protecting home care providers and the patients and families we serve cannot be done without commitment. When you and your home care colleagues contribute to the HCA PAC, it reinforces and reminds lawmakers of the importance of home care.

How Much Should I Contribute?
Any amount is welcome. If contributions are made by individuals from each HCA provider agency member in the state the HCA PAC would be hugely successful.

HCA Political Action Committee

NAME

OCCUPATION/TITLE

HOME ADDRESS

CITY/STATE/ZIP

DAYTIME PHONE

EMAIL ADDRESS

HOME CARE AGENCY

CONTRIBUTION

I will attend the HCA PAC Nite at the Races Reception and provide the following donation (minimum of $50):

☐ $2,500 ☐ $1,500 ☐ $1,000
☐ $500 ☐ $250 ☐ $100
☐ $50
☐ I will not be attending, but will donate $_____

PAYMENT

Personal Checks
Must be made out to: **HCA PAC**

Personal Credit Card
Please indicate card to be charged:
☐ Visa ☐ MasterCard ☐ AmExp

CARD NUMBER

EXPIRATION DATE SECURITY CODE

NAME AS IT APPEARS ON CARD

CARD BILLING ADDRESS

CITY, STATE, ZIP

CARDHOLDER'S SIGNATURE

Anonymous contributions are prohibited. However, if you do not want your name to be published in recognition materials, please check this box. ☐

ENGAGE, COLLABORATE AND PARTNER

An Educational Program on Innovative New Models of Service Delivery & Payment

TENTATIVE AGENDA

APRIL 23

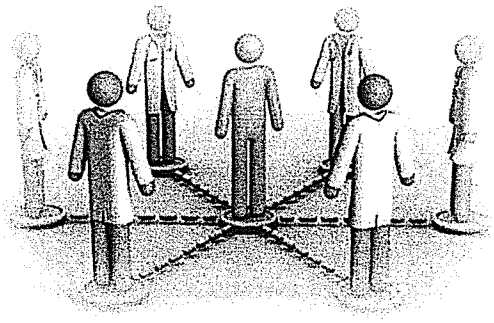
8:30am – 9:20am	Registration
9:20am	Welcome
9:30am to 10:30am	**New York State's Innovative Service and Delivery Reforms Overview of New Models & Description of the State's Policy and Program Directions** *Greg Allen, Director, Division of Program Development and Management, New York State Department of Health*
10:30am to Noon	**Home Care's Role in New Models – How to Position Your Agency for Positive Partnerships** *Joe Pofit, Cicero Consultants*
Noon to 12:45pm	Networking Lunch
12:45pm to 2:45pm	**Successful Planning and Execution – Panelists Share Descriptions of their Innovative Models in the New Health Care Marketplace** **Accountable Care Organizations** *Stephen Rosenthal, Chief Operating Officer (invited) The Care Management Company, Montefiore Medical Center* **Patient Centered Home** *John Rugge, MD, Executive Director, Hudson Headwaters Health Network* **Primary Care/Home Care/Hospital Partnership** *Sumir Segal, Medical Director, EssenMed House Calls* **Health Home** (TBA)
3:00pm to 4:00pm	**Cross-Model Analysis, Preliminary Findings, Lessons Learned** United Hospital Fund (invited)
4:00 pm	Closing Comments

Special Accommodations: In accordance with the **Americans with Disabilities Act** or special meal needs, please let us know how we can accommodate you:

_____

_____

Cancellation Policy: Cancellations received by April 14 will receive a full refund, less 25% of total due as an administrative fee. Cancellations received on April 15 or later will forfeit their registration fee, as will those who register and do not attend. Substitutions are permitted.



Register online at: www.eventville.com/hcanys

REGISTRATION

_____
Name

_____
Title

_____
Agency

_____
Address

_____
City/State/Zip

_____ _____
Phone/Ext. Email *(Required)*

PAYMENT

$229 HCA Member _____

$329 Non-Member √

____ VISA ____ MC ____ AM EX

Credit Card No._____

Expiration Date:_____ Sec. Code:_____

Card Billing Address:_____

_____

Name on Card:_____

Signature:_____

Or, make checks payable to: HCA Education and Research and mail to 388 Broadway, 4th Floor, Albany, NY 12207

FAX TO: (518) 426-8788

NEW YORK
state department of
HEALTH

Nirav R. Shah, M.D., M.P.H.
Commissioner

Sue Kelly
Executive Deputy Commissioner

03/03/2014

Patricia Auer, Administrator
Warren County Health Services
1340 State Route 9
Municipal Center
Lake George, NY 12845

Agency: **Warren Co Hlth Svs CHHA**
Medicare Provider #: **337045**
Type of Survey: **Recertification**
Event ID #: **FS0C11**
Survey Exit Date: **01/21/2014**

Dear Ms. Auer:

This office has reviewed the amended Plan of Correction (POC) for the above referenced survey. All items were found to be acceptable. It is expected that you will implement this plan within the time frames that were submitted.

Upon completion of your corrective actions, a post certification visit will be conducted to ensure the agency has implemented the corrections required.

If you have any questions regarding this matter, please contact Lori Novak at 518-408-5287.

Sincerely,

Rita Cedar

Rita Cedar
Program Manager
Home Health Services
Capital District Regional Office

cc: Sharon Schaldone, RN

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 01/31/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	337045	A. BUILDING _____ B. WING _____	01/21/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WARREN CO HLTH SVS CHHA	1340 STATE ROUTE 9 LAKE GEORGE, NY 12845

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 000	INITIAL COMMENTS The following statement of deficiencies represents the results of a full recertification survey of the Certified Home Health Agency (CHHA) and Long Term Home Health Care Program (LTHHCP). A standard level survey was conducted January 13 through January 21, 2014. Deficient practices were identified within high priority standards in CoP 484.18, 484.36, 484.48 and 484.55 resulting in a partial/extended survey. During the survey a total of twenty clinical records were reviewed which included ten observational home visits. Of the twenty clinical records reviewed four were LTHHCP records (Patient # 4, 6, 10 and 11) with three observational home visits (Patient # 6, 10 and 11). Twelve personnel files of professional staff were reviewed. The survey included a review of the agency's Telehealth Monitoring Program, clinical and administrative policies and procedures, OASIS (Outcome and Assessment Information Set) Reports for the period October, 2012 through September, 2013, contracts, emergency preparedness plan, Professional Advisory Committee meeting minutes and quality assurance activities for the most recent 12 months and the Complaint Investigation Log. The Assistant Director of Patient Services, Clinical Supervising Nurses of the CHHA, LTHHCP and Therapy Program and staff were interviewed. The findings were reviewed at the exit conference. The following deficiencies are being cited as a result of the survey.	G 000		
G 108	484.10(c)(1) RIGHT TO BE INFORMED AND PARTICIPATE The patient has the right to be informed, in advance about the care to be furnished, and of	G 108		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Sharon Schallner TITLE: Assistant Director PS Services (X6) DATE: 2/13/14

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

3/3/14 Amended POC emailed
Lori Dinah

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G 108	Continued From page 1 any changes in the care to be furnished. The HHA must advise the patient in advance of the disciplines that will furnish care, and the frequency of visits proposed to be furnished. The HHA must advise the patient in advance of any change in the plan of care before the change is made. This STANDARD is not met as evidenced by: Based on clinical record review and staff interview evidence is lacking in twenty out of twenty records (Patient # 1-20) the agency ensured patients were advised in advance of the disciplines that will furnish the care and the frequency of the visits proposed to be furnished. Failure to provide the patient with information concerning what disciplines will be furnishing care and the frequency of the proposed visits has the potential to result in the patient's inability to exercise their rights. Findings include: Patient records # 1-20 each contain the agency's authorization and consent for treatment form. The documents fail to include information regarding what disciplines will be providing services or the frequency of the visits proposed to be furnished. The finding was confirmed on 01/14/14 with the Assistant Director of Patient Services; no additional evidence was provided.	G 108	Staff In-service on New Consent to Treat form on 03/13/14, ADPS responsible. Business Associate will be notified via email on 03/13/14, Therapy Supervisor responsible. Assistant Director of Patient Services (ADPS) will be responsible to facilitate, coordinate and compile all data of the record audit findings to assure compliance with COP. - Record Audit will be done starting week of 03/17/2014, ending week of 06/23/14 - QI Team & Chart Committee Groups will perform Record Audits. o QI Team – 2 CSN, 1 Therapy CSN, 2-QI Assistants, 1-ADPS will review one record each (6)a week for 15 weeks, Total 90 records - Chart Committee – Members of the chart committee are the QI team and the Professional staff on a rotating basis - They will review 70 records starting Mar. 25, 2014, April 8 & 22, 2014; May 6 & 20, 2014 and June 10 & 24, 2014 = Total 70. - Record Audit Total = 160. - Compliance Goal is 95%-100% by 06/24/14. - ADPS will report % of compliance to the UR committee on June 9, 2014 and PAC on 5/21/2014 and 8/20/2014.	
G 158	484.18 ACCEPTANCE OF PATIENTS, POC, MED SUPER	G 158		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 01/31/2014
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G 158	Continued From page 2 Care follows a written plan of care established and periodically reviewed by a doctor of medicine, osteopathy, or podiatric medicine. This STANDARD is not met as evidenced by: Based on clinical record review and staff interview, the agency failed to ensure that services are provided in accordance with the Plan of Care (POC) in nine out of twenty records (Patient # 1, 3, 4, 8, 10, 11, 12, 14, 20). Failure to follow the POC has the potential for patients to receive care inconsistent with the physician's orders resulting in unmet patient needs and possible negative patient outcomes. Findings include: Patient # 1 (start of care 07/26/13) has diagnoses of Colostomy, Malignant Neoplasm of the Kidney, Malignant Neoplasm of the Brain/Spine, Chronic Pulmonary Embolism and Diabetes. The POC for the certification period 07/26/13 through 09/23/13 states "BP (blood pressure) sitting/standing". The Skilled Nurse (SN) visits conducted on 08/05, 08/16, 08/17 and 08/18/14 lack documented evidence the SN obtained sitting and standing blood pressures. Patient # 3 (start of care 10/03/13) has diagnoses of Calf Ulcer, Chronic Kidney Disease and Chronic Pain. The POC for the certification period 12/02/13 through 01/30/14 states the SN is to provide five to seven visits a week for nine weeks. The record lacks documented evidence a minimum of five visits were provided the week of 12/15/13.	G 158	• All Clinical Staff will be in-serviced on 03/13/14 on Policy / Procedure for Parameter setting & Record Audit Tool, Assistant Director responsible. • All Business Associates will be emailed Policy / Procedure for Parameter setting & Record Audit Tool on 03/13/14, Therapy Supervisor responsible. Assistant Director of Patient Services (ADPS) will be responsible to facilitate, coordinate and compile all data of the record audit findings to assure compliance with COP. - Record Audit will be done starting week of 03/17/2014, ending week of 06/23/14 - QI Team & Chart Committee Groups will perform Record Audits. o QI Team – 2 CSN, 1 Therapy CSN, 2-QI Assistants, 1-ADPS will review one record each (6)a week for 15 weeks, Total 90 records - Chart Committee – Members of the chart committee are the QI team and the Professional staff on a rotating basis - They will review 70 records starting Mar. 25, 2014, April 8 & 22, 2014; May 6 & 20, 2014 and June 10 & 24, 2014 = Total 70. - Record Audit Total = 160. - Compliance Goal is 95%-100% by 06/24/14. - ADPS will report % of compliance to the UR committee on June 9, 2014 and PAC on 5/21/2014 and 6/20/2014.	

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G 158	Continued From page 6 additional evidence was provided.	G 158		
G 159	484.18(a) PLAN OF CARE The plan of care developed in consultation with the agency staff covers all pertinent diagnoses, including mental status, types of services and equipment required, frequency of visits, prognosis, rehabilitation potential, functional limitations, activities permitted, nutritional requirements, medications and treatments, any safety measures to protect against injury, instructions for timely discharge or referral, and any other appropriate items. This STANDARD is not met as evidenced by: Based on clinical record review and staff interview, the agency failed to ensure a complete Plan of Care (POC) was developed to meet the individualized needs of the patient and/or included parameters for the administration of care and patient monitoring. This was evident in eleven out of twenty patient records (Patient # 1, 4, 5, 6, 7, 9, 11, 13, 16, 17, 19) Failure to establish a comprehensive POC has the potential for unmet patient needs and places patients at risk for receiving incorrect and/or inappropriate care. Findings include: Patient # 1 (start of care 07/26/13) has diagnoses of Colostomy, Malignant Neoplasm of the Kidney, Malignant Neoplasm of the Brain/Spine, Chronic Pulmonary Embolism and Diabetes. The POC for the certification period 07/26/13 through 09/23/13 states "BP (blood pressure) sitting/standing". The	G 159	• All Clinical Staff will be in-serviced on 03/13/14 on Policy / Procedure Medication Documentation Update addressing #1 - #4 & Record Audit Tool, Assistant Director responsible. • Therapy Supervisor will be responsible for doing Medication Profile for Therapy Only cases via Agency policy. This will be monitored by ADPS starting 03/17/14 ending 04/30/14 via Chart Audit one time a week totaling 7 records. Compliance Goal 100% by 04/30/14. ADPS will report findings to PAC 05/21/14 and UR by 06/09/14. Assistant Director of Patient Services (ADPS) will be responsible to facilitate, coordinate and compile all data of the record audit findings to assure compliance with COP. - Record Audit will be done starting week of 03/17/2014, ending week of 06/23/14 - QI Team & Chart Committee Groups will perform Record Audits. o QI Team – 2 CSN, 1 Therapy CSN, 2-QI Assistants, 1-ADPS will review one record each (6)a week for 15 weeks, Total 90 records - Chart Committee – Members of the chart committee are the QI team and the Professional staff on a rotating basis - They will review 70 records starting Mar. 25, 2014, April 8 & 22, 2014; May 6 & 20, 2014 and June 10 & 24, 2014 = Total 70. - Record Audit Total = 160. - Compliance Goal is 95%-100% by 06/24/14. - ADPS will report % of compliance to the UR committee on June 9, 2014 and PAC on 5/21/2014 and 8/20/2014.	

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G 159	Continued From page 11 between doses. The findings were confirmed on 01/15 and 01/17/14 with the Clinical Supervising Nurse; no additional evidence was provided.	G 159		
G 164	484.18(b) PERIODIC REVIEW OF PLAN OF CARE Agency professional staff promptly alert the physician to any changes that suggest a need to alter the plan of care. This STANDARD is not met as evidenced by: Based on clinical record review, observational home visit (HV) and staff interview, evidence is lacking in ten out of twenty records (Patient # 3, 4, 7, 8, 10, 11, 12, 14, 19, 20) that the physician was contacted regarding changes that alter or suggest the need to alter the patient's plan of care (POC). Failure to notify the physician regarding changes that alter or that suggests the need to alter the POC has the potential to result in unmet patient needs and possible negative outcomes. Findings include: Patient # 3 (start of care 10/03/13) has diagnoses of Calf Ulcer, Chronic Kidney Disease and Chronic Pain. The POC for the certification period 12/02/13 through 01/30/14 states the Skilled Nurse (SN) is to provide five to seven visits a week for nine weeks. The record lacks documented evidence a minimum of five visits were provided the week of 12/15/13 and lacks evidence the physician was notified of the alteration in the POC.	G 164	• All Clinical Staff will be in-serviced on 03/13/14 on Policy / Procedure on RN / LPN Supervision documentation procedure & Record Audit Tool, Assistant Director responsible. Assistant Director of Patient Services (ADPS) will be responsible to facilitate, coordinate and compile all data of the record audit findings to assure compliance with COP. - Record Audit will be done starting week of 03/17/2014, ending week of 06/23/14 - QI Team & Chart Committee Groups will perform Record Audits. o QI Team – 2 CSN, 1 Therapy CSN, 2-QI Assistants, 1-ADPS will review one record each (6)a week for 15 weeks, Total 90 records - Chart Committee – Members of the chart committee are the QI team and the Professional staff on a rotating basis - They will review 70 records starting Mar. 25, 2014, April 8 & 22, 2014; May 6 & 20, 2014 and June 10 & 24, 2014 = Total 70. - Record Audit Total = 160. - Compliance Goal is 95%-100% by 06/24/14. - ADPS will report % of compliance to the UR committee on June 9, 2014 and PAC on 5/21/2014 and 8/20/2014.	

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G 164	Continued From page 16 Patient # 20 (start of care 09/26/13) has diagnoses of Basal Cell Carcinoma of the Skin, Hypertension and Dementia. The POC for the certification period 11/25/13 through 01/23/14 states the SN is to provide three to five visits a week for nine weeks. The record lacks documented evidence a minimum of three visits were conducted the week of 12/22/13 and lacks evidence the physician was notified of the alteration in the POC. The findings were confirmed on 01/15 and 01/17/14 with the Clinical Supervising Nurse; no additional evidence was provided.	G 164		
G 169	484.30 SKILLED NURSING SERVICES The HHA furnishes skilled nursing services by or under the supervision of a registered nurse. This STANDARD is not met as evidenced by: Based on clinical record review and staff interview the agency failed to ensure adequate supervision of the Licensed Practical Nurse (LPN) staff in six out of twenty records (Patient # 1, 3, 8, 9, 15, 20). Failure to adequately supervise LPN staff has the potential to result in the provision of inappropriate and/or incorrect care and negative patient outcomes. Findings include: Patient # 1 (start of care 07/26/13) has diagnoses of Colostomy, Malignant Neoplasm of the Kidney, Malignant Neoplasm of the Brain/Spine, Chronic Pulmonary Embolism and Diabetes. The record	G 169	• All Clinical Staff will be in-serviced on 03/13/14 on Policy / Procedure on RN / LPN Supervision documentation procedure & Record Audit Tool, Assistant Director responsible. Assistant Director of Patient Services (ADPS) will be responsible to facilitate, coordinate and compile all data of the record audit findings to assure compliance with COP. - Record Audit will be done starting week of 03/17/2014, ending week of 06/23/14 - QI Team & Chart Committee Groups will perform Record Audits. o QI Team – 2 CSN, 1 Therapy CSN, 2-QI Assistants, 1-ADPS will review one record each (6)a week for 15 weeks, Total 90 records - Chart Committee – Members of the chart committee are the QI team and the Professional staff on a rotating basis - They will review 70 records starting Mar. 25, 2014, April 8 & 22, 2014; May 6 & 20, 2014 and June 10 & 24, 2014 = Total 70. - Record Audit Total = 160. - Compliance Goal is 95%-100% by 06/24/14. - ADPS will report % of compliance to the UR committee on June 9, 2014 and PAC on 5/21/2014 and 8/20/2014.	

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G 169	Continued From page 18 Patient # 15 (start of care 10/17/13) has diagnoses of Malignant Neoplasm of the Rectum and Insertion of a Vascular Access Device for the administration of Chemotherapy Medications. The record contain documentation of nursing visits conducted by the LPN dated 11/29, 12/02, 12/05 and 12/09/13. The record lacks documentation the RN reviewed the LPN's findings to ensure the provision of appropriate care. Patient # 20 (start of care 09/26/13) has diagnoses of Basal Cell Carcinoma of the Skin, Hypertension and Dementia. The record contains documentation of nursing visits conducted by the LPN dated 11/25 through 11/27, 12/02, 12/04, 12/09, 1211, 12/16, 12/18, 12/23, 12/30/13 and 01/06/14. The record lacks documentation the RN reviewed the LPN's findings to ensure the provision of appropriate care. The findings were confirmed on 01/15/14 with the Assistant Director of Patient Services; no additional evidence was provided.	G 169		
G 224	484.36(c)(1) ASSIGNMENT & DUTIES OF HOME HEALTH AIDE Written patient care instructions for the home health aide must be prepared by the registered nurse or other appropriate professional who is responsible for the supervision of the home health aide under paragraph (d) of this section. This STANDARD is not met as evidenced by:	G 224	All Clinical Staff will be In-serviced on 03/13/14 on updates to HHA/PCA Care Plans to address areas of Fall Risk, Bleeding Precautions, OT Precautions, Blood Sugar Parameters, Diet specifics in allergies when indicated in patient's Plan of Care. All staff will be given a copy of the Audit Tool used to monitor compliance. (Continued on Page 20)	

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G 224	Continued From page 19 Based on review of eight clinical records of patients receiving paraprofessional aide services and staff interview the agency failed to ensure in four out of eight records (Patient # 4, 6, 11, 19) that the aide Plan of Care (POC) was complete to meet the individualized needs of the patient. Failure to ensure the development of a comprehensive aide POC to reflect the patient's needs has the potential to result in inappropriate care, unmet patient needs and possible negative outcomes. Findings include: Patient # 4 (start of care 04/05/13) has diagnoses of Chronic Airway Obstruction, Diabetes and Anxiety. The physician POC for the certification period 12/01/13 through 01/29/14 states the states the patient is utilizing Lifeline (personal emergency response unit). The aide POC (last modified 09/27/13) is incomplete as it fails to include the use of the Lifeline. The physician POC also states "Oxygen (nasal) 3 liters continuous". The aide POC is incomplete as it fails to include the use of the oxygen. Patient #6 (start of care 10/16/13) has diagnoses of Epilepsy, Hemiplegia and Diabetes. The physician POC for the certification period 12/15/13 through 02/12/14 states the states the patient is utilizing Lifeline. The aide POC (last modified 01/07/14) is incomplete as it fails to include the use of the Lifeline. The physician POC states "Pt (patient) continues to have frequent falls (x2 falls in past two	G 224	(Continued from Page 19) All Business Associates will be emailed updates to HHA/PCA Care Plans as stated on page 19, on 03/13/14. Therapy Supervisor will be responsible. Assistant Director of Patient Services (ADPS) will be responsible to facilitate, coordinate and compile all data of the record audit findings to assure compliance with COP. - Record Audit will be done starting week of 03/17/2014, ending week of 08/23/14 - QI Team & Chart Committee Groups will perform Record Audits. o QI Team – 2 CSN, 1 Therapy CSN, 2-QI Assistants, 1-ADPS will review one record each (6)a week for 15 weeks, Total 90 records - Chart Committee – Members of the chart committee are the QI team and the Professional staff on a rotating basis - They will review 70 records starting Mar. 25, 2014, April 8 & 22, 2014; May 6 & 20, 2014 and June 10 & 24, 2014 = Total 70. - Record Audit Total = 160. - Compliance Goal is 95%-100% by 06/24/14. - ADPS will report % of compliance to the UR committee on June 9, 2014 and PAC on 5/21/2014 and 8/20/2014.	

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G 224	Continued From page 20 weeks)". The aide POC is incomplete as it fails to include fall precautions. Patient # 11 (start of care 04/19/12) has diagnoses of Atrial Fibrillation, Hypertension, Congestive Heart Failure and Legal Blindness. The physician POC for the certification period 12/10/13 through 02/07/14 states the patient is utilizing Lifeline. The aide POC (last modified 12/05/13) is incomplete as it fails to include the use of the Lifeline. The physician POC states "Xarelto Oral Tablet (oral anticoagulant) 15 mg (milligrams) 1 Tablet Daily" and lists "anticoagulant precautions" as a safety measure. The aide POC is incomplete as it fails to include these precautions. Patient # 19 (start of care 06/12/13) has diagnoses of Chronic Pain, Cystoscopy, Diabetes, Depressive Disorder and Insertion of a Vascular Access Device. The POC for the certification period 12/09/13 through 02/06/14 states the patient is utilizing Lifeline. The aide POC (last modified 12/06/13) is incomplete as it fails to include the use of the Lifeline. The findings were confirmed on 01/16 and 01/17/14 with the Clinical Supervising Nurses of the Certified Home Health Care Program and the Long Term Home Health Care Program; no additional evidence was provided.	G 224		
G 225	484.36(c)(2) ASSIGNMENT & DUTIES OF HOME HEALTH AIDE	G 225	(See Page 22)	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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FORM APPROVED
OMB NO. 0938-0391

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G 225	Continued From page 21 The home health aide provides services that are ordered by the physician in the plan of care and that the aide is permitted to perform under state law. This STANDARD is not met as evidenced by: Based on review of eight clinical records of patients receiving paraprofessional aide services and staff interview evidence is lacking in three out of eight records (Patient # 4, 11, 19) that services were provided in accordance to the established plan of care (POC). Failure to ensure care is provided in accordance with the POC has the potential to result in incorrect care being provided, unmet patient needs and possible negative outcomes. Findings include: Patient #4 (start of care 04/05/13) has diagnoses of Chronic Airway Obstruction, Diabetes and Anxiety. The aide POC (last modified 09/27/13) states "PCA (personal care aide) to assist with mouth care-tooth brushing. Wash nebulizer and MDI's (multidose inhaler) after patient uses them". The aide activity sheets dated 12/09 through 12/11, 12/13, 12/16 through 12/20, 12/23, 12/24, 12/26 and 12/27/13 lack documented evidence these tasks were completed. Patient # 11 (start of care 04/19/12) has diagnoses of Atrial Fibrillation, Hypertension, Congestive Heart Failure and Legal Blindness. On 01/06 through 01/10/14 the aide documents in the elimination category of the aide activity sheets "apply attend (incontinence brief)". The aide POC	G 225	All Clinical Staff will be In-serviced on 03/13/14 on updates to HHA/PCA Care Plans to address areas of Fall Risk, Bleeding Precautions, OT Precautions, Blood Sugar Parameters, Diet specifics in allergies when indicated in patient's Plan of Care. All staff will be given a copy of the Audit Tool used to monitor compliance. All Business Associates will be emailed updates to HHA/PCA Care Plans as stated on page 19, on 03/13/14. Therapy Supervisor will be responsible. Assistant Director of Patient Services (ADPS) will be responsible to facilitate, coordinate and compile all data of the record audit findings to assure compliance with COP. - Record Audit will be done starting week of 03/17/2014, ending week of 06/23/14 - QI Team & Chart Committee Groups will perform Record Audits. o QI Team – 2 CSN, 1 Therapy CSN, 2-QI Assistants, 1-ADPS will review one record each (6)a week for 15 weeks, Total 90 records - Chart Committee – Members of the chart committee are the QI team and the Professional staff on a rotating basis - They will review 70 records starting Mar. 25, 2014, April 8 & 22, 2014; May 6 & 20, 2014 and June 10 & 24, 2014 = Total 70. - Record Audit Total = 160. - Compliance Goal is 95%-100% by 06/24/14. ADPS will report % of compliance to the UR committee on June 9, 2014 and PAC on 5/21/2014 and 8/20/2014	

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G 225	Continued From page 22 (last modified 12/05/13) does not does not instruct the aide to apply an incontinence brief. Patient # 19 (start of care 06/12/13) has diagnoses of Chronic Pain, Cystoscopy, Diabetes, Depressive Disorder and Insertion of a Vascular Access Device. The aide POC (last modified on 12/06/13) states in the intervention category "Partial/ Full Shower". The aide activity sheets dated 12/09, 12/11, 12/13 and 12/18/13 state the patient received a sponge bath. The findings were confirmed on 01/16 and 01/17/14 with the Clinical Supervising Nurses of the Certified Home Health Care Program and the Long Term Home Health Care Program; no additional evidence was provided.	G 225		
G 236	484.48 CLINICAL RECORDS A clinical record containing pertinent past and current findings in accordance with accepted professional standards is maintained for every patient receiving home health services. In addition to the plan of care, the record contains appropriate identifying information; name of physician; drug, dietary, treatment, and activity orders; signed and dated clinical and progress notes; copies of summary reports sent to the attending physician; and a discharge summary. This STANDARD is not met as evidenced by: Based on clinical record review and staff interview, the agency failed to ensure in eight out of twenty records (Patient # 1, 3, 4, 5, 6, 8, 10, 19) that professional staff maintained an accurate	G 236	Assistant Director of Patient Services (ADPS) will be responsible to facilitate, coordinate and compile all data of the record audit findings to assure compliance with COP. - Record Audit will be done starting week of 03/17/2014, ending week of 06/23/14 - QI Team & Chart Committee Groups will perform Record Audits. o QI Team – 2 CSN, 1 Therapy CSN, 2-QI Assistants, 1-ADPS will review one record each (6)a week for 15 weeks, Total 90 records - Chart Committee – Members of the chart committee are the QI team and the Professional staff on a rotating basis - They will review 70 records starting Mar. 25, 2014, April 8 & 22, 2014; May 6 & 20, 2014 and June 10 & 24, 2014 = Total 70. - Record Audit Total = 160. - Compliance Goal is 95%-100% by 06/24/14. ADPS will report % of compliance to the UR committee on June 9, 2014 and PAC on 5/21/2014 and 8/20/2014	

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G 236	Continued From page 26 Vascular Access Device. The POC for the certification period 12/09/13 through 02/06/14 states "Home Health Aide 3 Visits Every Week For 9 Weeks" and "HHA (home health aide) 2-3 x per week x 1 hour each visit....". The record lacks documented evidence the frequency of visits was clarified to determine the appropriate level of services. The POC states "PT (physical therapy) Evaluation and follow up as needed". The record lacks documented evidence the evaluation was completed or that clarification was obtained to determine if this was an appropriate intervention. The findings were confirmed on 01/16 and 01/17/14 with the Clinical Supervising Nurse; no additional evidence was provided.	G 236		
G 332	484.55(a)(1) INITIAL ASSESSMENT VISIT The initial assessment visit must be held either within 48 hours of referral, or within 48 hours of the patient's return home, or on the physician-ordered start of care date. This STANDARD is not met as evidenced by: Based on clinical record review and staff interview, evidence is lacking in two out of twenty records (Patient # 1, 14) that the initial assessment visit was conducted within 48 hours of receiving the referral for services. Failure to conduct the initial assessment within the required time frame has the potential to result in unmet patient needs and negative patient outcomes. Findings include: Patient # 1 (start of care 07/26/13) has diagnoses	G 332	• All Clinical Staff will be in-serviced on 03/13/14 on Therapy Acceptance Policy, Assistant Director and Therapy Supervisor responsible. • All Business Associates will be emailed Therapy Acceptance Policy, Therapy Supervisor responsible. Assistant Director of Patient Services (ADPS) will be responsible to facilitate, coordinate and compile all data of the record audit findings to assure compliance with COP. - Record Audit will be done starting week of 03/17/2014, ending week of 06/23/14 - QI Team & Chart Committee Groups will perform Record Audits. o QI Team – 2 CSN, 1 Therapy CSN, 2-QI Assistants, 1-ADPS will review one record each (6)a week for 15 weeks, Total 90 records - Chart Committee – Members of the chart committee are the QI team and the Professional staff on a rotating basis - They will review 70 records starting Mar. 25, 2014, April 8 & 22, 2014; May 6 & 20, 2014 and June 10 & 24, 2014 = Total 70. - Record Audit Total = 160. - Compliance Goal is 95%-100% by 06/24/14. - ADPS will report % of compliance to the UR committee on June 9, 2014 and PAC on 5/21/2014 and 6/20/2014.	

New York State Department of Health

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J 404	763.4(a) Policies and Procedures of Service Delivery 763.4 Policies and Procedures of Service Delivery. (a) The agency shall ensure that written policies and procedures, consistent with current professional standards of practice, are developed and implemented for each service and are reviewed and revised as necessary; This Regulation is not met as evidenced by: Based on clinical record review, review of the agency's policy and procedure and staff interview, the agency failed to ensure staff implemented the agency's written policies and procedures. This was evident in three out of twenty records (Patient # 14, 16, 20). Failure to ensure the implementation of the agency's written policies and procedures has the potential to result in incorrect and/or inappropriate care and possible negative patient outcomes. Findings include: The agency's policy entitled "Central Line/Midline Dressing Change" (agency reviewed 05'2011) states as part of the procedure for a dressing change "Measure arm circumference and external catheter - (insertion to hub)". Patient # 16 (start of care 12/27/13) has diagnoses of Sepsis, Portal Pyemia and Insertion of a Vascular Access Device for the administration of antibiotics. The record contains	J 404	Record audits will be performed as noted below. Of the total 160 records: • 5 IV cases will be reviewed for Central / Midline dressing change procedure • Compliance Goal 100% • Completion date by 06/24/14 ADPS will be responsible and will report findings to UR and PAC as noted below. Assistant Director of Patient Services (ADPS) will be responsible to facilitate, coordinate and compile all data of the record audit findings to assure compliance with COP. - Record Audit will be done starting week of 03/17/2014, ending week of 06/23/14 - QI Team & Chart Committee Groups will perform Record Audits. o QI Team – 2 CSN, 1 Therapy CSN, 2-QI Assistants, 1-ADPS will review one record each (6)a week for 15 weeks, Total 90 records - Chart Committee – Members of the chart committee are the QI team and the Professional staff on a rotating basis - They will review 70 records starting Mar. 25, 2014, April 8 & 22, 2014; May 6 & 20, 2014 and June 10 & 24, 2014 = Total 70. - Record Audit Total = 160. - Compliance Goal is 95%-100% by 06/24/14. ADPS will report % of compliance to the UR committee on June 9, 2014 and PAC on 5/21/2014 and 8/20/2014	

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J 404	Continued From page 1	J 404		

documentation the Skilled Nurse performed vascular device dressing changes on 12/31/13 and 01/07/14. The record lacks documented evidence the arm circumference or external line length was measured with these dressing changes.

The finding was confirmed on 01/16/14 with the Clinical Supervising Nurse; no additional evidence was provided.

The agency's policy entitled "PT (physical therapy) Only Cases" (undated) states "To ensure that all patients receiving therapy services for PT, where there are no initial indicated nursing needs, have the medications reviewed for contraindications and duplication by the therapy supervisor who is a PHN (public health nurse)".

Patient # 14 (start of care 11/08/13) has diagnoses of Traumatic Fracture of the Hip and Hypertension and is receiving PT and OT (occupational therapy) services only. The record lacks documented evidence a drug regimen review was conducted by the therapy supervisor/PHN.

The finding was confirmed on 01/15/14 with the Therapy Program Supervisor; no additional evidence was provided.

The agency's policy entitled " Assessment and Documentation of Wounds" (revised 01.2011) states " A complete wound assessment is to be done at least weekly by an RN (registered nurse)

10 Therapy only charts. Of the 160 charts audited will be reviewed for Medication Review for contraindications and duplication by the Therapy Supervisor.

- Compliance Goal 100%
- Completion Date by 06/24/14

ADPS responsible and will report findings to UR as noted below.

Assistant Director of Patient Services (ADPS) will be responsible to facilitate, coordinate and compile all data of the record audit findings to assure compliance with COP.

- Record Audit will be done starting week of 03/17/2014, ending week of 06/23/14

- QI Team & Chart Committee Groups will perform Record Audits.
  - QI Team – 2 CSN, 1 Therapy CSN, 2-QI Assistants, 1-ADPS will review one record each (6)a week for 15 weeks, Total 90 records
- Chart Committee – Members of the chart committee are the QI team and the Professional staff on a rotating basis
- They will review 70 records starting Mar. 25, 2014, April 8 & 22, 2014; May 6 & 20, 2014 and June 10 & 24, 2014 = Total 70.
- Record Audit Total = 160.
- Compliance Goal is 85%-100% by 06/24/14.

ADPS will report % of compliance to the UR committee on June 9, 2014 and PAC on 5/21/2014 and 6/20/2014

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J 404	Continued From page 2 or when there is a significant change in the wound (s)". Patient # 20 (start of care 09/26/13) has diagnoses of Basal Cell Carcinoma of the Skin, Hypertension and Dementia and is receiving nursing services three to five times a week for wound care. The record lacks documented evidence the SN measured the size of the wound the week of 12/22/13. The finding was confirmed on 01/16/14 with the Clinical Supervising Nurse; no additiona evidence was provided.	J 404	J 404 Of the 160 records, 20 records will be audited for Focus Audit on assessment and documentation of wounds. • Compliance Goal 100% • Completion Date by 06/24/14 ADPS responsible and will report findings to UR as noted below. Assistant Director of Patient Services (ADPS) will be responsible to facilitate, coordinate and compile all data of the record audit findings to assure compliance with COP. - Record Audit will be done starting week of 03/17/2014, ending week of 06/23/14 - QI Team & Chart Committee Groups will perform Record Audits. o QI Team – 2 CSN, 1 Therapy CSN, 2-QI Assistants, 1-ADPS will review one record each (6)a week for 15 weeks, Total 90 records - Chart Committee – Members of the chart committee are the QI team and the Professional staff on a rotating basis - They will review 70 records starting Mar. 25, 2014, April 8 & 22, 2014; May 6 & 20, 2014 and June 10 & 24, 2014 = Total 70. - Record Audit Total = 160. - Compliance Goal is 95%-100% by 06/24/14. ADPS will report % of compliance to the UR committee on June 9, 2014 and PAC on 5/21/2014 and 8/20/2014	
J1108	763.11(a)(1) Governing Authority 763.11 Governing authority. (a)The governing authority shall: .... (1) ensure compliance of the agency with the applicable federal, state and local statutes, rules and regulations; This Regulation is not met as evidenced by: Based on a review of the agency's current emergency patient roster and staff interview, evidence is lacking the agency has developed a comprehensive emergency patient roster as outlined in the May 10, 2005 "Dear Administrator Letter". Failure to maintain a comprehensive emergency patient roster has the potential to	J1108	J1108 The "Disaster Responsiveness" roster provides the basic demographic information for the patient as well as an acuity rating to assist in triaging patients in the event that the agency must respond to an emergency situation involving active patients. Our software is remotely hosted which will allow access from any site as long as we have access to the Internet. As part of the Emergency Preparedness Program we are required to have a primary Internet access point as well as two other means by which to access the Internet. By accessing the patient's record we will have access to the emergency contact information as a required data element. • Our software company will be notified that we will need a program change to Disaster Responsiveness roster to include patient emergency contact • We will be notified of the fee for this request from our vendor and this will be presented to our Board of Directors for approval and we will need a resolution so that we can pay the vendor for the upgrade. • Responsibility for this Informatics Coordinator and Director of Patient Services. • Completion date to be determined	

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J1108	Continued From page 3 compromise both the speed and effectiveness of the agency's response to emergency situations, possibly jeopardizing patient and staff safety. Findings include: The current patient roster entitled "Disaster Responsiveness" fails to include any emergency contact telephone numbers of the patient's family and/or caregivers. The finding was confirmed on 01/13/14 with the Assistant Director of Patient Services; no additional evidence was provided.	J1108		
J1140	763.11(a)(8)(ii)(a-b) Governing authority 763.11 Governing authority. (a)The governing authority shall: .... (8) ensure the development and implementation of a patient complaint procedure to include: (ii) review of each complaint, with a written response to all written complaints or oral complaints, if requested by the individual making the oral complaint, to be provided within 15 days of receipt of such complaint: (a) describing the complaint investigation findings and the decisions rendered to date by the agency; and (b) advising the complainant of the right to appeal the outcome of the agency's complaint investigation and the appeal procedure to be followed;	J1140	See attached Complaint Policy • Will be monitored by ADPS as complaints received. This will be ongoing . • Staff will be in-serviced on 3/13-14/14 on Complaint Policy. ADPS will be responsible.	

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J1140	Continued From page 4 This Regulation is not met as evidenced by: Based on review of the agency's policy and procedure and staff interview the agency failed to ensure the development of a complaint policy that contained all required components. Failure to develop a complaint policy with all required components has the potential to jeopardize the complainant's ability to exercise their rights. Findings include: The agency's policy entitled "Complaint Log Policy and Procedure" (last reviewed 01/2013) lacks the following components: - a procedure to ensure that a written response to all written complaints, or oral complaints if requested by the individual making the oral complaint, will be provided by the agency within fifteen days of receipt of the complaint - a procedure to ensure the complainant is advised of the right to appeal the outcome of the agency's complaint investigation and the appeal procedure to be followed (review by a member or committee of the governing authority within 30 days of receipt of the appeal) The findings were confirmed on 01/13/14 with the Assistant Director of Patient Services; no additional evidence was provided.	J1140		
J1260	763.11(f) Governing authority 763.11 Governing authority. (f) Health Provider Network Access and Reporting Requirements. The governing authority of an agency shall obtain from the Department's Health Provider Network (HPN),	J1260	See attached Communication Directory Policy & Procedures • 2014-01-24. DAL letter • 2014-01-24 DAL: HCBS 14-1 Will be monitored by ADPS as stated in policy.	

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J1260	Continued From page 6 The findings were confirmed on 01/13/14 with the Assistant Director of Patient Services; no additional evidence was provided.	J1260		
J1328	763.12(a)(8)(i-iii) Contracts 763.12 Contracts. (a) The governing authority may enter into contracts with individuals, organizations, agencies or facilities, when necessary, to provide or obtain those services required by patients. Such contracts shall specify: .... (8) the following terms and conditions: "Notwithstanding any other provisions in this contract, the agency remains responsible for: (i) ensuring that any service provided pursuant to this contract complies with all pertinent provisions of Federal, State and local statutes, rules and regulations; (ii) planning, coordinating and ensuring the quality of all services provided; and (iii) ensuring adherence to the plan of care established for patients." This Regulation is not met as evidenced by: Based on contract review and staff interview the Governing Authority failed to ensure the "Notwithstanding any other provisions of this contract...." clause was included in 13 out of 25 contracts reviewed (Contract # 2, 3, 4, 6, 7, 9, 10, 11, 13, 14, 17, 21, and 25). Failure to include this clause in contractual arrangements has the potential to result in the agency's inability to ensure compliance with all Federal, State and	J1328	All contracts with Warren County Public Health / Patient Services contracts with therapists will include the required language Notwithstanding any other provision in this contract, the agency remains responsible for : I. Ensuring that any service provided pursuant to this contract complies with all pertinent provisions of Federal, State and local statutes, rules and regulations; II. Planning, coordinating and ensuring the quality of all services provided; and III. Ensuring adherence to the plan of care established for patients. Warren County's attorney's office will be responsible and this office ensures that all service contracts through this department will be amended to include the above. • Completion date unknown	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	337045	A. BUILDING: _____ B. WING _____	01/21/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WARREN CO HLTH SVS CHHA	1340 STATE ROUTE 9 LAKE GEORGE, NY 12845

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
J1328	Continued From page 7 local statutes, rules and regulations and ensure the provision of quality services. Findings include: Contract # 2, 3, 4, 6, 7, 9, 10, 11, 13, 14, 17, 21, and 25 fails to include the "Notwithstanding any other provisions of this contract...." clause. The findings were confirmed on 01/14/14 with the Director of Public Health and Patient Services; no additional evidence was provided.	J1328		
J1412	763.13(c) Personnel 763.13 Personnel. The agency shall ensure for all personnel: .... (c) that the health status of all new personnel is assessed prior to assuming patient care duties. The assessment shall be of sufficient scope to ensure that no person shall assume his/her duties unless he/she is free from a health impairment which is of potential risk to the patient or which might interfere with the performance of his/her duties, including the habituation or addiction to depressants, stimulants, narcotics, alcohol or other drugs or substances which may alter the individual's behavior. This Regulation is not met as evidenced by: Based on personnel file review and staff interview evidence is lacking in twelve out of twelve files (Employee # 1-12) that prior to assuming patient care duties the health status	J1412	See attached Pre-contract physical • Will be monitored by supervisors and ADPS with all new hires starting 02/13/14 and with all Annual Health Assessments starting 03/13/14.	