



SARATOGA COUNTY PUBLIC HEALTH  
**ANNUAL REPORT 2009**

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# *Saratoga County Public Health*

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## *Vision*

*Promote positive health practices for a  
healthy Saratoga County*

## *Mission*

*Assess, improve, and monitor the health  
status of our community*

## ***A Message from the Director .....***

*Saratoga County continues in a constant state of growth and progress, and Saratoga County Public Health Nursing Service is proud to contribute to meeting the health care needs of county residents.*

*In reviewing the events of 2009, I am impressed by the increasing demands placed upon public health agencies to continue to provide quality care and services in the face of funding reductions. Saratoga County Public Health provides quality public health services due to a dedicated and hard working staff within the department. On behalf of these dedicated employees, I am pleased to present the Annual Report for 2009.*

*The demands placed upon us continued to be defined by emerging infectious illness, emergency preparedness activities, an aging population and an ever-increasing proportion of the population suffering from chronic diseases and obesity resulting from poor lifestyle choices. The following pages summarize the efforts of Public Health to meet the needs of the citizens of this county. The report provides an opportunity for individuals to review and evaluate the programs administered through Public Health, as well as the statistical data on these programs.*

*Many successes and challenges occurred in 2009. Successes included: a Technical Assistance Review (TAR) by the NYS Department of Health of our Cities in Readiness Grant that resulted in a score of 97 out of 100; a survey of our Certified and Long Term Home Health Care Programs that showed we continue to provide quality care to our patients; and the completion of the 2010-2013 Community Health Assessment. The 2010-2013 Saratoga County Community Health Assessment, data, executive summary, and the full six-county report can be viewed at [www.arhn.org](http://www.arhn.org). Perhaps the greatest challenge faced by the agency in 2009 was the emergence of the 2009 Novel H1N1 or “swine flu”. As an agency, we were able to activate our emergency preparedness plans and conduct a successful campaign to immunize a vast number of residents of Saratoga County against the virus. We also continued to deal with grant funding reductions, while endeavoring to maintain the current level of services.*

*Goals for 2010 include:*

- Continuing our work with the Adirondack Rural Health Care Network, six neighboring counties, and Saratoga Hospital to focus on the indicators identified in the Community Health Assessment as needing to be addressed in our county.*
- Continuing our collaboration with community partners on Emergency Preparedness initiatives.*
- Continuing our collaboration with community partners on initiatives that serve to improve the health and quality of life for our county residents.*

*It is with the strong commitment and support of the Saratoga County Board of Supervisors, Public Health Committee, Professional Advisory Committee, and County Administrator that, each year, we are able to provide quality care to our residents and offer services to meet their changing health care needs. I want to take this time to extend our grateful appreciation and thanks to all of you for this support. That is what makes Saratoga County the special place it is -- to live and raise a family.*



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**SERVICES PROVIDED BY  
SARATOGA COUNTY PUBLIC HEALTH**

***Preventive Health Care***

- Health Education Programs
- Communicable Disease Control
- Early Intervention Program
- STD Clinic
- Lead Poisoning Prevention Program
- Maternal and Child Health Nursing
- Infant and Children's Health Assessment Program – Ages 0-3
- Synagis Administration Program (Respiratory Syncytial Virus)
- Newborn Home Visits / Well Child Clinics
- Tuberculosis Control Program
- Rabies Control Program
- Physically Handicapped Children's Program (PHCP) and Children With Special Healthcare Needs (CSHCN)
- Healthy Living Partnership
- Emergency Preparedness Planning
- International Travel Clinic
- Saratoga Springs Immunization Clinic (SSIC)

***Certified Home Health Agency (CHHA)***

- Nursing/Case Management/Coordination of Services
- Physical Therapy
- Occupational Therapy
- Medical Social Work
- Nutrition Services
- Speech Pathology
- Home Health Aide

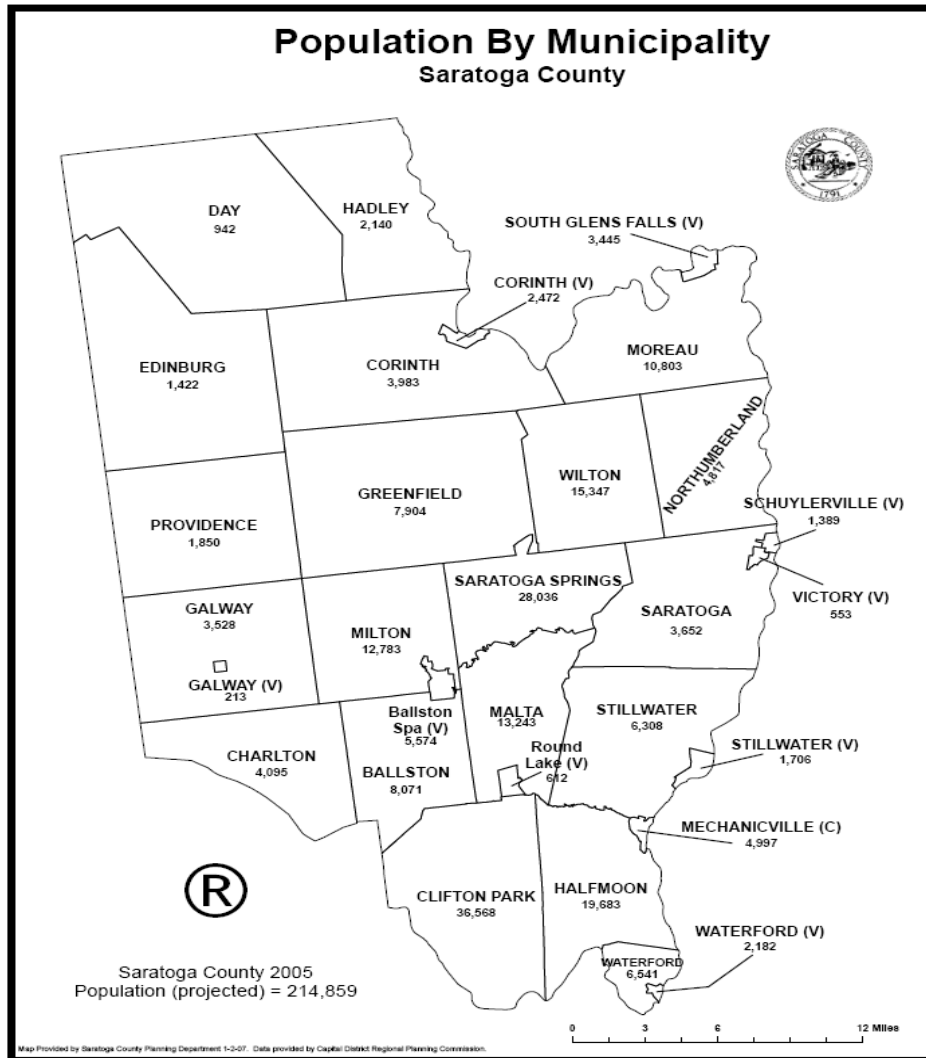
***Long Term Home Health Care Program (LTHHCP)***

In addition to the CHHA services listed above, the LTHHCP provides the following services:

- Personal Care Aide/Home Health Aide
- Homemaker/Housekeeper
- Nursing Case Management
- Medical Social Worker / Nutritional Therapy
- Respiratory Therapy
- Audiology
- Social Day Care
- Home Delivered Meals
- Lifeline

## SARATOGA COUNTY MAP

\*Map provided by Saratoga County Planning Department 01/02/07. Data provided by the Capital District Regional Planning Commission. Population numbers will be updated after the 2010 census numbers are compiled.



## **WHAT IS PUBLIC HEALTH?**

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

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

### **TEN ESSENTIAL PUBLIC HEALTH SERVICES**

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

## **PROFESSIONAL ADVISORY COMMITTEE (PAC)**

The primary purpose of the Professional Advisory Committee (PAC) is to advise the Board of Supervisors (via Public Health) on matters relating to services provided by Saratoga County Public Health.

The Committee membership includes the agency administrator and one or more representatives in each of the following areas: practicing physicians, members knowledgeable about the health care needs of the county, consumer representatives, professional nurses of the agency staff, and professional service therapy providers. Meetings are held four times a year.

The PAC reviews policies pertaining to the delivery of the health care services provided by Saratoga County Public Health and recommends to the Board of Supervisors such policies for adoption.

The PAC is also apprised of Agency quality reviews, receives information pertaining to the Utilization Review Committee, and evaluates the Agency's programs and services.

It is this participation from community members that strengthens the quality of services provided in the community.

We at Public Health want to thank all the committee members, especially Christopher Torino, Committee Chairman, for their dedication and support during 2009. Committee members include:

Patricia Atwell, Consumer  
Maribeth Benenati, PT  
Timothy Brooks, MD  
Lois Bullett, RN  
Robert Christopher, Commissioner of Social Services  
Sandy Cross, Director Office for the Aging  
Desmond DelGiacco, MD  
Diane Grabo, Speech Therapist  
Cynthia Lisuzzo, RN  
Gary Oberg, MD  
Christopher Torino, RT  
Nancy Weber, OT

## **PUBLIC HEALTH COMMITTEE**

Saratoga County Public Health Nursing Service is governed by the Board of Supervisors, which is the legislative body for the county. This Board constitutes the Board of Health, according to Chapter 55 of the New York State Public Health Law.

The Board is responsible for the management, operation, and evaluation of the Public Health Services Agency.

The Board is responsible to ensure compliance of Public Health with the applicable Federal, State and local statutes, rules, and regulations.

A subcommittee of the Saratoga County Board of Supervisors constitutes the Public Health Committee and advises the full Board of Supervisors regarding Health Services' concerns. We appreciate the direction and services provided by the 2009 Public Health Committee members:

Mr. Richard Lucia, Chairperson

Philip Barrett  
Shawn Connelly  
Thomas Richardson  
Patricia Southworth  
Thomas N. Wood, III  
Mindy Wormuth

*We would also like to thank:*

Mr. Arthur Johnson, Board Chairman  
Mr. Willard Peck, Chairman of Law and Finance  
Mr. David Wickerham, County Administrator

**SYNAGIS ADMINISTRATION PROGRAM**  
**(For the Prevention of Respiratory Syncytial Virus)**

Respiratory Syncytial Virus (RSV) is the most common cause of bronchiolitis and pneumonia among infants and children under one year of age. Symptoms include fever, runny nose, cough, and sometimes wheezing. Up to 2% of cases may require hospitalization.

Currently, there is no specific treatment for children with RSV other than management of symptoms. Children with severe disease may require oxygen therapy and mechanical ventilation. The majority of children hospitalized for RSV infection are under six months of age. Most children recover from illness in 8 to 15 days. Some infections may cause complications, which can cause permanent damage to the respiratory system, compromising pulmonary function.

RSV infections usually occur during annual community outbreaks, often lasting 4 – 6 months, during the late fall, winter, or early spring months. The timing and severity of outbreaks in a community vary from year to year. RSV is spread from respiratory secretions through close contact with infected persons or contact with contaminated surfaces or objects.

Current prevention options include good infection control practices and Synagis prophylaxis for children in high-risk groups, i.e. premature infants. Synagis can be given during an RSV outbreak season, October to April, to prevent serious complications from RSV infection.

Our Public Health nurses offer home visits to current patients participating in our programs. Monthly home visits are made to administer the Synagis injections during the outbreak season. Visits are reimbursed by insurance. This is Saratoga County's second year of administering this program.

**Synagis Administration Data**

	<b><u>October – End of 2009</u></b>	<b><u>October – End of 2008</u></b>
Referrals Obtained	67	23
Injections Given	58	46

## MATERNAL CHILD HEALTH PROGRAM (MCH)

The MCH Program provides services to parents and children up to age 18 years. Referrals are received from a variety of sources, such as hospitals, physicians, Women, Infant and Children’s Program (WIC), school district personnel, and clients themselves. Referrals are made to the program on all first-time mothers, breastfeeding mothers, and mothers and infants with health or social concerns. Telephone contact is made and home visits are offered. If the case appears particularly high risk, a visit is automatically attempted.

In general, visits focus on providing parenting information, physical assessment, nutrition, breastfeeding education, safety, dental health, immunizations, family planning, childhood growth and development information, and encouragement of routine primary and preventive medical care. All visits are individualized according to family needs, and the nurses strive to assist families to positively impact concerns they identify for themselves. Nurses work closely with physicians and other service agencies involved with families. Reimbursement for services is pursued, but clients are not billed for services if insurance does not cover visits. Unfortunately, insurance companies are not eager to reimburse for preventive health care because actual savings of hospital days or other medical care cannot be immediately demonstrated. Visits that are covered, especially with private insurance, require large amounts of documentation for reimbursement.

### MATERNAL CHILD VISITS

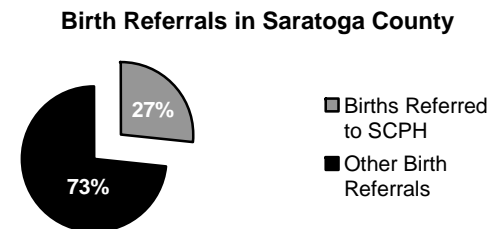
	2009	2008	2007
No Charge or Not Paid By Insurance Plan	839	1038	594
Billable	693	566	395
<b>TOTAL VISITS</b>	1532	1604	989
Amount Billed to Insurance Plans	\$85,188	\$59,288	\$43,743

### SUMMARY OF SERVICES

Year	Newborns Referred	Postpartum Clients Referred	Health Supervision Clients Referred	Antepartum Referrals
2009	614	595	14	46
2008	1,053	1,054	55	33

Forty weeks is considered a full-term pregnancy. Referral numbers indicate unduplicated numbers referred to the program. Telephone contact only may have been made to some clients, while others may have received more than one home visit. A telephone interview tool is utilized to assure that uniformity is promoted and all the same information is allocated when determining the need for visit.

There were 2,310 births in Saratoga County in 2009. Based on that figure, Saratoga County Public Health obtained 614 newborn referrals or 27% of the total birth referrals for Maternal Child Health visits.



## WELL CHILD CLINICS

Well Child Clinics are designed for healthy infants and children up to age six. Infants are checked for proper weight gain, and toddlers are measured and weighed to ascertain if growth is appropriate for age. The provider at the clinic does a physical examination and discusses feeding and development with parents. Immunizations are administered according to the CDC recommended schedule. We are seeing a decrease in the number of Well Child visits due to increased availability of insurances for Well Child exams and immunizations.

<u>WELL CHILD CLINICS</u>	<u>2009</u>	<u>2008</u>	<u>2007</u>
Children Attending for physician visit	10	20	29
Number of Well-Child Clinics held per year	12	8	11

## CHILD FIND

The Child Find Program is a statewide program to assure that children ages six months to three years old, are identified through periodic developmental screenings to receive the help and services needed for the best growth and development in their early years. Referrals to the Early Intervention (EI) Program are based on the screening results. Children can be referred based on their birth history/diagnosis, and/or by physicians, parents, or other social service and health professionals with concerns regarding the child's development.

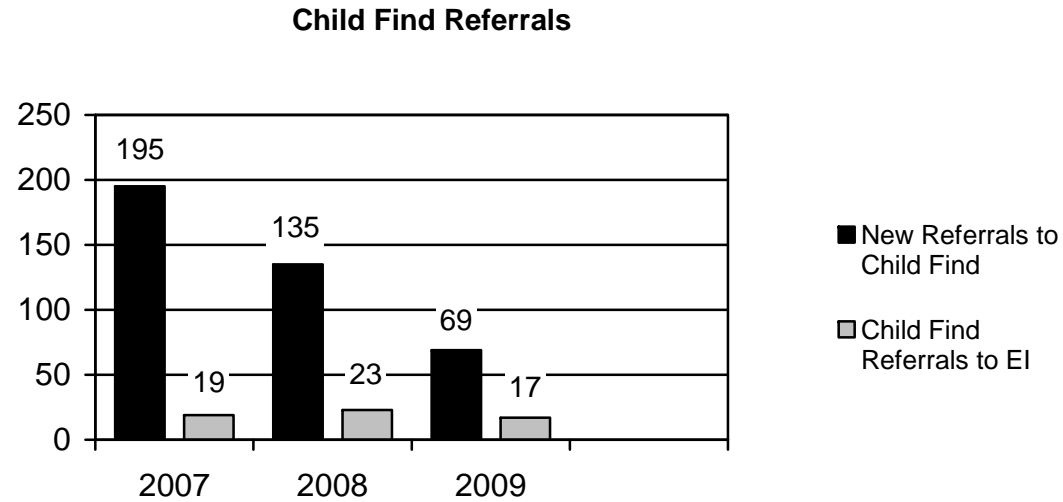
Since the major publicity efforts associated with the Early Intervention Program, parents and other service providers have a heightened awareness to developmental expectations for children and want them monitored, although they may not meet eligibility criteria for Early Intervention Services. Child Find continues to be a very cost-effective program and allows a great deal of opportunity for parent education. Physicians, pediatricians, and family practices in Saratoga County are very invested in the Child Find Program because of the ability the nurse has to do screenings in the home. Much documentation between the Child Find nurse and the physician is evident in this program. NYS Department of Health encourages physicians to do developmental screens on children during routine comprehensive well child care. Unfortunately, some of the most high-risk children do not see physicians regularly for preventive care – only for episodic acute care for illness. Thus, the important service provided by the Child Find nurse must be continued as a valued part of the Child Find Program.

<u>Year</u>	<u>New Referrals</u>	<u>Moved</u>	<u>Referred To EI</u>	<u>Refused Services</u>	<u>Improved/ Aged Out</u>	<u>Unable to Locate</u>	<u>Adopted Out</u>
2007	195	13	19	14	27	-	-
2008	135	18	23	43	32	-	-
2009	69	11	17	49	31	2	1

*(Continued)*

*Child Find (Continued)*

Even though there were fewer referrals made to the Child Find Program, more of these Child Find referrals were then made to Early Intervention.



Many families show an interest in the Child Find Program. Child Find is a parent-driven program. At four months of age, the parent(s) are sent a questionnaire to complete. It is at this interval that we see the lack of follow through by the parents.

## **EMERGENCY PREPAREDNESS PROGRAM**

In 2009, Saratoga County Public Health continued with outreach and planning with our community partners. The grant renewal continues with “deliverables” required by NYS Department of Health. We recall that the events of September 11, 2001 brought expectations from the federal and state level to the county level, for an “all hazards” approach to preparedness. New York State provides the guidelines, formats, and deliverable dates to assist the counties in emergency preparedness planning activities. Saratoga County was added to the Metropolitan Statistical Area Cities’ Readiness Initiative (MSA CRI) in October 2007, along with Albany, Schenectady, Rensselaer, and Schoharie counties. This is a labor intensive program for Saratoga County that builds on the deliverables by adding a requirement to prepare for an emergency event that may require the mass prophylaxis of the entire population within 48 hours of an all-hazards type of event. This includes an annual audit from the Center for Disease Control (CDC) and/or NYSDOH, utilizing a Technical Assistance Review Tool to measure compliance. The results of the audit may be published in an annual report by the CDC and Trust for America’s Health, a non-profit, non-partisan health advocacy organization. This grant cycle allotted another stream of funding to respond to the 2009 Novel H1N1 influenza campaign.

**Activities:** Saratoga County Public Health Nursing Services (SCPHNS) is an active member of the Saratoga Countywide Emergency Preparedness Committee (SCWEPC) that has met on a monthly basis since its formation in 2004. The committee meets quarterly, but during November, 2009 and December 2009, the Pandemic subcommittee met more often as the 2009 Novel H1N1 influenza spread to our area. Subcommittees will meet more frequently, as needed, and report any updates to the committee. The SCWEPC consists of representatives from Saratoga Hospital, the Medical Reserve Corps (MRC), Saratoga County Economic Opportunity Council, Wesley Health Care Center, Four Winds Hospital, Skidmore College, Ballston Spa Schools, Saratoga Springs Police Department, Knolls Atomic Power Lab (KAPL), Community Emergency Corps, Burke Funeral Home, County Coroner, NYS Police, Saratoga County Emergency Services, Saratoga County Sheriff, and a Saratoga Springs Supervisor.

- SCPHNS has organized the Special Needs Subcommittee to work with community partners in the identification of special needs populations and development of temporary shelter plans for them. SCPHNS continues to work with identifying the special needs populations in our county, e.g. nursing homes, the County Jail, Saratoga Bridges/AIM/DDSO and Four Winds Hospital. Plans have been formulated to assist these facilities with vaccination of their populations within their facilities during an emergency event. These groups sent representatives to the Pandemic subcommittee when meetings were increased due to the actual 2009 Novel H1N1 pandemic.
- The Strategic National Stockpile (SNS) Subcommittee has been active, and Saratoga Hospital utilized the assets during the 2009 Novel H1N1 pandemic. Due to our planning and past exercises, the process worked as planned and drilled.
- Photo ID badges for volunteers continue to be processed with the assistance of Saratoga County Emergency Services.
- A volunteer newsletter continues to be sent out quarterly.
- Throughout the 2009 Novel H1N1 pandemic, our volunteers were activated for response to staffing, telephone triage, appointments and information, and to assist with staffing our point of dispensing sites (PODS).

*(Continued)*

## **EMERGENCY PREPAREDNESS PROGRAM**

*(Continued)*

### **2009 Novel H1N1:**

- SCPHNS, along with Clifton Park/Halfmoon Emergency Corps, Community Emergency Corps, Moreau Emergency Corps, Saratoga County Sheriff, and Saratoga County Public Works, held three closed point of dispensing (POD) clinics in November 2009. It was offered for first responders and their families, along with other town employees. Due to the past planning with the EMS in Saratoga County, we were one of the only public health agencies to work with our county EMS. Emergency Services and Saratoga County Public Health have drilled PODs in past years, so all were familiar with the roles and responsibilities. The Community Emergency Response Team (CERT) and Public Health volunteers were utilized, which enabled us to provide the mass vaccinations for EMS.
- Saratoga County set up 2009 Novel H1N1 influenza vaccination PODS at our office initially. Once vaccine was more readily available, we then set up PODS in each school district.
- We participated in several alert notification drills to test our ability to receive and send messages via the NYS Commerce Network.

**Deliverables:** The emergency preparedness plan has developed as the guidelines have been met and the “deliverables” requested by NYSDOH completed. These included:

- SCPHNS, along with community partners, has updated the SNS Plan as required in the plan.
- A Technical Assistance Review Tool (TAR) Audit was done as part of the CRI Grant in May 2009. We received a score of 97%.

**Respirator Program:** The purpose of this program is to ensure that all employees required to wear respiratory protection as a condition of their employment are protected from respiratory hazards through the proper use of respirators.

- All staff have been fit tested.
- The fit test machine was recalibrated.
- Annual fit testing review is now required per OSHA and PESH guidelines.
- More fit testing will be offered to other groups in need, as identified by the 2009 Novel H1N1 pandemic.

## **Emergency Preparedness - H1N1 Campaign, 2009**

The Novel H1N1 influenza virus started circulating in the United States in April 2009. Most of the population of the United States did not have immunity to this virus. In June 2009, the spread of Novel H1N1 became worldwide, and the World Health Organization declared a pandemic. It has also been called the “swine flu” because part of its genetic makeup originated in pigs.

Once the Novel H1N1 influenza was identified, a novel H1N1 influenza vaccine was developed and manufacturing began. The five manufacturers that produce seasonal influenza vaccine produced the Novel H1N1 vaccine. While production continued, there were simultaneous clinical trials. Information from the trials started coming in during September 2009, and vaccine was to be available in October, 2009. The Novel H1N1 vaccine first became available in small amounts in October 2009. Only priority groups considered at highest risk for serious illness from the flu were the first to be immunized.

In October, Governor Patterson issued Executive Order No. 29 declaring a disaster emergency in the State of New York for the purpose of facilitating the timely distribution and administration of 2009 H1N1 influenza vaccine. This order would be renewed every thirty days until the pandemic recovery phase.

Upon the declaration of the pandemic, Saratoga County Public Health Emergency Preparedness staff and Prevention staff set up H1N1 vaccine clinics. Unfortunately, the slow distribution of vaccine prevented open point of dispensing (POD) sites. We began staffing closed PODs for priority groups only. Full and part-time staff was utilized for staffing. Funding provided by CDC through NYS Department of Health enabled us to hire two part-time RNs to assist with clinic staffing. This freed us from having to re-assign current staff from other programs and allowed us to keep all services stable. Medical Reserve Corps volunteers were utilized, along with NYSDOH staff, who graciously signed up to assist with staffing. Clinics were initially held at our 31 Woodlawn Avenue, Saratoga Springs office, utilizing all available space, starting with registration, through vaccination and discharge. All of the supporting documentation was organized, from the initiation of the CDMS registration form down to the special vaccine barcode labels. Clinics will continue into 2010, as long as there is a declared emergency and residents are requesting vaccine.

<b>H1N1 Clinic Data for 2009</b>	
Number of H1N1 clinics held at Saratoga County Public Health	27
Number of vaccines given to adults > 19 years of age	2927
Number of School clinics	3
Number of EMS clinics	3

## INTERNATIONAL TRAVEL PROGRAM

Saratoga County Public Health provides immunization services for people planning to travel internationally. In addition, immunization services are also available for adults who may require immunizations for work or college.

A clinic is held once weekly, by appointment, on Wednesdays. It is important to plan well in advance to receive travel immunizations to ensure maximum protection. It is recommended that you have an appointment 4-6 weeks prior to travel.

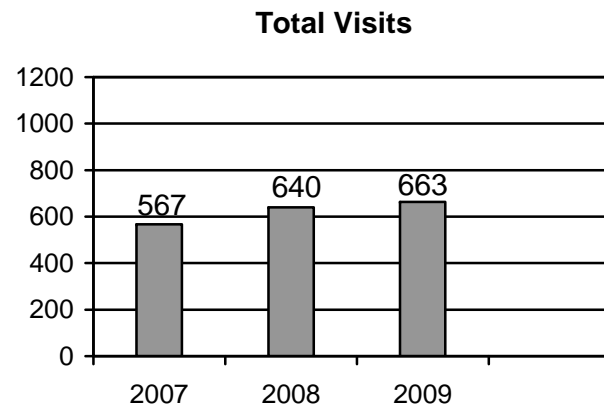
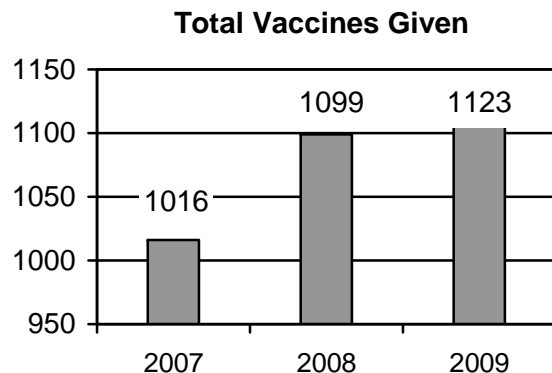
Some countries require Yellow Fever Immunization, while other immunizations are recommended to help travelers remain healthy while traveling. The clinical program staff researches your travel destination and provides information to the traveler.

Immunizations provided through the clinic include Yellow Fever, Typhoid, Hepatitis A and B, Polio, MMR, Tetanus, Diphtheria, Pertussis, Varicella, Herpes Zostavax, Rabies, Meningococcal, Japanese Encephalitis, Influenza, Pneumococcal, and Immune Globulin. Malaria prophylaxis information is provided; however, travelers will need to obtain a prescription from their provider to be filled at a pharmacy.

Costs for the clinic can include a consultation fee, as well as a vaccine fee and an administration fee. Also, there is an additional fee for those who do not live or work in Saratoga County.

For more information or to schedule an appointment you can call 584-7460 Monday through Friday from 8:00 a.m. to 4:00 p.m.

	<u>2009</u>	<u>2008</u>	<u>2007</u>
Unduplicated Count	477	505	388
Total Visits	663	640	567
Total Vaccines Given	1123	1099	1016



## **PHYSICALLY HANDICAPPED CHILDREN'S PROGRAM (PHCP)**

The Physically Handicapped Children's Program (PHCP) is a county-based program administered by the Bureau of Child and Adolescent Health, a division of the New York State Department of Health. The major purpose of PHCP is to ensure access to quality health care for chronically ill and physically disabled children. The program serves children from birth through age 21 years old, as well as adults with a diagnosis of polio. In order for a child to be eligible for the program, he or she must have a medical diagnosis and have been denied Medicaid. Children with other forms of medical insurance may be eligible for the program, but the PHCP is the payer of last resort. In these cases, PHCP is helpful to children and families in assisting with insurance deductibles or where insurance only covers a portion of the medical bill. Saratoga County Public Health has a program eligibility fee schedule based on family income. Income dependent families share, if indicated, in payments made by the PHCP.

### **Examples of Services Covered by the Physically Handicapped Children's Program:**

- Hospital Inpatient
- Hospital Outpatient Clinic/D & T Center
- Ambulatory Surgery
- Physician Office (visits for reasons regarding medical diagnosis)
- Home Health Services
- Durable Medical Equipment (lease/purchase/repair)
- Hearing Aids (including batteries)
- Transportation
- Drugs
- Out-of-State Authorizations for Special Procedures (limited basis)
- Special Diagnostic and Evaluation Services
- Orthodontics
- Cystic Fibrosis

These occur on a limited basis and must have the child's primary care physician's authorization and rationale and review or signature of the PHCP Medical Director. Generally, these referrals have been for speech and hearing evaluations when private health insurance did not cover. More than half of the children participate in the orthodontic portion of PHCP. Reimbursement is made by the PHCP for services at the Medicaid rate.

A total of 37 children participated in the Physically Handicapped Children's Program in 2009.

## **CHILDREN WITH SPECIAL HEALTH CARE NEEDS PROGRAM (CSHCN)**

### *A Historical Perspective*

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

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

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

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

The work group discussed the necessary elements of a comprehensive, integrated private and public health system that would improve the health of CSHCN by addressing the key issues. The work group adopted the following definition of children with special health care needs:

*Children with special health care needs are those children 0 – 21 years of age who have or are expected to have a serious or chronic physical, developmental, behavioral, or emotional condition and who also require health and related services of a type or amount beyond that required by children generally. This definition is broader than the definition currently used by the Physically Handicapped Children's Program (PHCP)*

New York State has a long history of concern for the health of all children, including those with special health care needs. The Health Department's involvement with children with disabilities dates back to polio clinics held in the beginning of the century. We continually assess our programs for children and align our public health and children advocate stakeholders with the broader child health vision. New York State is committed to

*(Continued)*

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

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

New York State Department of Health continues to provide funding to counties to facilitate the transition process of the Physically Handicapped Children's Program (PHCP) to the Children with Special Health Care Needs (CSHCN) Program. Counties are responsible for submitting quarterly data to the NYS Department of Health that identify the types of children's health problems involved with children participating in the PHCP. The goal is to identify "gaps" with insurance coverage for children's services, i.e. what types of things are not covered by insurance plans and what is the resultant impact on the involved child's health. At this point, the CSHCN Program is additional funding with additional clerical and reporting responsibilities for the county. The PHCP reimbursement mechanism remains unchanged.

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

## **LEAD POISONING PREVENTION PROGRAM**

Saratoga County has a Lead Poisoning Prevention Program funded by a NYS Department of Health grant. Key components of the program include education, screening, and follow up. Saratoga County Public Health is responsible for submitting the annual work plan and quarterly reports.

Lead poisoning can cause damage to the neurological system. Lead exposure at low levels has been known to cause anemia, growth and development deficiencies, mental impairment, irritability, and hyperactivity. Decreased IQ scores have also been associated with lead exposure. High levels can be severe and cause seizures, coma, and death.

Lead exposure is preventable if common sources are known. In addition, routine screening (blood tests) can diagnose cases prior to onset of symptoms, providing an opportunity to remove the hazard before serious complications. Prevention and screening are the focus of educational efforts.

Education: Health care providers are contacted annually to encourage screening and reporting of cases. Childcare providers are educated on lead, possible sources, and screening requirements. Parents are targeted through associations, health fairs, and informational calls to Public Health. Many pamphlets are available. Informal sessions are held quarterly to parents and groups at the Saratoga Springs Public Library.

Screening: NYS Department of Health requires lead testing (blood test) for all one and two year olds for lead exposure. Medical care providers are encouraged to test children six months to six years old with risk of lead exposure and are required to test all one and two year olds. Child care providers are encouraged to educate parents on lead screening if the child has not been screened prior to enrollment. Public Health will make arrangements for the test and cover the cost if there is a financial hardship preventing the family from getting a child tested.

Follow up: All children are tracked in the NYS Department of Health web based LeadWeb System. All lab results are entered in the system electronically, which updates the program as results are received.

- Lead level 10 – 15 mcg/dl: An elevated letter and educational packet is sent. A reminder letter is sent every three months for retest until the child is considered stable (two tests within normal limits or three lower than 15 mcg/dl). Preventative and dietary guidelines are reviewed. A phone call to family to complete a lead risk assessment and exposure history. A home visit is also offered for education and prevention information.
- Lead level 15 mcg/dl or higher: Same as above with the addition of an environmental referral to NYS Department of Health District Office for testing.

Services offered by Public Health are at no cost to the family. The Lead Poisoning Prevention Program provides a great service to the community especially to affected families. Despite educational efforts, services are not fully utilized. Referrals are received from a variety of sources, i.e., parents, medical care providers, childcare providers, Head Start, WIC, and other Public Health programs.

*(Continued)*

Upstate Medical Center in Syracuse is now the Regional Resource Center. They have been supportive in getting out newsletters to be used by local health departments in the community.

Health fairs were popular this year, where lead information, literature, pencils, and magnets were distributed to families. Many of these health fairs were tied to the night of the School Board budget voting or to a PTA sponsored event.

We are notified regularly of consumer product recalls concerning products that have been identified as containing lead. This information is then distributed to local providers.

The New York State Department of Health's theme at Halloween was "*Is Your House Haunted with Lead?*" A banner with that saying was made and displayed at immunization clinics, as well as all other clinics.

In January 2009, it was identified that teenagers in two towns had elevated blood lead levels. Upon investigation, it was found that these students participated in shooting at rod and gun clubs. Parents in the towns were given information entitled "*Aim at Lead Safety.*"

Spring of 2009 brought lead information to the Franklin Community Center. This information was formally presented to a group of young teenage mothers. Lead and toy safety was the topic. It was well received.

The Lead Coordinator attended a two-day training course in Albany entitled "*Essentials for Healthy Housing.*"

During the summer, Public Health provided an update to pediatricians and the nurses staffing the pediatric office of Capital Care Pediatrics in Clifton Park. This hour-long presentation reviewed the new guidelines associated with the lowering of the lead value.

In the fall, we worked with Saratoga County Head Start to identify children who have not had mandated lead testing. Seven children were tested. Hand washing education was provided, with age-appropriate teaching tools and materials.

*(Continued)*

## LEAD SCREENING PROGRAM STATISTICS

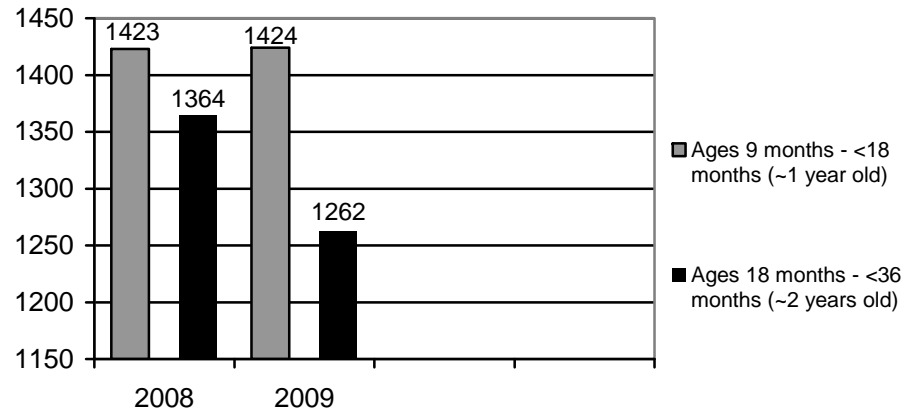
	2009	2008	2007
Total Initial Screenings (aged 9 months to 6 years)*	2,915	3,235	2,950
SCPHNS Lead Clinics	2	4	3
Children Screened at Public Health Clinics (Per LeadWeb Program)	9	16	4
Total Abnormal lead Values	29	11	9
Low (10 – 14 mcg/dl)	24	7	7
Moderate (15 – 19 mcg/dl)	4	3	0
High (>20 mcg/dl)	1	1	2

\*Statistical data from LeadWeb system

Blood Lead Screening Tests by Age Group Category  
(During the Selected Time Frame – 01/01/09 to 12/31/09)

Age (Months) at Blood Lead Draw	Screening Tests	
	2009	2008
<9 (before age one)	33	18
9 - <18 (at or around age one)	1,424	1,423
18 - <36 (at or around age two)	1,262	1,364
36 - <48	119	146
48 - <60	69	102
60 - <72	41	55
72+	106	127
<b>TOTAL</b>	<b>3,054</b>	<b>3,235</b>

**Blood Lead Screening Tests By Age**



## TUBERCULOSIS PROGRAM

Tuberculosis Skin Testing (TST) is offered on Mondays and Tuesdays to any Saratoga County resident requesting it. A fee of \$10 per test is charged. Agencies whose personnel must be screened for Tuberculosis also may request screening by Saratoga County Public Health.

Saratoga County Health Services is required to pay for preventive therapy medication for individuals who have Latent Tuberculosis infection or active Tuberculosis disease and have no insurance to cover the cost of medication. This is done in an attempt to assure compliance with prescribed treatment. Desmond DeGiaco, MD, is the medical consultant for the program and follows those individuals needing treatment. Saratoga County maintains an agreement with a local pharmacy whereby the agency is billed at the Medicaid rate for the medications which are not covered by private insurance.

<b>Year</b>	<b>Individuals Tested</b>	<b>Active TB Clients During Year</b>	<b>TB Suspect Cases</b>	<b>Total Home Visits to TB Patients</b>	<b>Total Visits to Chest Clinic</b>	<b>New Patients Seen at Chest Clinic</b>
2007	1,430	1	13	15	280	57
2008	1,279	2	11	212	312	57
2009	1,499	3	8	180	287	67

For 2009, note that there were a total of 1,499 skin tests performed. A total of 357 were administered at Public Health, 994 at the County Jail and 100 skin tests were administered off site, i.e. Shelters of Saratoga, Saratoga Race Trace and the Soup Kitchen.

A total of 48 TB screens were done for the Saratoga Springs School District.

As noted, there were 3 new cases of active TB. One was pulmonary and two were extrapulmonary.

## **RABIES PROGRAM**

The Rabies Program provides for the timely surveillance, education, and control to county residents exposed to or who have had an encounter putting them at risk for rabies. All animal bites/exposures are mandated by Public Health Law to be reported to the victim's county of residence. As of November 2002, a law went into effect requiring dogs, cats and ferrets to be vaccinated against rabies by the age of four months.

Once we receive notice of a bite or encounter, we gather the necessary data to assure the victim does not contract rabies. We give approval for the testing of any animal suspect, provide approval for post-exposure rabies prophylaxis, and can provide the vaccinations, if necessary. Regarding rabies prevention, we are able to facilitate the necessary testing for rabies titers and offer pre-exposure rabies vaccinations and boosters to veterinarians, staff, animal control officers, and Saratoga County Animal Shelter staff.

We work closely with the Saratoga County Animal Shelter on specimens to be sent for testing, animal ten-day confinement, and coordination of animal control issues. Saratoga County Public Health continues to deliver education, communicate with medical providers, animal control officers, and veterinarians to assure that the public health is protected against rabies.

<b>Year</b>	<b>Number of Bites Reported</b>	<b>Number of Animals Tested</b>	<b>Number of People Receiving PEP</b>	<b>Number of Animals Testing Positive for Rabies</b>
2003	411	134	53	14
2004	494	162	80	8
2005	624	195	72	14
2006	770	239	88	27
2007	857	236	99	24
2008	775	191	77	20
*2009	588	183	104	20

\*2009 – Although less bites were reported, we saw a 66% increase in people receiving PEP (Post-Exposure Prophylaxis), which was due to two separate encounters with baby raccoons. Although cute, they do carry rabies and this required over thirty people to receive treatment.

## **IMMUNIZATION ACTION PLAN (IAP)**

Saratoga County Public Health continues to participate as one of the members of a seven county consortium whose mission is to address the immunization status of our children. The Upper Hudson Primary Care Consortium serves as the coordinator for this endeavor. County health department officials meet regularly with Upper Hudson Consortium staff to review progress of the objectives and to identify changes and concerns as they occur. Each county individualizes the objectives to meet their own county's needs. Funding is allocated to each county based on individual needs.

The objectives identified for the Immunization Action Plan are as follows:

1. Collaboration: To establish and/or maintain a collaborative effort which includes public and private health care providers, businesses, community leaders, ethnic, racial, and religious organizations, voluntary and service organizations, and media affiliates to improve immunization rates and to coordinate service delivery.
2. To utilize the Provider Based Immunization Initiative (PBII) assessments and follow-up visits with private health care providers for the purpose of assessing immunization rates and the standards of pediatric immunization practices.
3. To assess county public clinic immunization rates annually and to report results.
4. Conduct education and outreach activities to inform health care professionals, daycare providers, other interested groups, and the public about the benefits of up-to-date immunization for children and adolescents.
5. To collaborate with the county Lead Screening Program to provide physician education to improve lead screening practices.
6. Increase awareness of the benefits of adult immunization against influenza, pneumococcal, Hepatitis B, Td, and varicella diseases.
7. Increase awareness of the benefits of Hepatitis A and B vaccination for high-risk adults through participation in the "Adult Hepatitis Vaccination Program."
8. Foster and support New York State's effort to implement a statewide immunization registry. NYSIIS is the acronym for the New York State Immunization Information System. NYSIIS is a free, web-based statewide immunization information system, also called a registry, which maintains computerized immunization data of persons of all ages in a confidential and secure manner. This is a mandate for children 19 years and younger since August 2006.
9. To provide immunization services in locations and at hours that facilitates immunization of children and adults in targeted communities.
10. To provide a resource for the community to obtain information on routine vaccines, as well as vaccines for travel.

## SEXUALLY TRANSMITTED DISEASE (STD) CLINIC

Saratoga County Public Health Preventative Services provides an STD Clinic for the residents of Saratoga County. It is our service goal to improve the health status of our county and promote healthy lifestyles.

The STD clinic is held weekly in Ballston Spa on Wednesdays from 1:15 – 4:00 p.m. The walk-in clinic is free and confidential and provides testing and treatment of STDs. Confidential HIV testing and counseling is provided. Emotional support and education is offered to patients and their families. Referrals are made according to each client’s needs.

### Sexually Transmitted Disease Clinic Statistics for 2009

Month	Clinics Held		Total Clinic Attendance		HIV Tests		STD Tests		Sex				New		Positive Results						
	2008	2009	2008	2009	2008	2009	2008	2009	2008		2009		2008	2009	Gonorrhea		Chlamydia		Syphilis		
									M	F	M	F			2008	2009	2008	2009	2008	2009	
January	5	4	30	26	18	20	4	42	22	8	22	4	25	24	0	1	0	0	0	0	0
February	4	4	16	25	11	10	14	40	13	3	22	3	8	16	1	0	0	2	0	0	1
March	4	4	25	23	13	11	26	51	18	7	21	2	20	17	0	0	1	1	1	1	
April	5	5	32	26	15	13	62	61	16	16	25	1	19	18	1	0	1	0	1	0	
May	4	4	30	33	14	21	52	64	22	8	25	8	23	23	0	0	1	0	1	0	
June	4	3	21	31	14	5	33	40	16	5	23	8	14	18	0	0	0	0	0	0	
July	4	5	28	17	12	10	47	22	21	7	12	5	19	10	1	0	1	0	0	0	
August	4	4	27	26	15	16	58	56	15	12	15	11	18	17	2	0	1	0	0	0	
September	4	5	21	27	10	13	32	42	18	3	20	7	17	20	0	0	1	0	0	0	
October	5	4	31	22	13	10	51	28	21	10	15	7	18	14	0	0	0	0	0	0	
November	3	2	13	24	9	13	31	44	11	2	15	9	9	15	0	0	0	0	0	0	
December	2	5	25	31	10	17	24	45	18	7	21	10	8	10	0	0	0	1	0	0	
<b>TOTALS</b>	<b>48</b>	<b>49</b>	<b>299</b>	<b>311</b>	<b>154</b>	<b>159</b>	<b>434</b>	<b>535</b>	<b>211</b>	<b>88</b>	<b>236</b>	<b>75</b>	<b>198</b>	<b>202</b>	<b>5</b>	<b>1</b>	<b>6</b>	<b>4</b>	<b>3</b>	<b>2</b>	

(Continued)

The New York State Health Department conducted two anonymous HIV Rapid Test Clinics on June 15, 2009 and June 22, 2009. The HIV Rapid Test Clinics were held at 31 Woodlawn Avenue, Saratoga Springs, NY

The total number of inmates attending the STD Clinic for 2009 was 42.

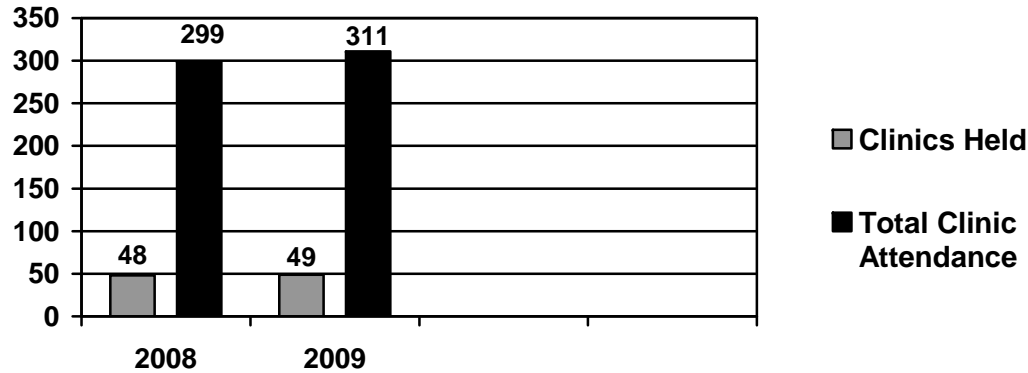
The STD Clinic participates in the NYS Department of Health Free Hepatitis Program. Hepatitis vaccines (Twinrix) are offered to all clients. An important component of the clinic is education regarding safer sex practices.

**Twinrix Vaccine Statistics (Hep A & B)**

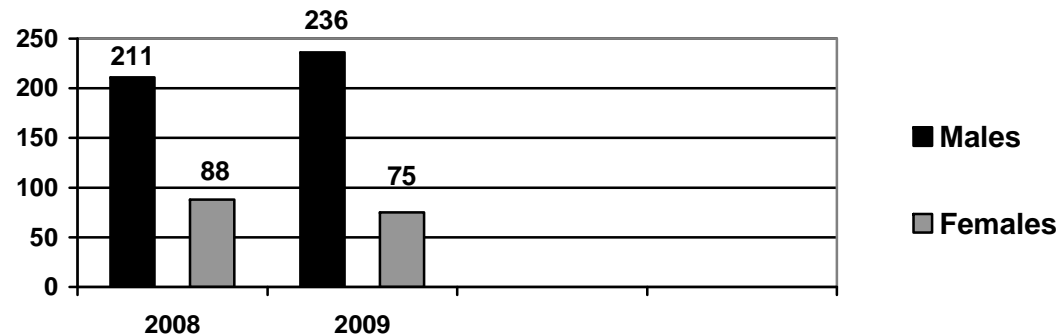
<b>Month</b>	<b><u>2008</u></b>	<b><u>2009</u></b>	<b><u>2008</u></b>	<b><u>2009</u></b>	<b><u>2008</u></b>	<b><u>2009</u></b>
	<b>#1</b>		<b>#2</b>		<b>#3</b>	
January	4	4	2	0	0	1
February	1	3	1	3	1	0
March	2	5	1	1	2	0
April	4	2	1	5	3	1
May	4	4	0	3	2	2
June	3	5	2	3	0	2
July	6	2	4	3	2	0
August	8	4	3	1	0	0
September	2	2	0	1	0	2
October	5	2	4	1	2	1
November	1	3	0	1	0	0
December	3	2	7	0	3	2
<b>TOTALS</b>	<b>43</b>	<b>38</b>	<b>25</b>	<b>22</b>	<b>15</b>	<b>11</b>

## STD Clinics By The Numbers

### Clinics Held / Total Attendance

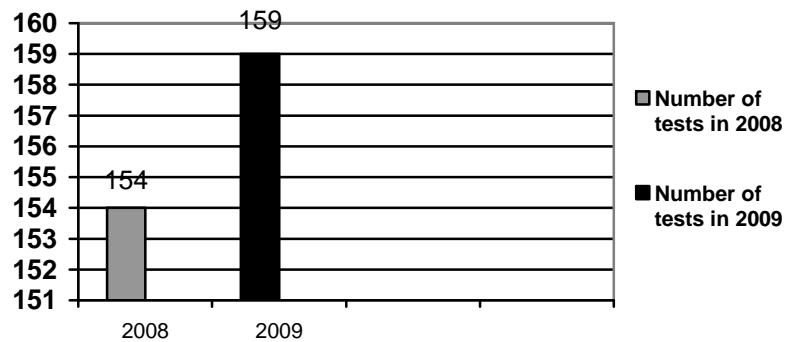


### STD Clinic Use By Gender

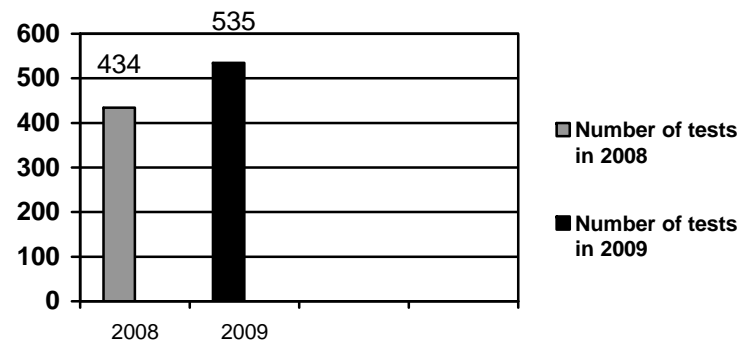


\*The graph "Clinic Use By Gender" represents the total number of patients that attend the STD Clinic. These numbers are not exclusive to people seeking only HIV testing/information. Anyone attending the clinic for HIV or STD or a combination of HIV/STD testing/information is included in these numbers.

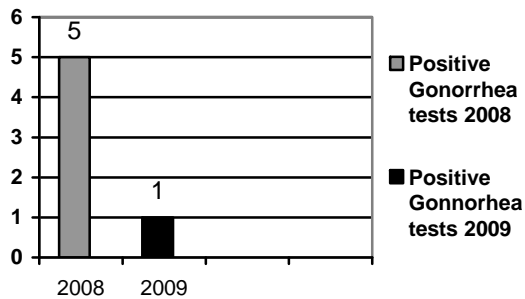
### HIV Tests



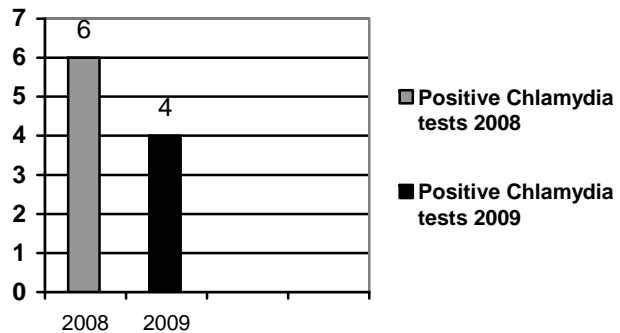
### STD Tests



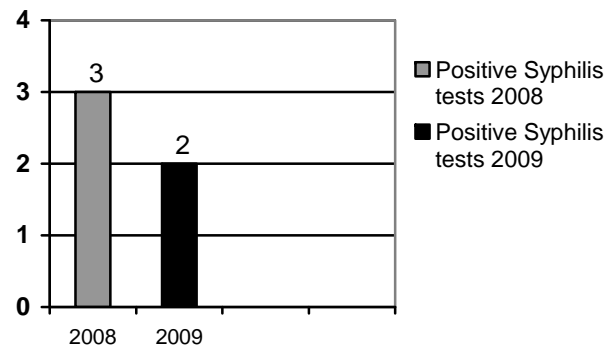
### Positive Gonorrhea Tests



### Positive Chlamydia Tests



### Positive Syphilis Tests



## **HEALTH SCREENING CLINICS**

Saratoga County Public Health Nursing Service offers health screening programs to elderly residents of Saratoga County (age 60 and over) at multi-purpose senior citizen centers and congregate nutrition sites located throughout the county. The health screening clinics include cholesterol, glucose, and hypertension screening.

### **HEALTH SCREENING CLINIC ATTENDANCE**

Site	2009	2008	2007
Raymond Watkins	11	32	13
Waterford Senior Center	7	8	15
Midtown Apartments	7	15	10
Corinth Senior Center	15	23	13
Stonequist Apartments	12	14	10
Galway Senior Center	14	20	5
Greenfield Community Center	8	17	-
Mechanicville Senior Center	23	56	42
Moreau Community Center	37	37	26
Clifton Park Senior Center	48	73	30
Edinburg Town Hall	12	30	21
Doubleday Woods	9	17	17
Milton Community Center	3	24	-
Hadley Town Hall	5	14	-
Halfmoon Senior Center	46	20	35
Malta Senior Center	11	8	10
Burnt Hills United Methodist Church	8	6	-
Bishop Hubbard Apartments	9	5	14
Saratoga County Senior Center	24	17	32
<b>TOTALS</b>	<b>309</b>	<b>436</b>	<b>293</b>

Although our total clinic attendance for 2009 was down significantly from 2008, these health screening clinics offer services to the elderly that do not require payment of an office co-pay. For five of the sites, the number we tested was up from the 2008 attendance.

*(Continued)*

Health Screening Clinics are also held at various County buildings throughout the year. Employees have the opportunity to have their blood pressure, glucose, and cholesterol tested free of charge. These other clinics were held in 2009 as follows:

<u>County Building Site</u>	<u>Number Attending</u>
Saratoga County Public Health	10
Dept. of Public Works	19
Solar Building	21
Dept. of Social Services	25
Sewer District	11

## **INFLUENZA CLINICS – 2009**

Trivalent influenza vaccine is offered each year in the fall. The groups most considered at risk for complications related to influenza or “flu” are senior citizens and adults and children with chronic illness requiring regular medical follow up, especially diabetes. Health education for the public is targeted to heighten individual awareness for the need to prevent and control the impact of influenza. Individuals may receive this immunization through their physician, Public Health clinic, or through other types of sponsors, such as employers. Medicare Part B covers the cost of the influenza vaccine as do some other types of insurance.

Health care workers were urged to receive the vaccine. Flu vaccine was offered at clinics held at meal sites or town halls throughout the county. At flu clinics, Saratoga County Public Health obtains information and clients’ signatures from those eligible and bills for reimbursement. A \$15 fee is collected for non-Medicare eligible clients and any clients who present with insurance that Saratoga County Public Health does not accept. Volunteers have proved to be an essential component of Public Health clinics. Flu Clinics are a setting for mammoth volunteer activity. Volunteers help the elderly with required paperwork and maintain order during the chaos of large clinics. Many volunteers have helped for several years and consider it a privilege to be asked to participate. We are very grateful to all our volunteers!

*\*Due to the H1N1 pandemic, our seasonal influenza clinics were ceased and the H1N1 clinics took precedence. Before the onset of the H1N1 clinics, Saratoga County Public Health was able to offer the seasonal influenza vaccine to 17 various sites throughout the county.*

### **Seasonal Influenza Vaccine Administration – 2009**

	<b><u>2009</u></b>	<b><u>2008</u></b>
Clinics Offered Throughout the County	17	38
Vaccine Doses Administered at Clinics	842	2,347
CHHA/Long Term Home Visits for Administration	3	5
Staff/Employee Clinics	4	4
Flu Clinics Offered at Public Health Building	4	16
Vaccine Doses Administered at Public Health Building	62	152

## **SARATOGA SPRINGS IMMUNIZATION CLINIC (SSIC)**

The Saratoga Springs Immunization Clinic (SSIC) is offered three times each month. This clinic follows the Vaccine for Children (VFC) guidelines. Children through 18 years of age who meet one of the following criteria are eligible for the vaccine:

- Medicaid eligible
- Uninsured or underinsured
- Indian

There is no administration fee for the vaccine. Saratoga County Public Health follows the Center for Disease Control guidelines for immunization requirements.

To accommodate children going back to school in September, we have increased our clinics to five times during the month of September. We have also increased clinics to five times per month in November for those children facing expulsion due to non-compliance with immunizations.

### **Saratoga Springs Immunization Clinic Statistics for 2009**

Number of clinics	40
Number of children vaccinated	367
Number of vaccines administered	667

## **INFECTION CONTROL AND COMMUNICABLE DISEASE CONTROL - 2009**

Communicable diseases are a part of everyday life. By working with the community, i.e. the consumer, schools, daycares, physicians, and other providers, we help to decrease diseases from spreading. Education is an important part of the process. With education, we can help prevent illness.

Saratoga County Public Health works closely with the New York State Department of Health (NYSDOH), the NYSDOH District Office in Glens Falls, physicians and other health care providers, health and urgent care centers, schools, Saratoga Hospital and area nursing homes to ensure that laboratory confirmed and/or clinically-suspected illnesses, which are reportable communicable diseases, are investigated in a timely manner. The confidential information from the investigation is reported to NYSDOH by telephone, as needed, and via a secure Internet reporting system (ECLRS).

The Infection Control Nurse contacts clients by telephone, home visits and/or mailings. The client is assessed to be sure appropriate treatments are being provided and to assure that the client's contacts are receiving treatment if the particular illness warrants this in order to prevent the spread of the disease. In this way, the health of the public at large is protected. Specific diseases require that follow-up testing is performed to ensure that a person is no longer infected with the disease before they are allowed to return to work (e.g. a person who has been infected with a foodborne illness, such as *Campylobacter*, and that person is employed in food service, health or child care). The Infection Control Nurse will follow these patients for the most current results and will release them back to work once they have been cleared of the disease. This protects us all by preventing the spread of the disease through the food chain.

There are occasions when Saratoga County incurs the cost for a person's medications simply because the person has no insurance to cover the cost and the out-of-pocket expense would be a financial hardship.

During the year, as the need arises, we "blast fax" publications to healthcare providers, hospitals, and urgent care centers. The New York State Department of Health disseminated frequent guidance documents during the H1N1 pandemic in 2009. These documents were "blast faxed" to all providers, hospitals, and the urgent care centers as soon as the information was received by Saratoga County Public Health's Prevention Unit. State Health Alerts are faxed out to the health care providers as soon as they are received by the local health department. Physicians who are unable to receive the "blast faxes" are mailed hard copies of the documents.

*(Continued)*

## REPORTABLE COMMUNICABLE DISEASES

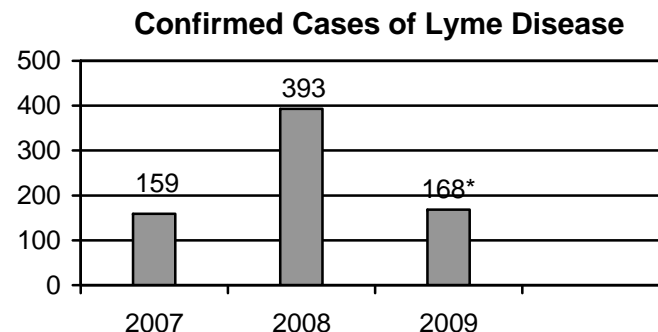
These numbers represent only those infections that were reported to our department. There may be additional infections that have gone unreported due to lack of testing.

Number of new cases for	2009	2008	2007
Amebiasis	0	1	0
Babesiosis	0	1	1
Campylobacter	32	23	25
Chlamydia	294	277	259
Cryptosporidiosis	1	9	6
Cyclospora	0	0	1
Dengue Fever	0	1	0
E-Coli O157:H7	3	3	0
E-Coli Non-0157	1	0	3
Ehrlichiosis	2	1	1
Encephalitis	2	1	3
Giardia	31	23	18
Gonorrhea	18	34	32
Haemophilis Influenzae, Invasive--not Type B	1	3	3
Hepatitis A	0	1	0
Hepatitis B	12	23	31
Hepatitis C	92	116	127
HUS--Hemolytic Uremic Syndrome	1	0	0
Legionellosis	7	4	6
Listeriosis	1	1	0
<b>*Lyme Disease</b>	168	393	159
Malaria	0	0	0
Meningitis - Meningococcal	1	0	0
Meningitis - Other bacterial	0	0	0
Meningitis--Viral	11	7	16
Mumps	1	0	1
Pertussis	1	14	1
Q Fever	0	0	0
Salmonellosis	22	26	21
Shigellosis	2	0	2

**\*Lyme** - Starting with 2009, we are investigating only 20% of the total number of lab results we receive. NYSDOH randomly picks the 20% we investigate. This number represents the positive cases of Lyme disease from that 20% sample.

Number of new cases for	2009	2008	2007
Staphylococcal Enterotoxin B	0	0	1
Streptococcus Group A, Invasive	4	6	4
Streptococcus Group B, Invasive	10	17	21
Streptococcus Group B, Invasive early/late onset	1	0	0
Streptococcus Pneumoniae, Sensitive	18	24	19
Streptococcus Pneumoniae, Intermediate	10	5	3
Streptococcus Pneumoniae, Resistant	0	1	1
<b>**Swine-Origin Influenza (H1N1)</b>	60	0	0
Syphilis	5	5	5
Toxic Shock Syndrome	1	1	0
Tuberculosis active cases	3	2	1
Vibrio	1	0	0
Viral Encephalitis (WNV)	0	0	0
Rabid Animals	21	20	21
Rabies Vaccine Recipient	104	78	99
West Nile Virus positive birds	0	0	0
Yersiniosis	1	1	1

**\*\*Swine-Origin Influenza** – Includes 1 pediatric death



\*This number may increase when Investigations are completed for 2009. SEE NOTE UNDER LYME RELATIVE TO THIS FIGURE.

## **EARLY INTERVENTION PROGRAM**

The Early Intervention Program is a New York State Department of Health program, which provides a variety of services for eligible infants and toddlers (in the birth to three age level) with identified developmental delays or disabilities and a high probability for a delay, such as Down Syndrome, Cerebral Palsy and Autism.

Each child referred to the EI program goes through either a screening and/or multi-disciplinary evaluation process that will identify the strengths and weaknesses of the child. If the child is found to have a significant delay in one area of development or moderate delays in two or more areas, the child then qualifies to receive services from the Early Intervention Program. If the child qualifies and the parents agree to services, an Individualized Family Service Plan (IFSP) is written. This plan describes the services appropriate for providing the family with education and support while learning to meet their child's individual needs. The program works with parents and families within their most natural environment, which is most often at home or at a day care setting.

Early Intervention Services include:

- Early identification, screening and assessment
- Medical services for diagnosis and evaluation
- Service Coordination
- Family training, counseling, home visits, parent support groups
- Special Instruction
- Speech pathology and audiological testing
- Occupational Therapy
- Physical Therapy
- Social work
- Respite
- Vision
- Psychological Services

The Early Intervention Official (EIO) and EI Program Manager, with a staff of seven full-time Initial and Ongoing Service Coordinators and one clerical support person, operate the Saratoga County Early Intervention Program. There are two additional subcontractors that provide four part-time Initial and Ongoing Service Coordinators to support the program. The Saratoga EI Program contracts with 114 independent contractors and 25 agencies to provide the screenings, evaluations, and services listed above.

Saratoga County had 518 referrals made to the Early Intervention Program this past year (October 1, 2008- September 30, 2009). Of these numbers, we have enrolled 42% (216) and found 35% (179) not eligible for our services. There have been 18% (92) that refused our program, 3 families that moved out of the county before the start of services, 8 families relocated either out of county or state and 2 children died, and 17 children that were referred directly to the Committee for Pre-school Special Education (CPSE). The largest age group that we service were in the one-to-two year-old population. We serve the majority (97%) of our children within the most natural environment setting. Since October 2008, we have served 212 children at home, 6 in family day care/nursery school settings, 3 in outpatient facilities (i.e., aqua PT) and 4 within a special classroom setting.

During the fiscal year (October 1, 2008 - September 30, 2009), the NYS Department of Health again collapsed funding for the EI Administrative Program with Child Find funding.

The NYS Bureau of Early Intervention has continued to provide trainings to staff and service providers for clinical practice guideline documents: “NYS Guidance on Evaluations and Eligibility Requirements,” “Hearing Loss,” “Down Syndrome,” “Vision,” “Program Records,” “Introductory Service Coordination,” “Advanced Service Coordination” and “EI 101: An Introduction to the NYS Early Intervention Program.” The practice guidelines offer recommendations for appropriate services to children and families active in the Early Intervention Program.

The Saratoga EIP Program Manager held three service provider meetings this past year to discuss program changes and annual contract obligations. Both agency and itinerant providers are invited to attend these meetings. At the spring meeting in April, contract changes were presented to both provider groups, which included timeliness in the delivery of services and 45-day timeline to IFSP among the topics of discussion. The summer meeting in July included an in-depth training on Child Outcomes. The process was reviewed and instructions were given to the evaluator and service provider. The service coordinators attended a separate meeting to discuss their role within the process. The fall meeting in September was an annual meeting to discuss contract obligations, including the following topics: Health and Safety, confidentiality, NYEIS, and billing.

As part of the EI program, Saratoga County Public Health is required to have a Local Early Intervention Coordinating Council (LEICC). The Saratoga County Local Early Intervention Coordinating Council (LEICC) meets at least three times per year (spring, summer and fall). All of the meetings are open to the public and announced as public service announcements one week prior to the meetings. The LEICC consists of 19 members, which includes 5 parents, 2 EI service providers, 1 OMRDD representative, 2 CEO/Designee from NYS Department of Health and Mental Health, 1 DDSO representative, 1 CPSE chairperson, 1 County Youth Bureau Director, 1 EI Program Manager and 1 Director of Prevention from Saratoga County Public Health. The Chairperson is Janet Glenn, Early Intervention Officer (EIO). A representative from both NYS Maternal Child Health and Head Start are formally invited to all meetings.

The role of the LEICC is to advise the EIO on matters pertaining to the planning, delivery and evaluation of EI services for eligible children and their families, including methods to identify and address gaps in services. The LEICC advises the EIO of identification of service delivery reforms necessary to promote the availability of EI services within natural environments. It coordinates public and private agencies, along with other matters that may be brought forward by parents, providers, and public agencies to the municipality, as they relate to the EI policies and procedures.

The Saratoga County LEICC’s mission statement is:

*The Local Early Intervention Coordinators Committee will work collaboratively with the Early Intervention Program to ensure all children and families of Saratoga County receive equal access to services and support to promote optimal development.*

**EARLY INTERVENTION PROGRAM and OUTREACH/CHILD FIND (C.F.) COMPARATIVE CHART**

	<b>2009</b>	<b>2008</b>	<b>2007</b>
Referrals to EI	518	475	389
New Children Enrolled - EI	216	200	202
Referrals to Child Find	50	135	195
Enrolled in Child Find at End of Year	85	104	108

## **CERTIFIED HOME HEALTH AGENCY (CHHA)**

Most individuals wish to receive the medical care they need in their own homes or with a friend or relative rather than enter a nursing facility. Home care is a form of health care service that allows individuals to receive such care whether they live in their own homes, with or without family members, or in an assisted living facility. Home care continues to grow in popularity. Most individuals are more comfortable in their own homes rather than in a hospital setting. In addition to the emotional comfort that the home environment may provide, home health care is usually less expensive than care provided in a medical facility.



The purpose of home care is to promote, maintain, or restore a patient's health. The goal is to provide the necessary services to help an individual get better, regain their ability to function and care for themselves, and become as independent as possible. Either a Certified Home Health Agency (CHHA) or a Licensed Agency can provide home care. A CHHA is Medicare certified by the Department of Health and Human Services and the New York State Department of Health. Saratoga County Public Health Nursing provides CHHA services. A licensed agency is licensed only by the NYS Department of Health. Home health care services can be provided on a temporary, short-term basis or on a long-term basis. For example, people who are in the process of recovery, such as those recently discharged from the hospital, can use home health care. Short-term care provides assistance following an illness or surgery.

Medical care is delivered in the home under physicians' orders. A variety of services are available to deliver home care. The Home Health Team includes, registered nurses, physical therapists, occupational therapists, speech/language pathologists, medical social workers, nutritionists, and home health aides. These professionals make regular home visits, depending on a patient's specific needs. Home health aides assist individuals with activities of daily living in the home, with their duties similar to those of nurses' aides in the hospital.

Clinical staff:

- Help individuals and families acquire the knowledge and learn the skills to manage at home.
- Collaborate with the physician to maximize the individual's return to health.
- Tailor home health services to the unique needs of the individual and family, i.e. assist with medication management, promote recovery following surgery (wound care, exercise), and manage the symptoms of chronic conditions (congestive heart disease, chronic lung disease, rehabilitation).
- Coordinate with other community agencies for services the individual or family may need.

Home care delivery is paid for either by the government through Medicare and/or Medicaid, by private insurance or health maintenance organizations (HMOs), or by patients themselves. Home care delivery services provided by Medicare-certified agencies (CHHAs) are tightly regulated. Private insurance companies and HMOs also have certain criteria for the number of visits that will be covered for specific conditions and services. Restrictions on the payment source, the physician's orders, and the patient's specific needs determine the length and scope of services.

*(Continued)*

Our agency continues to collaborate with area health care providers and facilities to address the issue of pressure ulcer prevention. The group, *Partners in Prevention*, meets every other month and focuses on decreasing the number of pressure ulcer in all health care settings. Wesley Health Care Center has taken the initiative in coordinating the group. In 2009, members of our staff participated in the production of a video made by Empire State College that will be used to educate healthcare providers on pressure ulcer prevention.

SCHPNS is also an active participant in the Aging and Disability Network of Saratoga County. The goal of the group is to promote community awareness of programs and services available to the aged and/or disabled population to better meet their needs.

Saratoga County Public Health Nursing Service’s CHHA is dedicated to providing high quality, cost-effective care and services to those in the community who are sick, dependent, or otherwise unable to manage their own care at home and recognizes that it is the right of every individual to receive quality care which allows the individual his or her potential for independent functioning at home. Home care staff is dedicated to helping individuals make good decisions about their care by providing them with reliable information about their conditions.

We are continually improving and updating our clinical practices to improve patient outcomes through the application of state-of-the-art technology.

**CERTIFIED HOME HEALTH AGENCY (CHHA) PROGRAM STATISTICS**

<b>BILLABLE VISITS:</b>	<b>2009</b>	<b>2008</b>	<b>2007</b>
Nursing	6026	5921	7047
Nursing – PRI	199	207	193
Physical Therapy	5931	5957	6772
Occupational Therapy	224	270	329
Speech Pathology	158	194	230
Medical Social Worker	46	86	104
Home Health Aide	1712	2359	2796
Nutritionist	25	20	16
<b>SUB-TOTAL</b>	<b>*14321</b>	<b>15014</b>	<b>17487</b>
<b>NON-BILLABLE VISITS:</b>			
All Disciplines, other than nursing	202	164	231
Nursing No Charge	452	307	576
<b>TOTAL CHHA VISITS</b>	<b>*14975</b>	<b>15485</b>	<b>18294</b>
<b>HOME HEALTH AIDE HOURS</b>	1783	2597	3086
<b>CENSUS:</b>			
January 1	101	105	120
December 31	95	101	105

\* There is an overall decrease in visits since 2007. As more individuals become enrolled in managed care health insurance plans, either Medicare or private, we are finding that most plans put a limit on or authorized less visits than individuals received prior to managed care.

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

The Saratoga County Long Term Home Health Care Program (SCLTHHCP) has been in existence since 1986. Since that time, 500 Saratoga County residents have received services through the program. During 2009, 44 patients were served by the LTHHCP (15 male and 29 female). We are authorized to provide service for 63 patients, and our patient census as of December 31, 2009 was 25. Our staff currently consists of three fulltime nurses since October 16, 2009. When staff is replaced, we will work toward achieving capacity.

The LTHHCP offers a multidisciplinary approach to meeting the health care needs of disabled and elderly patients who would otherwise be unable to continue living in the community or in their own homes. The program offers a variety of services including nursing case management; differing levels of aide service, i.e. home health aide (HHA), personal care aide (PCA), homemaker (HMK), housekeeper (HSKPR); medical social worker (MSW); respiratory therapy (RRT); nutritional therapy (NT); audiology (Aud); Lifeline (Personal Emergency Response System [PERS]); and meals on wheels (MOW). Patients in the LTHHCP can also receive physical, occupational, and speech therapy; but these services are not unique to LTHHCP.

*Nursing Case Management:* This service has proven invaluable to all of our LTHHCP patients. The nurse is able to work cooperatively with the patient and physician(s) to facilitate follow through with diagnostic tests, treatment and medication changes and compliance. The nurse also coordinates the referrals to various therapy modalities, communicates regularly with therapists to assure that services are being provided as ordered, and assures that the patient is compliant and satisfied with services.

*Aide Service:* Aide service is an integral part of the LTHHCP. Patients are able to receive various levels of aide services depending on their care needs. A total of 27 patients received aide service during 2009. The number of hours and time of day that aide hours are scheduled is individualized for each patient. Aide service assists patients in managing completion of ADLs so they may remain safely in their own home.

*Medical Social Worker Services:* A total of 28 LTHHCP patients utilized this extremely valuable service in 2009. Many of our patients live alone and are socially isolated while struggling with mental and physical limitations brought on by their medical conditions. MSW services can assist patients and families in expressing their feelings, developing coping strategies, assisting with financial matters, and planning for future care needs. MSW services continue to be helpful in assisting patients with navigating the Medicare D Program and changing plans as needed. Many of our patients are confused as to which plan is best for them and often needed MSW intervention to choose a plan and what to do when their medications are not covered under their plan.

*Respiratory Therapy:* This service is unique to the LTHHCP and greatly benefits patients with cardio-pulmonary illnesses. A total of 27 patients utilized this service during 2009. Respiratory therapy helps the patient to learn breathing techniques for improved lung aeration, energy conservation, and panic control. Additionally, proper use of oxygen, bipap, and inhaled medications are taught by respiratory therapy. Patients who receive therapy often avoid exacerbations of their illnesses, which prevent hospital admissions and the physical and emotional stress of hospitalization. An added benefit is the reduced costs to the health care system.

(Continued)

*Social Day Care:* This special service available through the LTHHCP has proven very effective in maintaining patients safely in the community for a longer period of time. In 2009, 6 patients attended social day care. Wesley Health Care Center is the day care provider for the LTHHCP. Patients in the LTHHCP often live alone or live with family members. While family members are at work during the day, the patients are left alone all day. Patients may no longer be safe to be left alone at home due to physical or mental impairments, which put them at risk for injury. Social day care offers patients an opportunity to socialize with others, participate in structured activities, develop friendships, enjoy their mid-day meal with others, and even receive PT and OT services if needed. It provides a nurturing, supportive environment for patients to spend quality time with others.

*Nutritional Therapy:* Services by a registered dietician are available to patients in the LTHHCP. A total of 12 patients received nutritional services during 2009. Patients can learn to make more appropriate food choices, learn about a special diet, and how to prepare foods for their special diets. The registered dietician may even enlist the assistance of a patient’s HHA to assist in preparing meals.

*Audiology:* Services are available to homebound LTHHCP patients who wouldn’t otherwise be able to access these services. The audiology service allows patients to have their hearing tested and be fitted with hearing devices as needed in the comfort of their own home.

*Lifeline:* Services are offered by the LTHHCP through Glens Falls Hospital and have proven invaluable to many of our patients. There were 38 LTHHCP patients subscribed to Lifeline in 2009. Many of our patients live alone or spend many hours of the night or day alone. Lifeline provides patients and their families with a sense of security that, if anything happens, the patient can get help within minutes.

*Meals on Wheels:* A large number of our patients take advantage of the MOW Program offered through the LTHHCP. The Saratoga County Office of the Aging and two congregate meal sites in senior housing buildings provide the meals throughout all of Saratoga County. During 2009, 25 LTHHCP patients received MOW. Patients, who can no longer prepare meals, can still enjoy warm nutritious means and a friendly interaction with the delivery volunteer each weekday. Evening and weekend meals are also available if needed.

The Saratoga County LTHHCP – also referred to as the nursing home without walls – continues to fill a very unique niche in the home health care environment. The program offers a comprehensive array of services, but at a cost per patient of 50 - 75% that of nursing homes. It enables qualified disabled and elderly patients of Saratoga County to continue to live safely in the comfort of their own home – at a reduced cost to the health care system – while maintaining their quality of life.

**LONG TERM HOME HEALTH CARE PROGRAM STATISTICS**

<b>BILLABLE VISITS:</b>	<b>2009</b>	<b>2008</b>	<b>2007</b>
Nursing	1266	1205	1301
Nursing – PRI	2	5	3
Physical Therapy	731	801	584
Occupational Therapy	86	66	63

(Continued)

Long Term Home Health Care Statistics (*Continued*)

<b>BILLABLE VISITS (Continued)</b>	<b>2009</b>	<b>2008</b>	<b>2007</b>
Speech Pathology	1	4	1
Medical Social Worker	366	393	373
Home Health Aide	2111	1440	1285
Nutritionist	66	55	19
Personal Care Aide	1753	3062	4564
Respiratory Therapy	239	231	205
Homemaker	0	0	0
Housekeeper	0	0	0
Audiology	0	0	0
<b>SUB-TOTAL</b>	<b>6621</b>	<b>7262</b>	<b>8398</b>
<b>NON-BILLABLE VISITS:</b>			
All Disciplines, other than nursing	64	51	74
Nursing No Charge	523	577	676
<b>TOTAL LTHHCP VISITS</b>	<b>7208</b>	<b>7890</b>	<b>9148</b>
Home Health Aide Hours	3631	1822	1362
Personal Care Aide Hours	2970	5122	7232
Homemaker Hours	0	0	0
Housekeeper Hours	0	0	0
<b>LTHHCP WAIVERED SERVICES:</b>			
Social Day Care	321	455	724
Meals On Wheels Delivered	5567	7967	6799
Lifeline (Monthly Rentals)	286	346	396
<b>CENSUS:</b>			
January 1	31	32	42
December 31	25	31	32
<b>PAYMENT SOURCE:</b>			
Medicaid	32	35	34
Medicare and Medicaid	12	9	12
Medicaid and Other Insurance	0	3	2

## PERSONAL CARE AND OTHER DSS PROGRAMS

Upon receipt of a request from a Department of Social Services (DSS) caseworker, the Public Health nurse accompanies the caseworker on a home visit to complete a joint assessment of the patient's needs. The physician's order is reviewed and a plan of care is established.

The caseworker then contacts an aide agency to secure the Personal Care Aide (PCA). The Saratoga County Public Health nurse makes a home visit to orient and supervise the aide. Supervisory visits are routinely made on an every-three-month schedule. The nurse and caseworker visit the patient at least every six months to re-assess the patient's status. Some patients require assessments more frequently.

The Public Health nurses orient new aides and supervise ongoing aide services, often making visits more frequently than every three months to orient new aides.

In addition to assessing and supervising personal care cases, the nurses perform assessments for Medicaid patients requiring private duty nursing care at home. Other agencies provide the private duty nursing care, but the Saratoga County Public Health nurse, along with a DSS caseworker, is responsible for completing the program assessment.

The Public Health nurses also perform assessments for the Care-At-Home Program. This program serves Saratoga County residents less than 18 years of age. Assessments are completed every six months unless changes in services are needed sooner.

The Consumer Directed Personal Assistance Program (CDPAP) continues to grow. The Public Health nurses evaluate patients to determine if services in the home setting are manageable and appropriate. The patient or their caregiver secure their own care providers and local DSS (Medicaid) reimburses the patient's care costs. CDPAP may be provided supplemental to other home care programs. Reassessments are done at least every six months.

### PERSONAL CARE AND OTHER DSS PROGRAM STATISTICS

<b>CENSUS</b>	<b>2009</b>	<b>2008</b>	<b>2007</b>
<i>Personal Care Program</i>			
January 1	24	24	31
December 31	27	24	24
<i>Private Duty Nursing Cases</i>			
January 1	12	9	11
December 31	10	12	9
<i>Care at Home Program</i>			
January 1	12	13	8
December 31	15	12	13
<i>Consumer Directed Personal Assistance Program (CDPAP)</i>			
January 1	182	153	135
December 31	188	182	153

	<b>2009</b>	<b>2008</b>	<b>2007</b>
<b>REFERRALS</b>			
Personal Care Program	70	82	87
Private Duty Nursing Cases	20	21	17
Care at Home Program	23	20	34
Consumer Directed Personal Assistance Program CDPAP	370	307	291
<b>TOTAL REFERRALS RECEIVED</b>	<b>483</b>	<b>430</b>	<b>429</b>

## UTILIZATION REVIEW COMMITTEE

Home Health may be defined as an array of services provided to individuals and families in their places of residence for the purpose of promoting, maintaining or restoring health, or minimizing the effects of illness and disability. Services appropriate to the needs of the individual patient are planned, coordinated, and made available by an organized health agency.

Home health services of good quality are an essential part of the health care system. These services must be available to the total population and must include all service components that are necessary to ensure the health and safety of those for whom such services is appropriate.

The question to be answered will always be, "Are we doing the best we can for our patient?" This is the simplest statement that can be made about the quality of the care that is being provided. Are we making the best use of what we have in order to do the best we can for the individual recipient? Appropriate use of staff includes the interrelationship of services and personnel, whether they are under one roof or under several, in the interest of a smooth, well-meshed service at the point of delivery to the recipient.

To ensure the appropriate utilization and application of Home Health Services, a system of *Utilization Review* in agencies providing such services is required. It is a process that has traditionally been maintained in almost all agencies of good quality -- either formally or informally.

The process of reviewing the utilization of services provided by home and community health agencies addresses itself to three basic problems of today's health care systems. These are:

- The shortage and inappropriate nature of many health care services
- The escalating cost of services
- The variable quality of these services

The purpose of Utilization Review is to improve service and ensure the appropriate use of services rendered to individuals, families and the community. The process also produces information for program evaluation, planning and staff development. Utilization Review is intended to enhance the quality of service.

The Utilization Review committee is interdisciplinary. A representative of each service that is provided by the agency is included on the Committee: nursing, social worker, speech, physical therapy, respiratory therapy, occupational therapy, and nutrition. There is also a physician, as well as a consumer on the Committee. The Professional Advisory Committee appoints the UR committee members, who meet four times a year.

The objective of Utilization Review is best served when sampling presents the Committee with a sufficient number of active, closed and rejected cases to provide a valid picture of the agency service. A review of at least 10% of the active and discharged caseload from the previous year is reviewed.

*(Continued)*

This information, as used by the agency director and/or governing body through Committee action, will directly and indirectly affect agency services and program evaluation.

### **Year 2009**

The Utilization Review (UR) Committee met on February 19, June 18, August 20, and November 19, 2009 to review patient records and patient services. The active caseload as of December 31, 2008 was 135, which included 104 for the CHHA and 31 for the LTHHCP.

A total of 34 patient records were reviewed, which is more than 10% of the caseload for the previous year. This past year, the UR Committee focused on active/discharged patient records for the CHHA and LTHHCP.

Areas selected for review by the Committee in 2009 included: Active and discharge charts and the appropriateness of services provided; patients receiving charity care; patients receiving HHA services; patients receiving services for diabetes; patients receiving one or more skilled service; patients receiving services for wound care; patients listed on our adverse outcome report; and patients assessed but not admitted to the agency. Charts reviewed were found to meet the criteria of each review. Any problem areas were reviewed with the clinician by their supervisor, and results of UR findings were reported to the Professional Advisory Committee (PAC) and at team meetings.

Goals for 2010 include: Increased focus on patient outcomes and service utilization. Additional focus will also be placed on return of signed orders within thirty days of service and visit frequency.

## QUALITY ASSURANCE PROGRAM

Quality in health care is more than successful patient outcomes, friendly and compassionate care, and efficiency. Quality is multidimensional, and involves:

- a) Setting standards that meet professionals' and customers' requirements
- b) Doing the right thing..... in the right way
- c) Utilizing competent and knowledgeable staff

Quality can, therefore, be defined as:

*"The degree to which health services for individuals and populations increase the likelihood of desired health outcomes as defined by our customer (who includes patients, families, the community at large, physicians, employees and payers), decrease the likelihood of undesirable outcomes (such as Iatrogenic occurrences and denial of access), and are consistent with current but constantly changing professional knowledge."*

Barry S. Bader, 1991  
Informing the Board about Quality

At Saratoga County Public Health, multiple functions are in play throughout the year to maintain the highest level of quality assurance.

Daily, quality is monitored by *supervisors and staff* as the computer system of notes, orders, and plans are processed.

Monthly, there is a *Peer Meeting* where staff review active and discharged charts. An internal *Professional Improvement* meeting is held monthly to go over policies, procedures and newly identified areas of technology, equipment and/or patient related issues.

Quarterly, there is an "*Adverse Outcome*" report generated. Each identified chart is looked at in depth to see 1) if there truly was an adverse outcome and, 2) if there was anything that SCPHNS could have done differently to avoid a negative outcome. The *QA Meeting* is held quarterly with the Medical Director to keep him informed of all new, open and resolved issues. The *Professional Advisory Committee*, made up of various occupations from the community, also meets quarterly. This group helps to provide the balance of needs of the community and services that SCPHNS can provide. Many of the same things presented internally are also presented to this group. Creative thinking and new initiatives have been a benefit from these caring and specialized individuals.

## SOURCE OF PATIENT REFERRALS

*(By Number of Referrals)*

Referral Source	2009	2008	2007
Hospitals	2028	2837	2248
Physicians	132	139	102
Other (CHHA)	94	66	77
Agencies	520	495	440
Other (Prevention)	671	945	784
PRI	231	243	253
<b>TOTAL</b>	<b>3676</b>	<b>4725</b>	<b>3904</b>

*(Percent to Totals)*

Referral Source	2009	2008	2007
Hospitals	55%	60%	58%
Physicians	4%	3%	3%
Other (CHHA)	3%	1%	2%
Agencies	14%	11%	11%
Other (Prevention)	18%	20%	20%
PRI	6%	5%	6%
<b>TOTAL</b>	<b>100%</b>	<b>100%</b>	<b>100%</b>

Total “*Hospital*” referrals reflect those for the CHHA and Maternal/Child Health.

The “*Other (CHHA)*” category includes referrals for home care from rehabilitation centers and nursing homes.

The “*Agencies*” category includes LTC/PCP referrals to better reflect referrals from Saratoga County DSS.

The “*Other (Prevention)*” category includes EI/Child Find, Lead, and other pediatric referrals from varied sources.

**\*TOTAL AGENCY VISITS MADE**

<b>BILLABLE VISITS:</b>	<b>2009</b>	<b>2008</b>	<b>2007</b>
Nursing	8470	8248	9296
Nursing – PRI	201	212	196
Physical Therapy	6664	6758	7348
Occupational Therapy	310	336	392
Speech Pathology	160	198	231
Medical Social Worker	412	479	477
Home Health Aide	3823	3799	4081
Nutritionist	91	75	35
Personal Care Aide	1753	3062	4564
Respiratory Therapy	239	231	205
Homemaker	0	0	0
Housekeeper	0	0	0
Audiology	0	0	0
<b>SUB-TOTAL</b>	<b>22123</b>	<b>23398</b>	<b>26825</b>
<b>NON-BILLABLE VISITS:</b>			
All Disciplines, other than nursing	364	420	334
Nursing No Charge and Maternal Child Health	1874	1895	1982
Early Intervention Program	1486	1709	1796
<b>TOTAL AGENCY VISITS</b>	<b>25847</b>	<b>27422</b>	<b>30937</b>

**\*Total visits include CHHA, LTC, Personal Care and other DSS Programs, and Maternal Child Health.**

## AGENCY STAFF

### PAYROLL POSITIONS

	2009	2008	2007
<b>Administrative Staff</b>			
Administrators	3	3	3
Nursing Supervisors	5	5	5
Therapy Supervisor	1	1	1
Clerical/Support Staff	13	12	12
<b>Field Staff</b>			
Public Health Nurse	10	10	10
Liaison Nurse	1	1	1
Registered Nurse	16	16	16
Registered Nurse, Part-time or Per-diem	12	12	12
EI Care Coordinator	4	4	4
Home Health Aides	2	2	2
Home Health Aides, Part-time	3	3	3
BT Grant Staff (PHN and Info. Proc. Spec.)	2	2	3
Outreach Worker (Part-time)	1	1	1

### CONTRACTED SERVICES

	2009	2008	2007
<b>Contracted Services*</b>			
Physical Therapy	10	9	9
Occupational Therapy	4	4	5
Outpatient Physical Therapy	1	0	0
Outpatient Occupational Therapy	0	0	0
Outpatient Speech Pathology	0	0	1
Medical Social Worker	3	2	1
Speech Pathology	4	3	4
Nutrition	1	1	1
Respiratory Therapy	1	1	2
<b>Aide Agencies**</b>			
Home Health Aide (HHA)	4	4	5
Homemaker (H/M)	0	0	0
Personal Care Aide (PCA)	4	4	5

\*This is the number of different individuals/organizations providing service during the year.

\*\*Four agencies but only three provided the service listed.

## FINANCIAL ANALYSIS

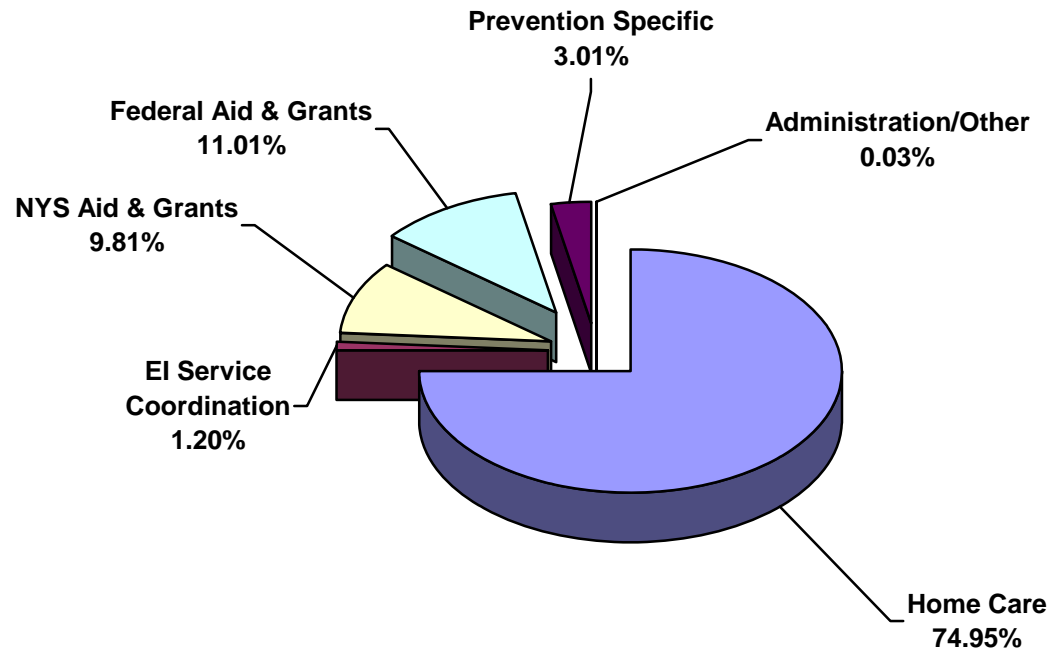
The 2009 Long Term Cost Report was completed in September 2009 and the 2008 Medicaid cost report was completed July 2009. The agency charges per visit were raised as of August 2008.

We continue to provide a sliding fee scale for the uninsured for CHHA and Prevention Services and will continue to provide charity care as needed.

The last rates in effect for 2009 were:

<b>HOME HEALTH CARE SERVICES</b>		<b>LONG TERM HOME HEALTH CARE PROGRAM</b>	
Nursing	\$170 / visit	Nursing	126.05/ visit
Physical Therapist	\$115 / visit	Physical Therapist	88.54 / visit
Occupational Therapist	\$115 / visit	Occupational Therapist	87.45 / visit
Speech Therapist	\$115 / visit	Speech Therapist	96.29 / visit
Medical Social Worker	\$115 / visit	Medical Social Worker	90.51 / visit
Nutritionist	\$115 / visit	Nutritionist	81.82 / visit
Home Health Aide	\$50 / hour	Respiratory Therapist	88.24 / visit
		Audiologist	70.85 / visit
		Home Health Aide	33.23 / hour
		Housekeeper	20.50 / hour
		Homemaker	14.50 / hour
		Personal Care Aide	33.82 / hour

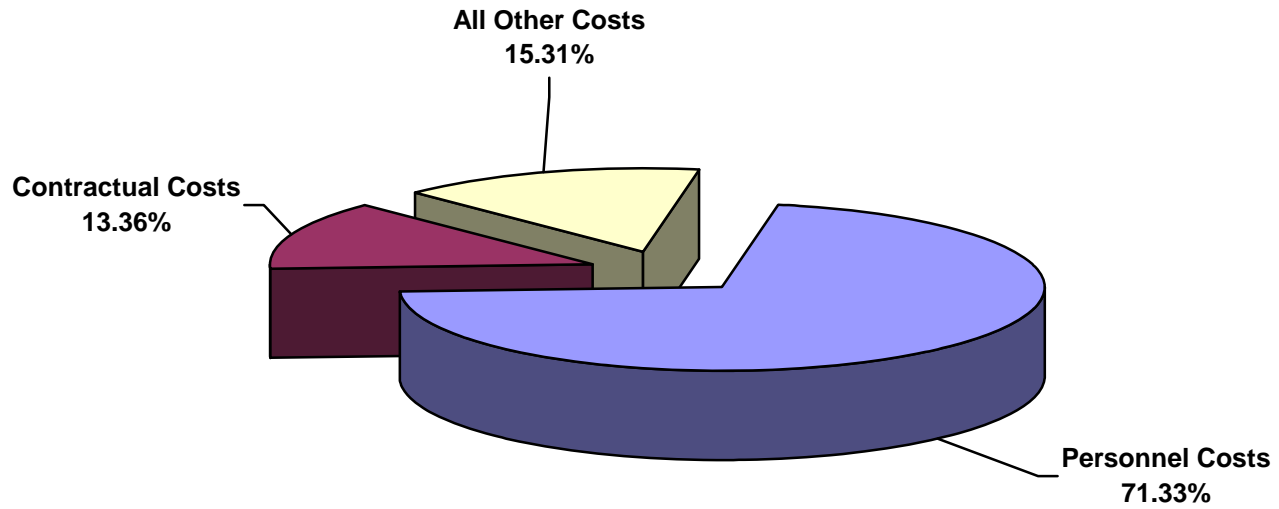
## TOTAL REVENUE 2009



The booked revenues for 2009 include Medicare, Medicaid, other insurances, and State Aid for a total of \$4,044,656.20. The majority of the Revenues were for home health care services.

NOTE: Due to changes implemented in 2006, most revenue is now reported on a cash basis rather than an accrual basis. That is, late receipts for the prior year are reported in the year received.

## TOTAL EXPENSES 2009



The total expenses for 2009 were \$5,859,582. The majority of expenses were Personnel/Fringes.

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