



Saratoga County Public Health Nursing Service  
Annual Report 2011

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# *Saratoga County Public Health Nursing Service*

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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.....*

*As I now approach the end of my first year as Director of Public Health in Saratoga County, I am amazed at the community development going on each and every day, even as the economy is in such a state of uncertainty. Preparing the agency to meet the increasing demands for services from those who have not needed to rely on public services in the past, new state mandates, required programmatic changes and decreasing resources has indeed been a challenge.*

*CY 2011 was a year of change for the agency. Many years of experience left with those retiring, at the same time providing an opportunity for others to move into these positions and grow professionally. CY 2011 was a year of planning and expanding knowledge in areas new to the agency to assure competency in our public health responsibilities in the future of Saratoga County.*

*Staff in programs throughout the agency providing both nursing services and prevention services continued to provide exceptional care to patients and the community. A job well done!*

*CY 2012 will see more challenges and changes within the department as new services are developed and implemented. Working in collaboration with the County Board of Supervisors and Administration, Saratoga County Public Health Nursing Service will grow over the next few years to accept new responsibilities to meet the needs and provide public health protection for the residents and guests of our beautiful County.*

*Karen A. Levison, MSHSA, PTA  
Director of Public Health*



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**SERVICES PROVIDED BY  
SARATOGA COUNTY PUBLIC HEALTH NURSING SERVICE**

***Preventive Health Care***

- Health Education Programs
- Communicable Disease Control
- Early Intervention Program
- STD Clinic
- Lead Poisoning Prevention Program
- Maternal and Child Home Visits
- Child Find Program – Ages 0-3
- Synagis Administration Program (Respiratory Syncytial Virus)
- Migrant and Seasonal Farm Workers
- 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
- Adult Immunization Clinic
- Saratoga Springs Immunization Clinic (SSIC)
- Backstretch Health Fair
- Seasonal Influenza Clinics

***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
- Medical Alert Service (Formerly Lifeline)

# SARATOGA COUNTY MAP – POPULATION BY MUNICIPALITY

\*Map provided by Saratoga County Planning Department 03/28/11.  
Total Population = 219,607



## **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 Nursing Service.

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 Nursing Service 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 Saratoga County Public Health Nursing Service want to thank all the committee members, especially Christopher Torino, Committee Chairman, for their dedication and support during 2011. Committee members include:

Christie Britton-Hare, Speech Language Pathologist

Timothy Brooks, MD

Lois Bullett, RN

Robert Christopher, Commissioner of Social Services

Sandy Cross, Director Office for the Aging

Desmond DelGiacco, MD

Karann Durr, Certified Dietician/Nutritionist

Cynthia Lisuzzo, RN

Gary Oberg, MD

Christopher Torino, RT

Nancy Weber, OT

GUESTS: Ryan Moore, Management Analyst, Saratoga County

Anita Gabalski, NYSDOH, Dir. Regional Environmental Health

## **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 Saratoga County Public Health Nursing Service 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 2011 Public Health Committee members:

Mr. Arthur M. Wright, Chairperson

Anita Daly  
Edward Kinowski  
Richard Lucia  
Jean Raymond  
Tom Richardson  
Patti Southworth

*We would also like to thank:*

Mr. Thomas Wood, Board Chairman  
Mr. Frank Thompson, Chairman of Law and Finance  
Mr. Spencer Hellwig, 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 fourth year of administering this program.

**Synagis Administration Data**

(Includes data from October through the end of Synagis season for each given year)

	<b><u>2011</u></b>	<b><u>2010</u></b>	<b><u>2009</u></b>	<b><u>2008</u></b>
Referrals Obtained	10	11	67	23
Injections Given	49	19	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**

	<b>2011</b>	<b>2010</b>	<b>2009</b>
No Charge or Not Paid By Insurance Plan	460	783	839
Billable	299	580	693
<b>TOTAL VISITS</b>	759	1363	1532
Amount Billed to Insurance Plans	\$44,324	\$98,600	\$85,188

### **SUMMARY OF SERVICES**

Year	Newborns Referred	Postpartum Clients Referred	Health Supervision Clients Referred	Antepartum Referrals
2011	601	592	4	7
2010	682	679	21	21
2009	614	595	14	46

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.

## 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. All uninsured clients are referred to Saratoga Care to help establish insurance.

<u>WELL CHILD CLINICS</u>	<u>2011</u>	<u>2010</u>	<u>2009</u>
Children Attending for physician visit	11	12	10
Number of Well-Child Clinics held per year	7	21	12

## CHILD FIND

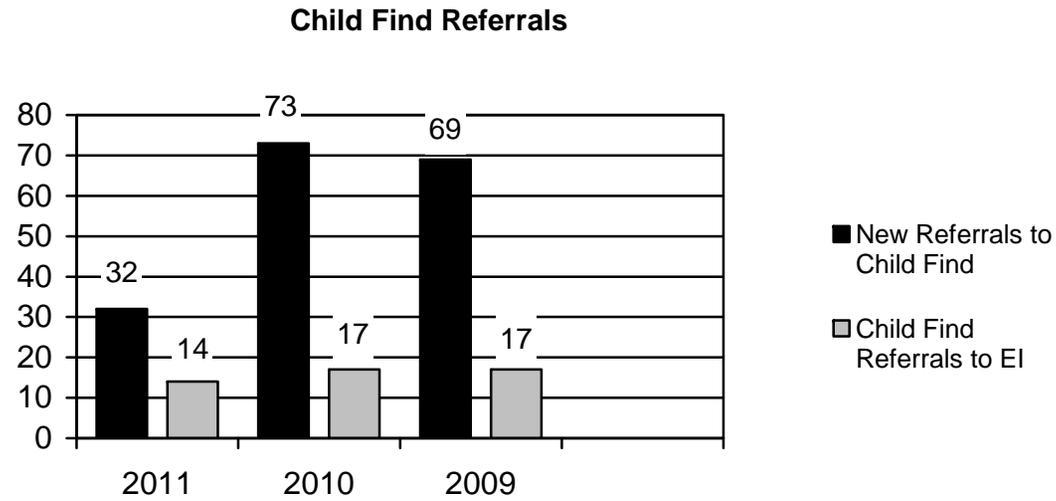
The Child Find Program is a statewide program to assure that children ages six months to three years old, are identified through periodic developmental screenings to receive the help and services needed for the best growth and development in their early years. Referrals to the Early Intervention (EI) 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>	<u>Total CPS Referrals</u>
2011	32	2	14	16	11	6	0	54
2010	73	9	17	29	35	5	-	
2009	69	11	17	49	31	2	1	

*(Continued)*

*Child Find (Continued)*



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 2011, Saratoga County Public Health Nursing Service (SCPHNS) 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 (TAR) 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.

**Activation:** In response to Hurricane Irene, SCPHNS helped staff the Waterford/Halfmoon Emergency Shelter at the Waterford/ Halfmoon School. Five SCPHN staff members supported the Waterford/Halfmoon Emergency Shelter on August 28-29, 2011.

**Activities:** Saratoga County Public Health Nursing Services is an active member of the Saratoga Countywide Emergency Preparedness Committee (SCWEPC) since its formation in 2004. The committee started to meet quarterly in 2009. 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), Global Foundry, 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 community partners in identifying the special needs populations in our county, e.g. town emergency coordinators, Saratoga Bridges, AIM, Head Start, National Grid, Red Cross, OES, Saratoga Hospital and Four Winds Hospital are on the committee.
- The Strategic National Stockpile (SNS) Subcommittee has been active. The subcommittee meets annually and as needed to review and update the County SNS Plan in order to prepare for the annual TAR audit. Participates with NYSDOH in drills and exercises. SCPHNS, along with community partners, updates the SNS Plan as required.

*(Continued)*

## **EMERGENCY PREPAREDNESS PROGRAM** *(Continued)*

- The Medical Reserve Corps (MRC) Subcommittee has been active.
  - There are several groups that meet regularly under the MRC: a) The Education Committee – provides free speakers to give the First 72 Hours emergency preparedness presentation to community groups. In 2011 five presentations were given and a total of 182 people attended; b) The Volunteer Coordinator Committee- manages the Volunteer Call Tree and organizes volunteers for any requests for help from Public Health; c) the Annual Updates Committee assisted Office of Emergency Services (OES) with updates for the Special Needs Registry. It maintains the Pet Friendly Hotels and Motels list for Saratoga County.
  - The Medical Reserve Corp was activated in response to Hurricane Irene on August 29, 2011. Two volunteers helped staff the Waterford/Halfmoon Emergency Shelter. One of the volunteers did face painting with the children in the shelter. This was a great diversionary activity for the children at the shelter.
  - Medical Reserve Corps volunteers assisted at the END Game Exercise on May 24, 2011. They assisted at an Open and Closed Point of Distribution (POD). In this state functional exercise, they provided an invaluable service to SCPHN and the residents of Saratoga County.
  - The Medical Reserve Corp volunteers help staff the SCPHNS table at the Saratoga County Fair on July 19-24, 2011. Twenty-five volunteers worked fifty hours staffing the SCPHNS table.
  - During the 2011 flu season, Medical Reserve Corps volunteers assisted Public Health at county wide seasonal flu clinics in October and November. Nine MRC volunteers worked a total of eighteen hours at four clinics.

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

- SCPHNS participated in the State END Game on May 24, 2011. An Open and Closed POD were held at SCPHN building in Saratoga Springs.
- A Local Technical Assistance Review Tool (LTAR) Audit was done with CDC and NYSDOH on June 17, 2011. We received a score of 98%.
- SCPHNS held a Closed Influenza POD Exercise Clinic for SCPHN staff members on October 25, 2011. In addition, this drill tested the SCPHNS’s ability to use the Clinical Data Management System (CDMS) during a mass prophylaxis/vaccine clinic. As Healthcare workers, SCPHNS staff members are identified as a specific population that can be separated from those attending a public POD. The SCPHNS staff would receive their prophylaxis/vaccine prior to working at public PODs and a significant burden would be taken off of the public POD system.
- SCPHNS participated in several alert notification drills to test our ability to send and receive messages via the NYS Commerce Network.

*(Continued)*  
**EMERGENCY PREPAREDNESS PROGRAM**  
*(Continued)*

**eHealth On-Line Scheduling System:**

- Since February 2011, eHealth on-line scheduling system has been used for the International Travel/Adult Immunization Clinics. eHealth scheduling has increased county residents' ability to schedule their appointments via the internet and it has reduced the amount of telephone calls.
- In the fall, Saratoga Springs Immunization Clinics (SSIC) clinics have used eHealth scheduling. At this time, it is staff only access. There is no internet access. This has improved the SSIC scheduling.
- In December, two seasonal flu clinics were held with the new eHealth on-line scheduling system. Participants in the clinic that utilized the system to schedule their influenza clinic appointments.

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

- All SCPHNS staff have been fit tested.
- The fit test machine is recalibrated annually.
- 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.
- SCPHNS fit tested Saratoga County jail staff in September.

## INTERNATIONAL TRAVEL PROGRAM

Saratoga County Public Health Nursing Service 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 six times per month, 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, 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.

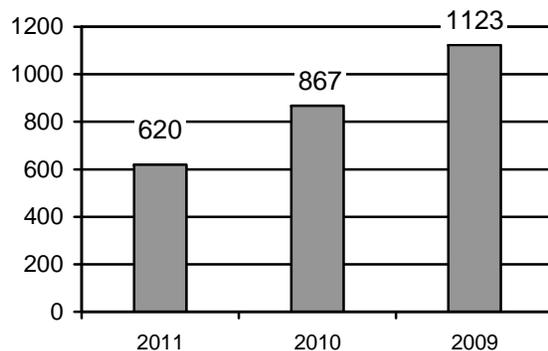
Costs for the clinic include a consultation fee, vaccine fee and an administration fee. Also, there is an additional fee for those who do not live or work in Saratoga County.

For more information or to schedule an appointment you may schedule through eHealth Scheduling on the Saratoga County website at [www.saratogacountyny.gov](http://www.saratogacountyny.gov) or call 584-7460 Monday through Friday from 8:00 a.m. to 4:00 p.m.

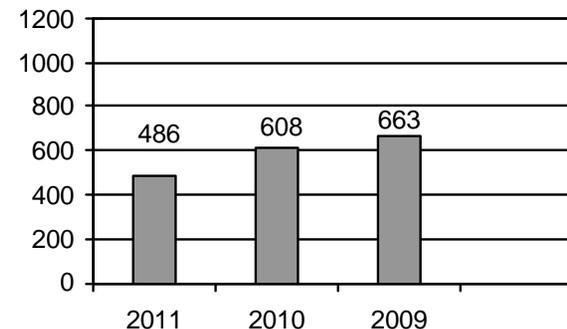
	<u>2011</u>	<u>2010</u>	<u>2009</u>
Unduplicated Count	341	489	477
Total Visits	486	608	663
Total Vaccines Given	620	867	1123

\*A total of 74 clinics were held in 2011

**Total Vaccines Given**



**Total Visits**



## **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 Nursing Service 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 32 children participated in the Physically Handicapped Children's Program in 2011.

*(Continued)*

**Physically Handicapped Children's Program 2011**

	Age < 1	Age 1 < 3	Age 3 < 5	Age 5 < 13	Age 13 < 19	Age > 19	Total
Unduplicated count of children authorized under the <i>Diagnostic and Evaluation Program</i>	0	0	0	0	0	0	0
Unduplicated count of children authorized under the <i>Treatment Program (Public Health Law Only)</i> . There were no children denied authorization for the Treatment Program.	0	0	3	15	12	2	32
Unduplicated count of children authorized under the Diagnostic and Evaluation Program who then became authorized for the Treatment Program	0	0	0	0	0	0	0

<b>Breakdown by PHCP Diagnosis For Children in the Treatment Program</b>	
Blood Dyscrasia	0
Heart Disease	0
Apnea	0
Hearing Loss	8
Cerebral Palsy	0
Prematurity	0
Asthma	0
Scoliosis	0
Seizure Disorder	0
Cystic Fibrosis	3
Diabetes	0
Spina Bifida	0
Hydrocephalus	0
Neoplasms	0
PKU	0
Dental	19
Other – Club Foot	1
Other – Leukemia	1
<b>TOTAL</b>	<b>32</b>

<b>Unduplicated Count of Children in the Treatment Program By Race</b>		
White	23	
Black, African American or Negro	0	
Asian	0	
American Indian or Alaska Native	0	
Native Hawaiian or other Pacific Islander	0	
Other	0	
Unknown	9	
<b>TOTAL</b>	<b>32</b>	

\*With regard to ethnicity: There were 2 children of Spanish, Hispanic or Latino ethnicity and one "Other"

## **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 Nursing Service is responsible for submitting the annual work plan and quarterly reports. Our new, full-time lead coordinator did not start until late February 2011.

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 5 – 9 mcg/dl: A letter is sent to the family along with “what your lead test means.” Letter states that current research suggests that there is no “safe” blood level for a young child and they may want to contact their medical provider for their recommendation regarding possible follow-up testing. All lead levels 5 – 9 and >10 are tracked on separate spreadsheets and monitored regularly; now also tracked in the “blue book”.
- 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.

*(Continued)*

- 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 Saratoga County Public Health Nursing Service 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.

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. Their July 2011 update was faxed to primary care and obstetrical providers, along with an introduction letter from the Lead Poisoning Prevention Coordinator.

Health fairs were popular this year, where lead information, literature, magnets, and grocery totes were distributed to families.

We are notified regularly of consumer product recalls concerning products that have been identified as containing lead. This information is displayed for the public in our building.

**Lead activities in 2011 included the following:**

- In the spring and fall, we continued coordination with Saratoga County Head Start to identify children in need of mandated lead testing. Eighteen children were tested. Hand washing education was provided with age-appropriate tools and materials.
- Lead information/education was disseminated at the Saratoga County Fair, Saratoga Springs Immunization Clinic, Women, Infants and Children's Program (WIC), various health fairs throughout the county, and Saratoga County Public Library System.
- Lead Webinar training was completed on the New York State Immunization Information System (NYSIIS) for 4 staff members.
- Outreach education provided to obstetrical groups involved questionnaire sheets entitled "*Lead Screening Risk Questions in Pregnancy.*"
- EI nurses and Service Coordinators routinely hand out lead packets to parents on their evaluation visits.
- Quarterly meetings with NYSDOH Environmental, Warren and Washington County, to discuss current issues, strategies, and open cases.

*(Continued)*

## LEAD SCREENING PROGRAM STATISTICS

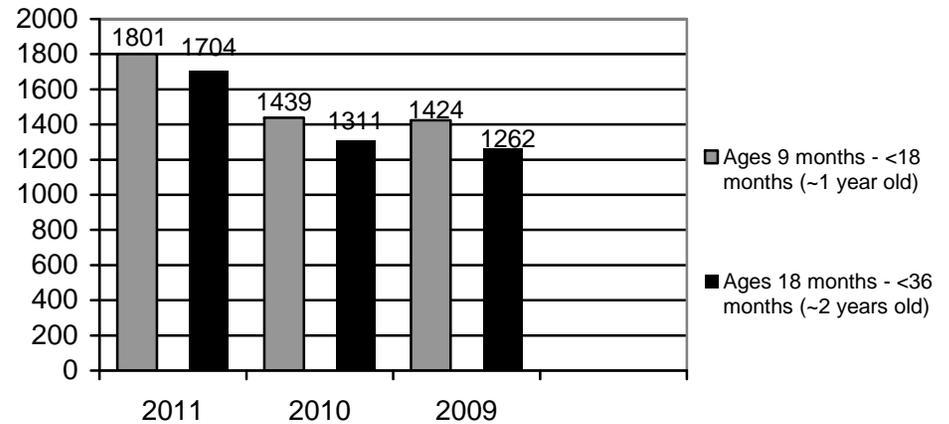
	2011	2010	2009
Total Initial Screenings (aged 9 months to 6 years)*	3,898	3,000	2,915
SCPHNS Lead Clinics	0	8	2
Children Screened at Public Health Clinics (Per LeadWeb Program)	0	41	9
Total Abnormal lead Values	27	57	29
Low (10 – 14 mcg/dl)	16	20	24
Moderate (15 – 19 mcg/dl)	7	21	4
High (>20 mcg/dl)	4	16	1

\*Statistical data from LeadWeb system

Blood Lead Screening Tests by Age Group Category  
(During the Selected Time Frame – 01/01/11 to 12/31/11)

Age (Months) at Blood Lead Draw	2011	2010	2009
<9 (before age one)	24	42	33
9 - <18 (at or around age one)	1,801	1,439	1,424
18 - <36 (at or around age two)	1,704	1,311	1,262
36 - <48	118	124	119
48 - <60	43	81	69
60 - <72	31	45	41
72+	81	85	106
TOTAL	3,802	3,127	3,054

**Blood Lead Screening Tests By Age  
9 - 18 Months and 18 - 36 Months**



## 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 Nursing Service.

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 DelGiaccio, 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>
2011	1,337	0	8	0	261	70
2010	1,477	2	17	147	357	62
2009	1,499	3	8	180	287	67

For 2011, note that there were a total of 1,337 skin tests performed. A total of 300 were administered at Saratoga County Public Health Nursing Service, 933 at the County Jail and 109 skin tests were administered off site, i.e. Shelters of Saratoga (20), Saratoga Race Track (39) and the Soup Kitchen (0), Home of the Good Shepherd (4), and Saratoga Springs Fire Department at Public Health (46).

\*Of note, we did not have a full-time Program Coordinator for the TB Program until June, 2011.

## **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. Since November 2002, a law has been in 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 Nursing Service 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>
2011	591	135	52	12
2010	611	136	62	10
*2009	588	183	104	20

\*There were less bites reported in 2009; however, 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 Nursing Service 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 Adirondack Health Institute, Inc. (formerly called Upper Hudson Primary Care Consortium) serves as the coordinator for this endeavor. County health department officials meet regularly with Adirondack Health Institute 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.

## 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	2011	2010	2009
Raymond Watkins 2x year	24	30	11
Waterford Senior Center 2x year	8	12	7
Midtown Apartments 2x year	8	7	7
Corinth Senior Center 2x year	11	15	15
Stonequist Apartments 2x year	18	25	12
Galway Senior Center 2x year	30	22	14
Greenfield Community Center 1 Scheduled in 2011- no shows	0	9	8
Mechanicville Senior Center 2x year	35	41	23
Moreau Community Center 2x year	21	31	37
Clifton Park Senior Center 2x year	48	41	48
Edinburg Town Hall 1x year	15	14	12
Doubleday Woods 1x year	15	12	9
Milton Community Center Not held in 2011	0	0	3
Hadley Town Hall 2x year	9	0	5
Halfmoon Senior Center 2x year	41	54	46
Malta Senior Center 2x year	11	18	11
Burnt Hills United Methodist Church Not held in 2011	0	0	8
Bishop Hubbard Apartments 1x year	6	4	9
Saratoga County Senior Center 2x year	31	1	24
Van Schoonhoven Senior Apts. 1x year	8	9	-
<b>TOTALS</b>	<b>339</b>	<b>345</b>	<b>309</b>

These health screening clinics offer services to the elderly that do not require payment of an office co-pay.

*(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 2011 as follows:

<u>County Building Site</u>	<u>2011 Number Attending</u>
Saratoga County Public Health Nursing Service	10
Dept. of Public Works	33
Solar Building	4
Dept. of Social Services	18
Sewer District	9
Main Complex	19
<b>TOTAL</b>	<b>93</b>

## INFLUENZA CLINICS – 2011

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, Saratoga County Public Health Nursing Service 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. Community held clinics were decreased this flu season due to fiscal constraints.

In addition, Saratoga County Public Health Nursing Service has been able to administer flu vaccine free of charge through our Point of Distribution (POD) vaccine. This vaccine is provided to any individuals that do not have health insurance or cannot afford the \$15 fee. Clinics are held to target this population, specifically at the Salvation Army, Shelters of Saratoga, soup kitchens, and at Saratoga County Public Health Nursing Service walk-in clinics. It is offered to under-insured parents at the Saratoga Springs Immunization Clinics (SSIC), as well. A total of 85 doses were given in 2011.

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 Nursing Service 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 Nursing Service does not accept.

Volunteers have proved to be an essential component of Saratoga County Public Health Nursing Service clinics. Flu Clinics are a setting for 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!

### **Seasonal Influenza Vaccine Administration – 2011**

	<u>2011</u>	<u>2010</u>
Clinics Offered Throughout the County	19	50
Vaccine Doses Administered at Clinics	592	2150
CHHA/Long Term Home Visits for Administration	3	10
Staff/Employee Clinics (POD)	1	4
Flu Clinics Offered at Public Health Building	2+ Walk-ins	2
Vaccine Doses Administered at Public Health Building	58	42

## **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

All uninsured clients are referred to Saratoga Care to help establish insurance. There is often a facilitated enroller present at clinics. This initiative started in the second half of 2011. A total of 14 children have been enrolled since Saratoga Care has been attending clinics.

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

To accommodate children going back to school in September, we increased our clinics to six times each month in August and four times each month during September and October.

### **Saratoga Springs Immunization Clinic Statistics for 2011**

	<u>2011</u>	<u>2010</u>
Number of clinics	43	40
Number of children vaccinated	304	340
Number of vaccines administered	753	808

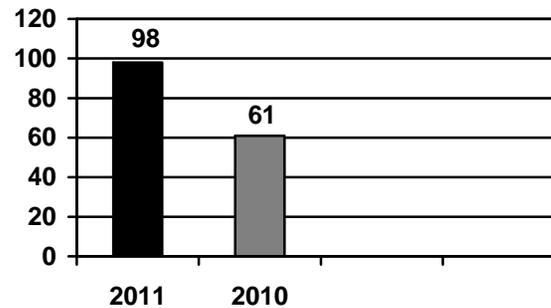
## **BACKSTRETCH HEALTH FAIR**

It is Saratoga County Public Health Nursing Service's third year participating in the Backstretch Health Fair. A variety of vendors and service providers from around the Capital District participated. Public Health was unable to provide health screening this year due to fiscal constraints. Educational pamphlets on a variety of topics and a directory of services were made available to the participants in both English and Spanish, to include diabetes, tick information/Lyme disease, nutrition, asthma, rabies, lead prevention, immunization, Hepatitis C, poison control, and West Nile virus.

### **Total Number of Participants**

<u>2011</u>	<u>2010</u>
98	61

### **Total Participants**



## **MIGRANT AND SEASONAL FARM WORKERS**

The vision of this project is that “Migrant workers and their families living and working in Saratoga County will be able to easily access culturally and linguistically appropriate health services that address their needs and improve their quality of life.”

Migrant and seasonal farm workers are defined for federal funding purposes as “individuals who are employed in agriculture on a seasonal basis that establish a temporary residence for the purpose of such employment.” These workers face a number of challenges in accessing adequate health care related to their working and living arrangements, their high rate of mobility, limited income, and lack of health insurance, as well as depending upon their country of origin, cultural and language barriers.

For the purpose of this health initiative, the broadest definition of migrant worker will be used. This includes individuals employed at the Saratoga Racetrack during the summer flat track season.

Saratoga County Public Health Nursing Service was at the Backstretch of Saratoga Racecourse once a week from April 25, 2011 through October 31, 2011 and were able to see 62 people during this timeframe. Vaccines administered were as follows:

	<u><b>2011</b></u>	<u><b>2010</b></u>
Total number of clients seen:	62	77
<u><b>Vaccines Administered</b></u>		
Hepatitis A & B (Twinrix)	45	34
Tdap (Tetanus, diphtheria, acellular pertussis)	47	56
Influenza	28	16
Pneumovax	31	0
<b>Total</b>	<b>151</b>	<b>106</b>

## SEXUALLY TRANSMITTED DISEASE (STD) CLINIC

Saratoga County Public Health Nursing Service's 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 2010

Month	Clinics Held		Total Clinic Attendance		HIV Tests		STD Tests		Sex				New		Gonorrhea		Chlamydia		Syphilis	
	*2011	2010	2011	2010	2011	2010	2011	2010	2011		2010		2011	2010	2011	2010	2011	2010		
									M	F	M	F								
January	3	5	9	25	3	11	6	44	8	1	23	2	8	21	0	1	0	1	0	0
February	3	3	17	19	7	7	26	34	17	0	11	8	14	12	0	0	1	0	0	0
March	5	5	31	32	12	11	67	41	20	11	28	4	26	24	0	0	2	1	0	0
April	4	5	23	21	12	10	42	30	18	5	19	2	13	15	0	0	0	1	1	0
May	3	4	16	16	4	5	17	27	10	6	11	5	9	8	0	0	0	1	0	0
June	4	5	21	25	9	11	37	46	13	8	18	7	14	16	0	0	1	0	0	0
July	4	4	27	30	12	10	54	55	23	4	21	9	18	16	1	0	1	1	0	0
August	4	4	17	37	9	17	41	52	13	4	28	9	15	19	0	0	2	1	1	0
September	4	4	24	31	5	13	33	41	14	10	25	6	15	13	0	0	0	1	0	0
October	3	3	18	19	3	7	21	14	15	3	15	4	8	13	0	0	1	0	0	0
November	4	2	11	11	2	3	12	9	8	3	10	1	5	5	0	0	0	1	0	0
December	4	4	12	10	3	8	15	27	9	3	8	2	6	6	0	0	1	0	0	0
<b>TOTALS</b>	45	48	226	276	81	113	371	420	168	58	217	59	151	168	1	1	9	8	2	0

\*Additionally, a total of 104 clinics were provided in 2011 to review test results with patients. This was outside the regular clinic schedule.

(Continued)

The total number of inmates attending the STD Clinic for 2011 was 43.

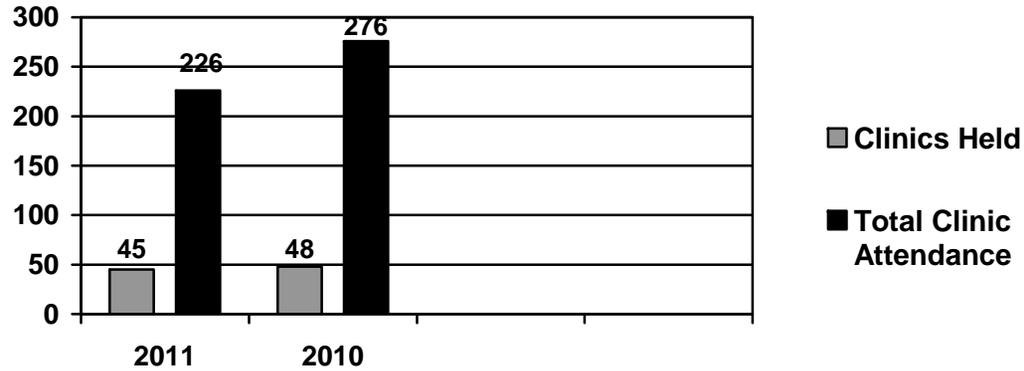
The STD Clinic participates in the NYS Department of Health Free Hepatitis Program. Hepatitis vaccines (Twinrix) are offered to all clients. An important component of the clinic is education regarding safer sex practices.

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

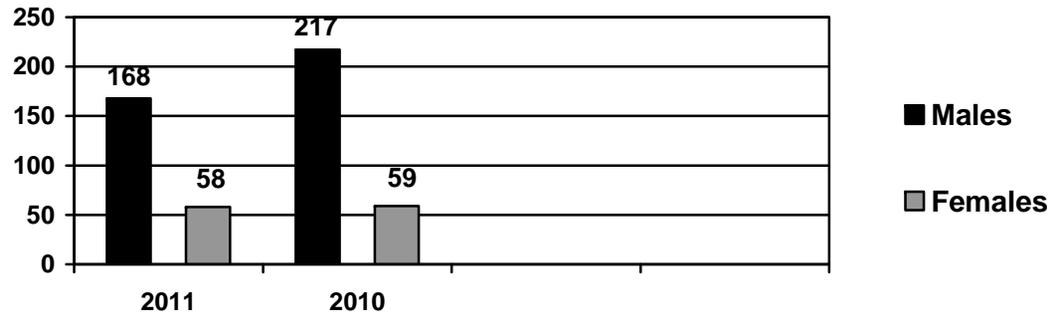
<b>Month</b>	<b><u>2011</u></b>	<b><u>2010</u></b>	<b><u>2011</u></b>	<b><u>2010</u></b>	<b><u>2011</u></b>	<b><u>2010</u></b>
	<b>#1</b>		<b>#2</b>		<b>#3</b>	
January	0	2	1	3	0	2
February	1	2	1	0	0	3
March	2	6	1	1	1	0
April	4	0	2	1	0	2
May	3	1	2	1	1	0
June	3	2	0	1	0	1
July	0	2	2	2	0	1
August	3	2	0	1	2	1
September	4	4	1	4	1	0
October	0	3	4	2	1	0
November	1	0	0	0	0	0
December	2	3	0	0	0	0
<b>TOTALS</b>	<b>23</b>	<b>27</b>	<b>14</b>	<b>16</b>	<b>6</b>	<b>10</b>

## STD Clinics By The Numbers

### Clinics Held / Total Attendance

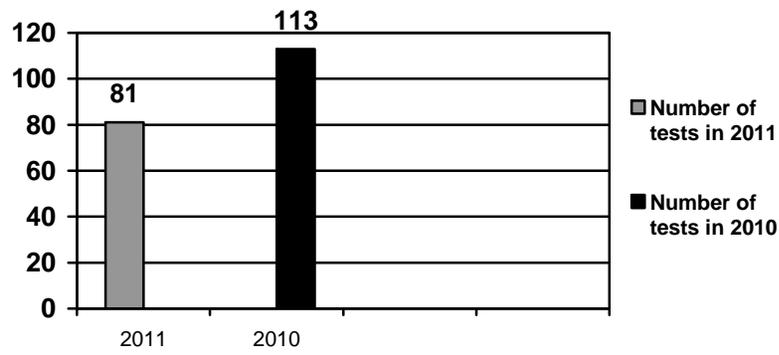


### STD Clinic Use By Gender

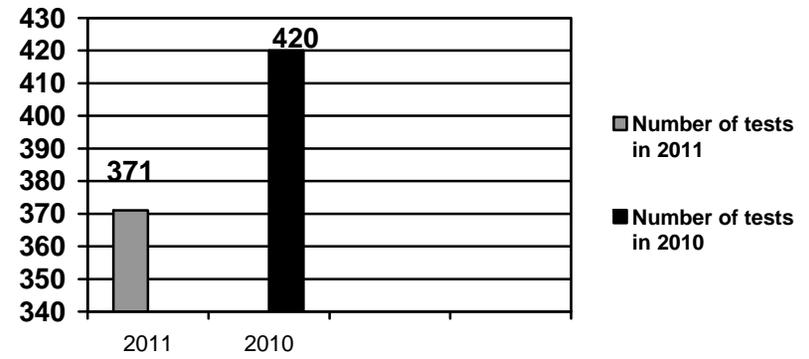


\*The graph "Clinic Use By Gender" represents the total number of patients that attend the STD Clinic. These numbers are not exclusive to people seeking only HIV testing/information. Anyone attending the clinic for HIV or STD or a combination of HIV/STD testing/information is included in these numbers.

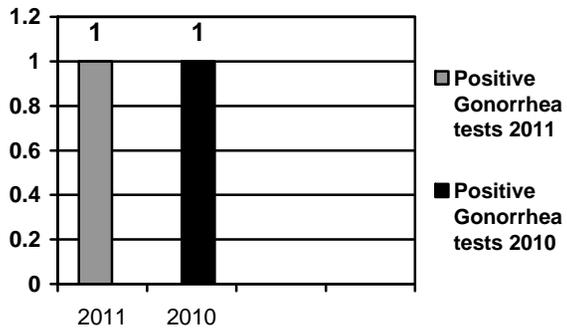
### HIV Tests



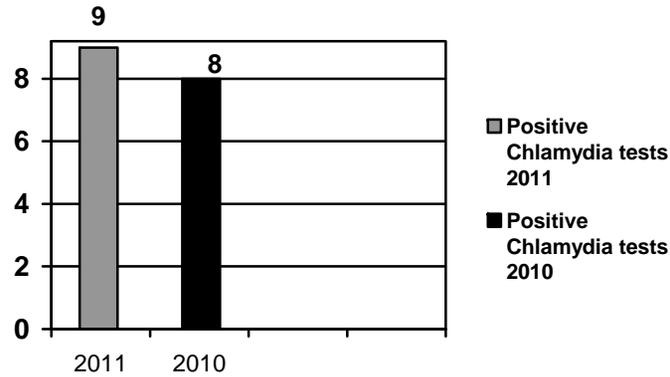
### STD Tests



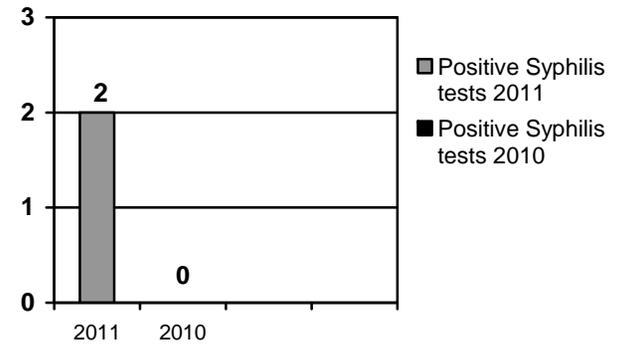
### Positive Gonorrhea Tests



### Positive Chlamydia Tests



### Positive Syphilis Tests



## **INFECTION CONTROL AND COMMUNICABLE DISEASE CONTROL - 2011**

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 Nursing Service 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.

As the need arises during the year, we "blast fax" publications to healthcare providers, hospitals, and urgent care centers. 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

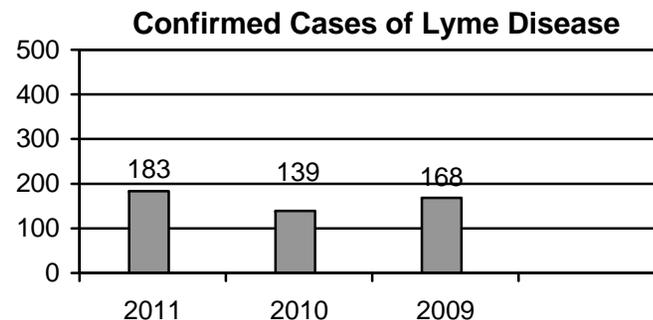
These numbers represent only those infections that were reported to our department. There may be additional infections that have gone unreported due to lack of testing.

Number of new cases for	2011	2010	2009
Amebiasis	4	0	0
Babesiosis	1	0	0
Campylobacter	36	34	32
Chlamydia	363	323	294
Cryptosporidiosis	4	1	1
Cyclospora	0	1	0
Dengue Fever	0	1	0
E-Coli O157:H7	2	1	3
E-Coli Non-0157	1	1	1
Ehrlichiosis	3	2	2
Encephalitis	1	0	2
Giardia	21	22	31
Gonorrhea	32	26	18
Haemophilis Influenzae, Invasive--not Type B	1	5	1
Hepatitis A	1	0	0
Hepatitis B	13	12	12
Hepatitis C	105	95	92
HUS--Hemolytic Uremic Syndrome	1	0	1
Legionellosis	6	2	7
Listeriosis	1	0	1
<b>*Lyme Disease</b>	<b>183</b>	<b>139</b>	<b>168</b>
Malaria	0	0	0
Meningitis - Meningococcal	3	0	1
Meningitis - Other bacterial	0	1	0
Meningitis--Viral	9	3	11
Mumps	0	0	1
Pertussis	30	33	1
Q Fever	0	0	0
Salmonellosis	27	32	22
Shigellosis	4	3	2

**\*Lyme** – We investigate 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	2011	2010	2009
Staphylococcal Enterotoxin B	0	0	0
Streptococcus Group A, Invasive	11	12	4
Streptococcus Group B, Invasive	11	15	10
Streptococcus Group B, Invasive early/late onset	0	1	1
Streptococcus Pneumoniae, Sensitive	17	23	18
Streptococcus Pneumoniae, Intermediate	0	1	10
Streptococcus Pneumoniae, Resistant	0	1	0
<b>**Swine-Origin Influenza (H1N1)</b>	<b>1</b>	<b>3</b>	<b>60</b>
Syphilis	4	6	5
Toxic Shock Syndrome	3	0	1
Tuberculosis active cases	0	2	3
Vibrio	0	0	1
Viral Encephalitis (WNV)	0	0	0
Rabid Animals	12	11	21
Rabies Vaccine Recipient	52	62	104
Yersiniosis	0	0	1

**\*\*Swine-Origin Influenza** – This number is from the time period of the 2009 to 2010 outbreak.



## **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 is one additional agency that provides part-time Initial and Ongoing Service Coordinators to support the program. The Saratoga EI Program contracts with 95 independent contractors and 22 agencies to provide the screenings, evaluations, and services listed above.

- Saratoga County has had 507 referrals for this past year (October 1, 2010 – September 30, 2011); 405 evaluations were performed and, of these numbers, we have enrolled 53% (213) and found 47% (192) not eligible for our services.
- 2 families moved from our county prior to receiving services
- 88 re-referrals had evaluations repeated anywhere from 3 to 12 months after their initial core evaluation. Of those re-referrals, 65% qualified.
- 92 refused our program.
- 19 went directly to CPSE instead of starting with the EIP (over 30 months old).
- There were no new referrals to the Child Find program from EI.

*(Continued)*

- 55 referrals were received from CPS and given to the Child Find program (only 22 families participated in Child Find).
- 42 children were closed out from the program this year due to inability to locate (7), relocation outside of county (21), aged out for 3-5 without completing transition process (14).
- We assisted 136 families through the transition process to CPSE (3-5) program and 5 aged-out, not to CPSE but transitioned to another program.
- 30 children were closed due to delay/condition resolved in this past year, (16 <2.5 yrs; (12) 2.5-3 yrs; (2) 3+ yrs.

We served 102 infants under 1-year of age, which was 20% of our referrals; 51% of this age group qualified for EI services. The largest age group (57%) that we service continues to be in the one to two year old age ranges. There were 118 (23%) of our referrals within the 25-33 month age range. The majority (89%) of our children services are delivered within the most natural environment setting. We currently serve 198 children at home, 15 in family day care settings, and 19 are at a provider/agency setting.

During the fiscal year (October 1, 2010 - September 30, 2011), 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: *“Introductory Service Coordination,” “IFSP,” and “Natural Environment.”* 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 May, the providers were instructed about the NYEIS process, program and regulatory changes. The summer meeting in July included a speaker from CARD, with presentation on Best Practices for Students with ASD. The fall meeting in October was an Annual meeting to discuss contract obligations, including the following topics: Health & Safety, confidentiality, NYEIS, billing and training on Corporate Compliance.

As part of the EI program, Saratoga County Public Health Nursing Service 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 16 members, which, during 2011, included 2 parents, 4 EI service providers, 1 child care provider, 1 OMRDD representative, 2 CEO/Designees from NYS Department of Health and Mental Health, 1 DDSO representative, 1 CPSE chairperson, 1 County Youth Bureau Director, and 1 EI Program Manager. In 2011, the Chairperson was Karen Levison, Early Intervention Officer (EIO), and the Co-Chairperson was Heather Straughter, parent. 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.

*(Continued)*

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>2011</b>	<b>2010</b>	<b>2009</b>
Referrals to EI	507	486	518
New Children Enrolled - EI	213	207	216
Referrals to Child Find	32	73	50
Enrolled in Child Find at End of Year	43	60	85

## **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. 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 Service 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 through 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 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 periodically 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. During 2011, the staff reviewed the video and skin care modules that were created in 2010 by Partners in Prevention in conjunction with Excelsior College.

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. SCPHNS recognizes that it is the right of every individual to receive quality care which allows the individual to achieve 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 and teaching them to manage their health 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>2011</b>	<b>2010</b>	<b>2009</b>
Nursing	4415	5312	6026
Nursing – PRI	202	200	199
Physical Therapy	4874	5108	5931
Occupational Therapy	443	336	224
Speech Pathology	50	30	158
Medical Social Worker	79	34	46
Home Health Aide	1233	1659	1712
Nutritionist	12	22	25
<b>SUB-TOTAL</b>	<b>11308</b>	<b>12701</b>	<b>*14321</b>
<b>NON-BILLABLE VISITS:</b>			
All Disciplines, other than nursing	137	158	202
Nursing No Charge	328	484	452
<b>TOTAL CHHA VISITS</b>	<b>11773</b>	<b>13343</b>	<b>*14975</b>
<b>HOME HEALTH AIDE HOURS</b>	284	232	1783
<b>CENSUS:</b>			
January 1	73	95	101
December 31	76	73	95

\* There is a tremendous decrease in Home Health Aide visits. As more individuals become enrolled in managed care health insurance plans, either Medicare or private, we are finding that most plans are authorizing fewer visits.

## **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, 513 Saratoga County residents have received services through the program. During 2011, 24 patients were served by the LTHHCP (8 male and 16 female). We are authorized to provide service for 48 patients, and our patient census as of December 31, 2011 was 16. Our staff currently consists of three fulltime nurses since October 16, 2009. When staff is replaced, we will work toward achieving capacity. No referrals were taken in 2011.

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 5 patients received aide service during 2011. 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 16 LTHHCP patients utilized this extremely valuable service in 2011. 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 8 patients utilized this service during 2011. 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 2011, 1 patient 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 8 patients received nutritional services during 2011. 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.

*Medical Alert Service (Formerly Lifeline):* Services are offered by the LTHHCP through Glens Falls Hospital and have proven invaluable to many of our patients. There were 21 LTHHCP patients subscribed to Medical Alert Service in 2011. Many of our patients live alone or spend many hours of the night or day alone. Medical Alert Service 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 2011, 10 LTHHCP patients received MOW. Patients, who can no longer prepare meals, can still enjoy warm nutritious meals 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>2011</b>	<b>2010</b>	<b>2009</b>
Nursing	783	1065	1266
Nursing – PRI	2	4	2
Physical Therapy	390	581	731
Occupational Therapy	7	2	86

(Continued)

Long Term Home Health Care Statistics *(Continued)*

<b>BILLABLE VISITS (Continued)</b>	<b>2011</b>	<b>2010</b>	<b>2009</b>
Speech Pathology	0	0	1
Medical Social Worker	281	302	366
Home Health Aide	2191	2245	2111
Nutritionist	38	70	66
Personal Care Aide	513	985	1753
Respiratory Therapy	76	124	239
Homemaker	0	0	0
Housekeeper	0	0	0
Audiology	0	0	0
<b>SUB-TOTAL</b>	<b>4281</b>	<b>5378</b>	<b>6621</b>
<b>NON-BILLABLE VISITS:</b>			
All Disciplines, other than nursing	16	31	64
Nursing No Charge	167	421	523
<b>TOTAL LTHHCP VISITS</b>	<b>4464</b>	<b>5830</b>	<b>7208</b>
Home Health Aide Hours	3688	3416	3631
Personal Care Aide Hours	996	2113	2970
Homemaker Hours	0	0	0
Housekeeper Hours	0	0	0
<b>LTHHCP WAIVERED SERVICES:</b>			
Social Day Care	2	101	321
Meals On Wheels Delivered	3112	4199	5567
Lifeline (Monthly Rentals)	181	248	286
<b>CENSUS:</b>			
January 1	25	25	31
December 31	16	25	25
<b>PAYMENT SOURCE:</b>			
Medicaid	5	9	32
Medicare and Medicaid	13	20	12
Medicaid and Other Insurance	2	2	0
Medicare	3	3	

## PERSONAL CARE AND OTHER DSS PROGRAMS

Upon receipt of a request from a Department of Social Services (DSS) caseworker, the Saratoga County Public Health Nursing Service (SCPHNS) 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 SCPHNS 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 SCPHNS 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 SCPHNS nurse, along with a DSS caseworker, is responsible for completing the program assessment.

The SCPHNS 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 SCPHNS 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>2011</b>	<b>2010</b>	<b>2009</b>
<i>Personal Care Program</i>			
January 1	20	27	24
December 31	19	20	27
<i>Private Duty Nursing Cases</i>			
January 1	8	10	12
December 31	9	8	10
<i>Care at Home Program</i>			
January 1	17	15	12
December 31	22	17	15
<i>Consumer Directed Personal Assistance Program (CDPAP)</i>			
January 1	252	188	182
December 31	258	252	188

	<b>2011</b>	<b>2010</b>	<b>2009</b>
<b>REFERRALS</b>			
Personal Care Program	31	40	70
Private Duty Nursing Cases	14	14	20
Care at Home Program	33	36	23
Consumer Directed Personal Assistance Program CDPAP	468	461	370
<b>TOTAL REFERRALS RECEIVED</b>	<b>546</b>	<b>551</b>	<b>483</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 2011**

The Utilization Review (UR) Committee met on February 17, May 19, August 18, and November 17, 2011 to review patient records and patient services. The active caseload as of December 31, 2010 was 100, which included 75 for the CHHA and 25 for the LTHHCP.

A total of 71 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 2011 included: Active and discharge charts and the appropriateness of services and coordination of care; compliance with documenting emergency contact and patient acuity; receipt of MD orders within 30 days; signed welcome letter and acknowledgement sheet; patients receiving HHA services, charity care, wound care, and patients on the adverse outcome report. Charts reviewed were found to meet criteria of each review. Any problem areas were reviewed by the clinician and their supervisor and it was reported to the Professional Advisory Committee (PAC).

Goals for 2011 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 Nursing Service, 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.

A Process-Based Quality Improvement Report is generated quarterly. This report provides Saratoga County Public Health Nursing Service a means to evaluate use of specific evidence-based processes of care (Best Practices). Process quality measures include such factors as Timely Initiation of Care, Care Coordination, Assessment Care Planning, Care Plan Implementation, Education and Prevention. 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	2011	2010	2009
Hospitals	1104	673	2028
Physicians	169	170	132
Other (CHHA)	90	100	94
Agencies	638	619	520
Other (Prevention)	599	664	671
PRI	259	232	231
<b>TOTAL</b>	2859	2458	3676

*(Percent to Totals)*

Referral Source	2011	2010	2009
Hospitals	39	28	55%
Physicians	6	7	4%
Other (CHHA)	3	4	3%
Agencies	22	25	14%
Other (Prevention)	21	27	18%
PRI	9	9	6%
<b>TOTAL</b>	100%	100%	100%

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

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 (includes CDPAP, Care at Home, and Private Duty Nursing).

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>2011</b>	<b>2010</b>	<b>2009</b>
Nursing	7002	7394	8470
Nursing – PRI	315	204	201
Physical Therapy	5301	5687	6664
Occupational Therapy	455	338	310
Speech Pathology	50	30	160
Medical Social Worker	365	336	412
Home Health Aide	3446	3904	3823
Nutritionist	52	92	91
Personal Care Aide	513	985	1753
Respiratory Therapy	76	124	239
Homemaker	0	0	0
Housekeeper	0	0	0
Audiology	0	0	0
<b>SUB-TOTAL BILLABLE VISITS</b>	<b>17575</b>	<b>19094</b>	<b>22123</b>
<b>NON-BILLABLE VISITS:</b>			
All Disciplines, other than nursing	162	348	364
Nursing No Charge and Maternal Child Health	1043	1675	1874
Early Intervention Program	1342	1400	1486
<b>SUB-TOTAL NON-BILLABLE VISITS</b>	<b>2547</b>	<b>3423</b>	<b>3724</b>
<b>TOTAL AGENCY VISITS</b>	<b>20122</b>	<b>22517</b>	<b>25847</b>

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

## AGENCY STAFF

### PAYROLL POSITIONS

	2011	2010	2009
<b>Administrative Staff</b>			
Administrators	2	2	3
Nursing Supervisors	4	5	5
Therapy Supervisor	1	1	1
Clerical/Support Staff	12	13	13
<b>Field Staff</b>			
Public Health Nurse	4	8	10
Liaison Nurse	1	1	1
Registered Nurse	18	19	16
Registered Nurse, Part-time or Per-diem	8	11	12
EI Care Coordinator	4	4	4
Home Health Aides	1	1	2
Home Health Aides, Part-time	1	1	3
BT Grant Staff (PHN and Info. Proc. Spec.)	2	2	2
Outreach Worker (Part-time)	0	0	1

### CONTRACTED SERVICES

	2011	2010	2009
<b>Contracted Services*</b>			
Physical Therapy	10	10	10
Occupational Therapy	3	3	4
Outpatient Physical Therapy	2	3	1
Outpatient Occupational Therapy	0	0	0
Outpatient Speech Pathology	0	0	0
Medical Social Worker	3	3	3
Speech Pathology	2	2	4
Nutrition	1	1	1
Respiratory Therapy	1	1	1
<b>Aide Agencies**</b>			
Home Health Aide (HHA)	4	5	4
Homemaker (H/M)	0	0	0
Personal Care Aide (PCA)	0	0	4

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

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

## FINANCIAL ANALYSIS

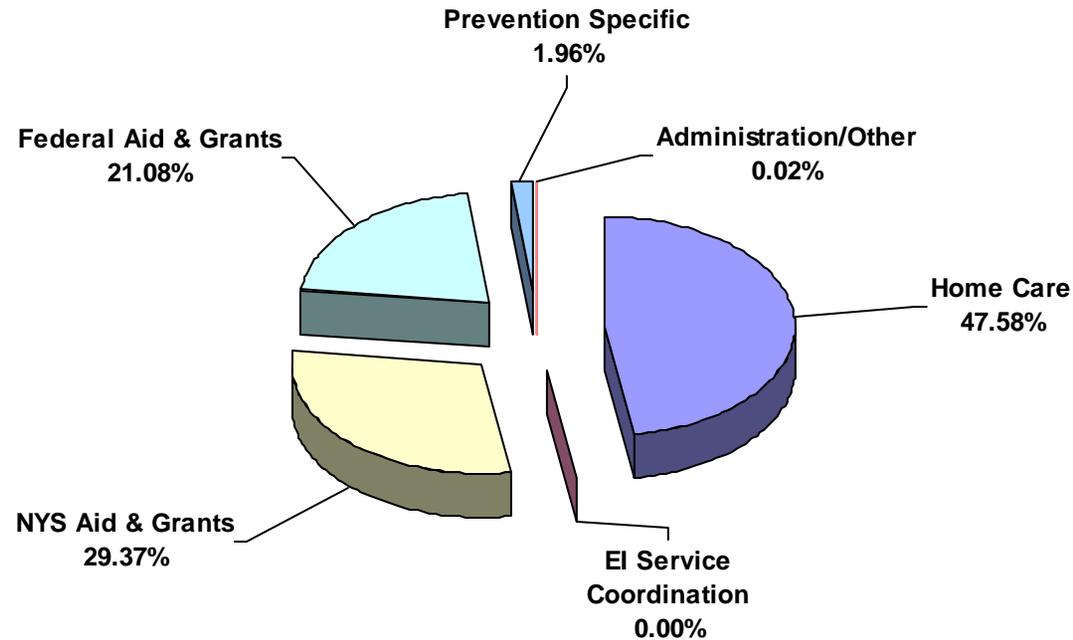
The 2010 Long Term Cost Report was completed in July 2011 and the 2010 Medicaid cost report was completed July 2011. The agency charges per visit were raised as of August 2008.

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 2011 were:

<b>HOME HEALTH CARE SERVICES</b>		<b>LONG TERM HOME HEALTH CARE PROGRAM</b>	
Nursing	\$170 / visit	Nursing	126.27/ visit
Physical Therapist	\$115 / visit	Physical Therapist	92.49 / visit
Occupational Therapist	\$115 / visit	Occupational Therapist	86.82 / visit
Speech Therapist	\$115 / visit	Speech Therapist	103.04 / visit
Medical Social Worker	\$115 / visit	Medical Social Worker	103.05 / visit
Nutritionist	\$115 / visit	Nutritionist	97.79 / visit
Home Health Aide	\$50 / hour	Respiratory Therapist	86.08 / visit
		Audiologist	88.44 / visit
		Home Health Aide	32.88 / hour
		Housekeeper	20.30 / hour
		Homemaker	16.25 / hour
		Personal Care Aide	29.49 / hour

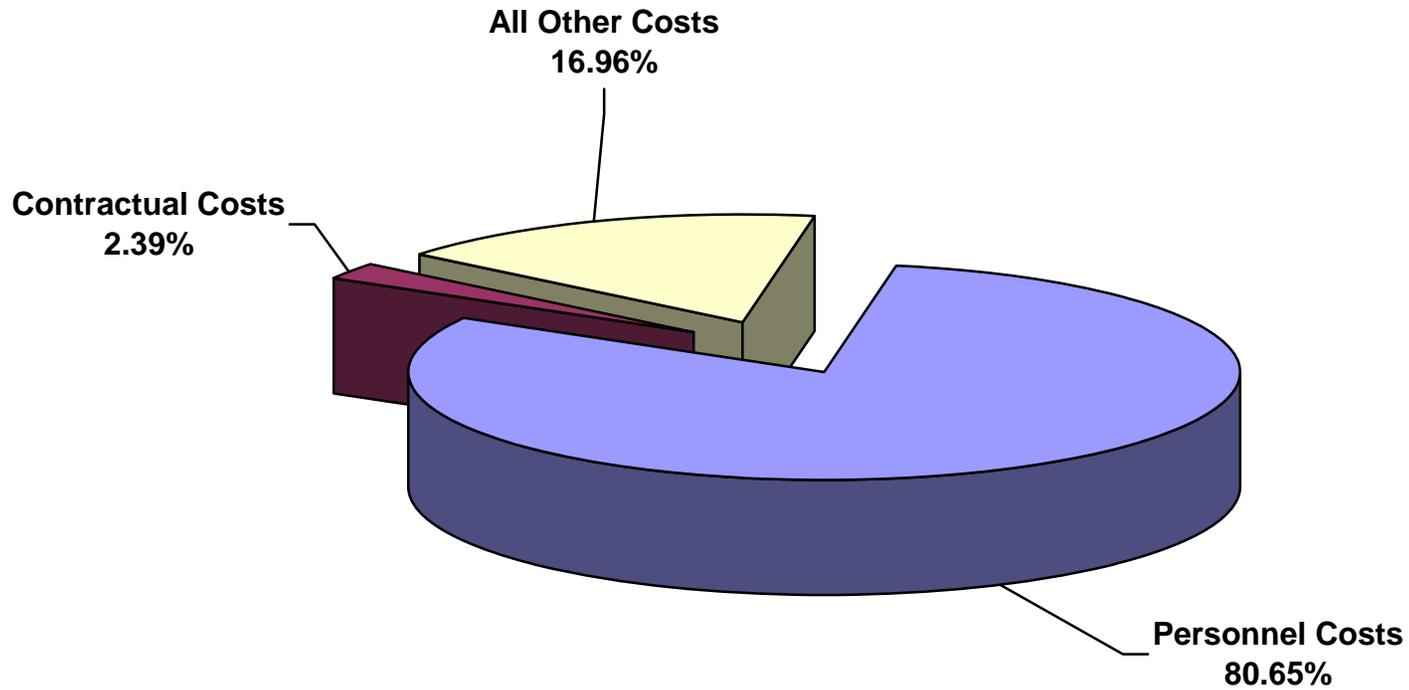
## TOTAL REVENUE 2011



The booked revenues for 2011 include Medicare, Medicaid, other insurances, and State Aid for a total of \$4,251,028.08. 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 2011



The total expenses for 2011 were \$4,991,096. The majority of expenses were Personnel/Fringes.



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