CHHA: Certified Home Health Agency

- **Capacity:** Operated at capacity during the second half of June; 20 referrals could not be accepted due to available staffing/caseload capacity. Physical therapy remains one of the CHHA's most frequently requested services and a significant capacity need. Under Medicare requirements, a home health agency must be able to provide or arrange for the services necessary to meet a patient's identified needs and plan of care. When a patient requires both skilled nursing and physical therapy and the CHHA does not have sufficient PT capacity, the agency may be unable to accept the referral, resulting in the patient receiving services from another home health agency.

- **Patient Cost-Sharing/Revenue Cycle:** As a reminder, the CHHA is an Article 36 certified home health agency and is not a general or automatically available county service. Patients must meet applicable clinical, eligibility, payer, and home health requirements for admission and continued services. Services are billed to the appropriate payer, and patients remain responsible for applicable copayments, coinsurance, or other patient-responsibility amounts based on their coverage.

  Identified a gap in the CHHA's historical collection of applicable patient copayments and coinsurance. A formal collection process is being developed to ensure applicable patient-responsibility amounts are billed and collected moving forward. The CHHA will also be initiating a review of outstanding prior balances to pursuing collection of eligible amounts, where appropriate.

- **Electronic Medical Report (EMR) Transition:** Awaiting signed contracts. Preparing for the planned transition to Homecare Homebase (HCHB).
- **Census & Productivity:** Achieved the highest average daily census (ADC) and productivity levels recorded in the past two years.

CHHA Monthly Data														
	2025 Total	January	February	March	April	May	June	July	August	September	October	November	December	2026 YTD
Staff Productivity	4.84	4.93	4.62	4.82	4.91	4.98	5.13							4.90
New Patients*	1027	69	43	76	62	63	86							399
Discharges*	1105	70	43	70	68	84	64							399
RN/LPN Visits*	6330	413	389	473	490	463	576							2804
PT/PTA Visits	6698	389	309	360	386	334	428							2206
OT Visits*	2567	132	117	239	220	180	183							1071
ST Visits*	786	66	54	66	61	66	78							391
PCA		5	2	3	5	4	0							19
PRI/Screen		5	1	3	5	6	2							22
HHA Visits*	795	32	49	55	37	53	87							313
Total Visits	17749	1042	921	1199	1204	1106	1354							**6826**

Table 1 * based on billable visits entered in our system by all clinicians

<table>
<tr><th>Goal / Area of Focus</th><th>Key Performance Indicators</th><th>Update / Progress</th></tr>
<tr><td>Increase and maintain the daily census of the CHHA Program to ensure consistent enrollment, maximize resource utilization, and support the growing demand for home healthcare professionals.</td><td>Average daily census (ADC)</td><td>ADC: 122</td></tr>
<tr><td>Increase the number of new patient admissions through enhanced referral partnerships, physician outreach, and digital marketing strategies.</td><td># of referrals
Referral Conversion Rate (RCR) (referrals → admissions)
Target RCR: 40-60%
# of new patients
# of discharges</td><td># of referrals: 103
RCR: 83%
new patients: 86
discharges: 64</td></tr>
<tr><td>Maintain Full Staffing

Achieve an average of 5 points per day, per clinician while maintaining high-quality care, measured through patient satisfaction scores and clinical outcome improvements.</td><td># of staff for all CHHA positions
Staff Productivity
# of visits by type:
RN- Registered Nurse
PT- Physical Therapy
OT- Occupational Therapy
ST- Speech Therapy
MSW- Master Social Work Visit
HHA- Home Health Aid Visit</td><td>Staff Productivity: 4.91
See table below
<table><tr><th>Field</th><th>full-time</th><th>perdiem</th><th>total</th></tr><tr><td>RN</td><td>6</td><td>2</td><td>8</td></tr><tr><td>LPN</td><td>1</td><td></td><td>1</td></tr><tr><td>PT</td><td>4</td><td>0</td><td>4</td></tr><tr><td>PTA</td><td>1</td><td></td><td>1</td></tr><tr><td>OT</td><td>2</td><td></td><td>2</td></tr><tr><td>ST</td><td>1</td><td></td><td>1</td></tr><tr><td>total</td><td>16</td><td>4</td><td>18</td></tr></table></td></tr>
<tr><td>Ensure timely and accurate completion of Patient Review Instrument (PRI) and Health Screens for Next Stage of Life Healthcare participants to support appropriate placement and continuity of care for individuals requiring nursing home or long-term care services.

(PRI established by the NYSDOH, is used to assess the physical, medical, and mental characteristics of individuals who may require nursing home care, and to document the level of services needed to support their ongoing health and safety.)</td><td># PRI assessments</td><td># PRI assessments: 2</td></tr>
<tr><td>Ensure Personal Care Assessments (PCA) are completed thoroughly and in alignment with program standards to support effective care planning.
(PCA is an evaluation used to determine an individual’s need for assistance with daily living tasks such as bathing, dressing, mobility, meal preparation, and medication support.)</td><td># PCA assessments</td><td># PCA assessments: 0</td></tr>
</table>

Maternal and Child Health Programming

- **Clarification Regarding MCH:** Maternal and Child Health is not synonymous with a single home-visiting program. MCH encompasses a continuum of public health activities addressing the health of pregnant and postpartum individuals, infants, children, and families. SCDPH's MCH activities include newborn outreach and risk identification, immunization/VFC, childhood lead prevention and follow-up, newborn hearing follow-up, Early Intervention and CYSHCN linkages, Healthy Families referrals, Public Health Nursing, and connection to appropriate healthcare and community resources. The Department's current restructuring is intended to strengthen this continuum while ensuring that each service is provided by the appropriate program, within the appropriate scope, and with appropriate clinical documentation.

- **Maternal & Child Health (MCH):** The Maternal and Child Health program **has not been abolished**. Certain historical MCH practices were paused after Public Health identified concerns regarding program structure, documentation, and appropriate scope of service. The Department is restructuring these activities to ensure services are delivered and documented within the appropriate Public Health program.

  New baby outreach continues using birth certificate data. Additional attention is given to births with identified risk factors, including prematurity, low birth weight, limited or no prenatal care, substance use, and other maternal or infant health concerns. Based on identified needs, families are referred or connected to the appropriate services, including the CHHA, Early Intervention (EI), Children and Youth with Special Health Care Needs (CYSHCN), Healthy Families New York, and other appropriate community or healthcare resources.

  Public Health Nursing home visits have not yet resumed. Historically, documentation for some of these visits was entered into the CHHA electronic medical record despite the visits not being CHHA services. To ensure appropriate separation of records and compliant documentation practices, Public Health Nursing visits will resume following implementation of the Department’s Patagonia EHR, which will provide the appropriate documentation platform for these non-CHHA Public Health services.

  This represents a restructuring and compliance improvement—not an elimination of maternal and child health activities. Outreach, risk identification, referral, and care coordination continue while the appropriate infrastructure for Public Health Nursing visits is being implemented.

- **Additional Maternal & Child Health Services:** MCH encompasses a broad range of activities beyond traditional home visiting. Public Health is actively working to strengthen additional MCH services, including:
  - **Childhood Lead:** The Department is exploring the purchase of point-of-care lead testing equipment and training Public Health Nurses to provide appropriate follow-up testing for children requiring additional lead screening or monitoring. This would improve access to timely follow-up testing and reduce barriers for families.
  - **Newborn Hearing:** The Department is exploring the purchase of hearing screening equipment and training Public Health Nurses to provide follow-up screening for infants who do not pass their initial newborn hearing screen. This would provide families with a local option for timely follow-up and help facilitate referral for additional evaluation when indicated.
  - **Child Passenger Safety & Safe Sleep:** SCDPH's MCH activities also include injury prevention and infant safety initiatives. Through the Child Passenger Safety program, trained staff provide car seat education, safety checks, and assistance to help families ensure children are appropriately and safely restrained. Safe sleep education is incorporated into maternal and infant outreach to reinforce evidence-based practices that reduce the risk of sleep-related infant injury and death. These prevention activities are an important component of the Department's broader MCH continuum and support families before a health or safety concern occurs.
  - **Immunization/Vaccines for Children (VFC):** Provides access to recommended childhood immunizations, including vaccines for eligible children through the federal VFC program, while supporting immunization education, outreach, and follow-up.
  - **CAPTA/CARA – Planned Expansion:** SCDPH is preparing to incorporate CAPTA/CARA activities into its MCG continuum to better support infants and families affected by prenatal substance exposure. Implementation will begin following deployment of the Department's new Patagonia HER which will provide the appropriate platform for documentation, care coordination, and tracking. Once implemented, Public Health will support Plans of Safe Care and facilitate connections to appropriate maternal and infant health, behavioral health, substance use, and community-based services.

These initiatives further demonstrate that MCH services have not been eliminated; rather, the Department is restructuring and expanding its MCH capacity to provide appropriate, accessible, and compliant services based on identified community needs.

Child Passenger Safety Program (Car Seat Program)

Goal / Area of Focus	Key Performance Indicators	Update / Progress
Car Seat Distribution and Education	• # of car seats distributed • # of car seats checks	• # of car seats distributed: 10 • # of education provided: 13

Healthy Families

- **Service Delivery:** Services were provided to 56 families during June, with a 93% home visit achievement rate.
- **Program Capacity:** The program is currently serving 56 families, with an overall program capacity of 80. However, current staffing levels and Healthy Families New York (HFNY) caseload weighting requirements limit the program's ability to safely increase enrollment at this time.
- **Staffing:** Effective July, one Family Support Specialist (FSS) was promoted to Program Supervisor. While recruitment is underway to fill two FSS vacancies, the new Program Supervisor will continue carrying a caseload to support continuity of services and maintain program capacity.

<table>
<tr><th>Goal / Area of Focus</th><th>Key Performance Indicators</th><th>Update / Progress</th></tr>
<tr><td>Family Support Staff (FSS) will conduct at least 90% of scheduled home visits per month to ensure consistent family engagement.</td><td>• # of enrolled families (capacity = 60)
• Total of 150 home visits expected per month.
○ Target completed home visits: 85%</td><td>• # of enrolled families: 56
• 98% completed home visits (128 out of 130)</td></tr>
<tr><td>Increase the number of new patient admissions through enhanced referral partnerships, physician outreach, and digital marketing strategies.</td><td>• # of referrals
• # of assessments completed (Frogs)
• # of referrals agreed to services and registered
• Referral Conversion Rate (RCR) (how many referrals turned into admissions)
○ Target RCR: 17%</td><td>• # of referrals: 4
• # agreed to services and registered: 0
• RCR: 0%</td></tr>
<tr><td>Maintain Full Staffing</td><td>• # of staff for all HF positions</td><td><table><tr><th>Staffing</th><th></th></tr><tr><td>Family Support Worker</td><td>2</td></tr><tr><td>Bilingal FSW</td><td>1</td></tr><tr><td>Program Supervisor</td><td>0</td></tr><tr><td>Program Manager</td><td>1</td></tr><tr><td>Total</td><td>4</td></tr></table></td></tr>
</table>

Children and Youth with Special Healthcare Needs / Early Intervention

- **Early Intervention Provider Capacity:** Early Intervention (EI) waitlists remain due to an ongoing shortage of available service providers. Children are referred and matched with available providers as quickly as possible; however, provider availability continues to impact the timeliness of service initiation.

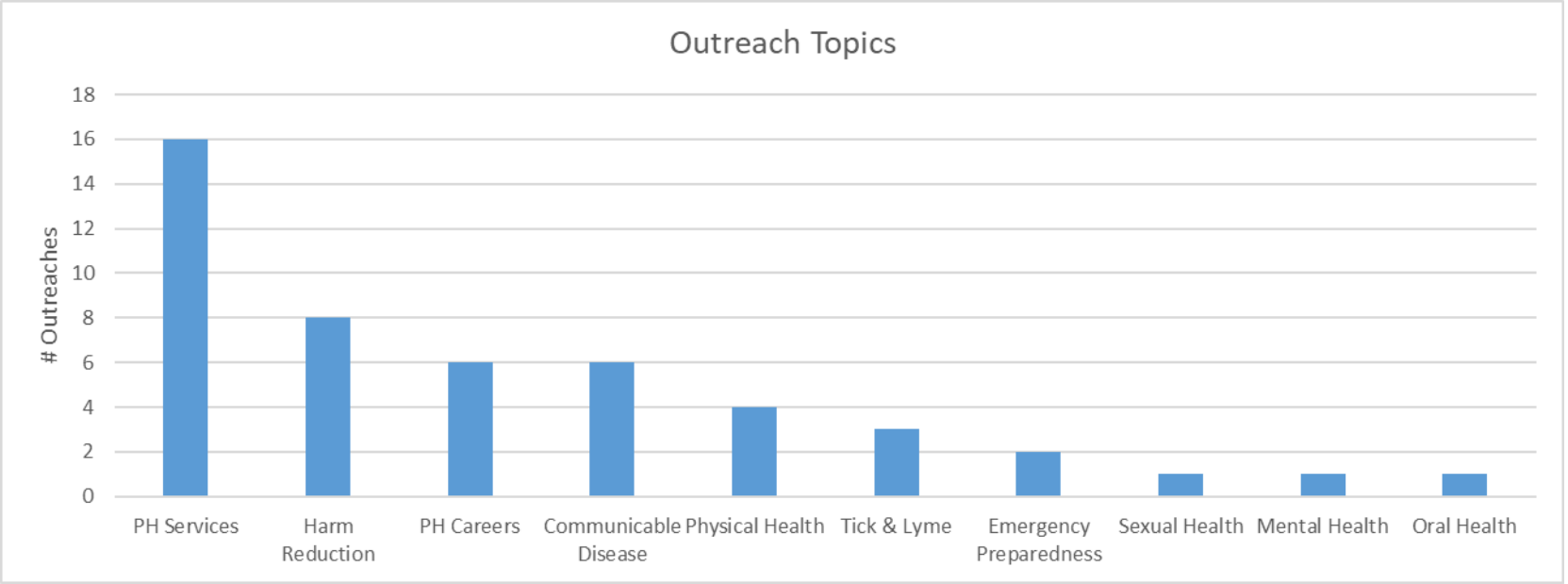
<table>
<tr><th>Goal / Area of Focus</th><th>Key Performance Indicators</th><th>Update / Progress</th></tr>
<tr><td>Ensure that initial CPSE evaluations are completed within 60 calendar days of referral.</td><td>• # of active cases</td><td>• # of active cases: 203</td></tr>
<tr><td>Complete initial EI evaluation and develop Individualized Family Service Plans (IFSPs) within 45 days of referral.</td><td>• # of active cases
○ # of new referrals</td><td>• # of active cases: 192
○ # of new referrals: 17</td></tr>
<tr><td>Early Intervention Ongoing Service Coordinators (EI OSC) will maintain an active caseload of 35-50 families, depending on case complexity and program capacity.</td><td>• EI OSC caseload
○ Recommended 26-60, best practice = 35.</td><td>• EI OSC caseload: average of 71</td></tr>
<tr><td>Increase outreach and engagement for Children and Youth with Special Healthcare Needs (CYSHN)</td><td>• # of active CYSHCN
○ # of new referrals
• # of Education or Resource Events</td><td>• # of active cases: 40
○ # of new referrals: 2
• # of Events: 1</td></tr>
<tr><td></td><td>• % of parents receiving reimbursement
• # of children on waitlist for bussing</td><td>• % of parents receiving reimbursement:
○ EI: 46.35%
○ CPSE: 15.61%
• # of children on waitlist for bussing: 0</td></tr>
<tr><td>Authorized Services and Waitlisted</td><td>• EI Service Type, # children authorized to receive the service
• EI Waitlist: # of children waitlisted for services</td><td>
Service Delivery Summary
<table>
<tr><th>EI Service Type</th><th># Authorized Services</th><th># Delivered Services</th><th>Waiting List (#)</th></tr>
<tr><td>Service Coordination</td><td>197</td><td></td><td>0</td></tr>
<tr><td>Speech Therapy</td><td>105</td><td></td><td>23</td></tr>
<tr><td>Occupational Therapy</td><td>66</td><td></td><td>13</td></tr>
<tr><td>Physical Therapy</td><td>100</td><td></td><td>5</td></tr>
<tr><td>Special Instruction</td><td>94</td><td></td><td>7</td></tr>
<tr><td>Group Dev. Model</td><td>32</td><td></td><td>0</td></tr>
<tr><td>Parent Group</td><td>2</td><td></td><td>0</td></tr>
<tr><td>Social Work</td><td>0</td><td></td><td>0</td></tr>
</table>
</td></tr>
</table>

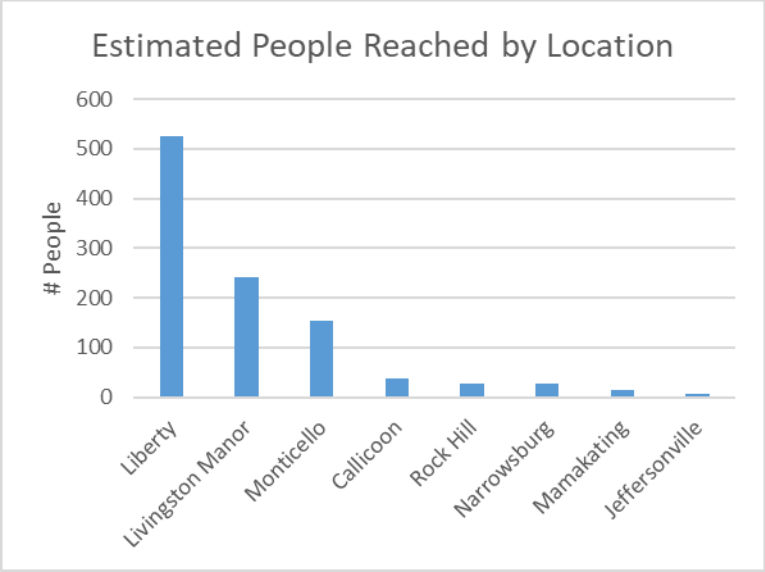
Community Education & Outreach

Health Education

- PH Education organized a collaboration with Sun River at the Federation for the Homeless to offer free blood pressure and A1c testing. Of the 13 people screened, 10 were referred for follow up, either with Sun River or their primary care physician.
- Community Health Worker position is currently vacant.

<table>
<tr><th>Goal / Area of Focus</th><th>Key Performance Indicators</th><th>Update / Progress</th></tr>
<tr><td>Outreach/Education</td><td>• # of educational/outreach workshops
○ Outreach type & # of events
○ # of individuals reached
• # of PH kits distributed
○ Dental Hygiene ADULT
○ Dental Hygiene KIDS
○ Emergency Preparedness Kit
○ Hygiene Kit
○ Overdose Rescue Kit
○ Sexual Health Kit
○ Tick Removal Kit
○ Wound Care Kit</td><td>• # of educational workshops: 21
○ Tabling: 14
○ Educational Workshops (skill building): 1
○ Education Lessons (prevention education): 6
*see table below for outreach topics and County location of participants
○ 1032 individuals reached
• # of PH kits distributed through outreach: 298 total
○ See table
<table><tr><th colspan="2">Public Health Kit Distribution</th></tr><tr><th>Description</th><th>Education/Outreach</th></tr><tr><td>Dental Hygiene ADULT</td><td>12</td></tr><tr><td>Dental Hygiene KIDS</td><td>4</td></tr><tr><td>Emergency Preparedness Kit</td><td>40</td></tr><tr><td>Hygiene Kit</td><td>21</td></tr><tr><td>Sexual Health Kit</td><td>8</td></tr><tr><td>Mental Health Kit</td><td>31</td></tr><tr><td>Tick Removal Kit</td><td>102</td></tr><tr><td>Overdose Rescue Kit</td><td>70</td></tr><tr><td>Wound Care Kit</td><td>10</td></tr><tr><td>Total</td><td>298</td></tr></table></td></tr>
<tr><td>Narcan Training</td><td>• # of Narcan trainings
○ # of participants
• # of 1-on-1 Narcan trainings</td><td>• # of Narcan trainings: 1
○ # of participants: 27
• # of 1-on-1 Narcan trainings: 25</td></tr>
<tr><td>Community Health Workers (CHW)</td><td>• # of CHW visits
• # of referrals provided</td><td>• # of CHW visits: 0
• # of referrals provided: 0</td></tr>
</table>





***Liberty reach due to CDC Ambassador Program implementation in Liberty School District.**

Quality

Training & Quality

- Obtained access to new County training platform
- **Public Health Fellowship:** The two-year Public Health Fellowship has concluded. NYSDOH has encouraged local health departments to utilize Public Health Infrastructure Grant (PHIG) funding, where appropriate, to retain fellowship talent and preserve the capacity developed through the program. SCDPH is currently working to bring the former Fellow back in a part-time capacity to support data analysis, performance dashboards, program evaluation, and other quality improvement activities.

Goal / Area of Focus	Key Performance Indicators	Update / Progress
Staff education	• # staff trainings offered • Topics covered • # of participants	• # staff trainings offered: 1 • Sun River Health presented at All staff meeting, 54 participants in attendance.
Quality Quality is the ongoing process of evaluating how well Public Health programs and services are performing and using data to make measurable improvements.	• **CHHA QAPI (Quality Assessment and Performance Improvement):** Ongoing review of CHHA quality, patient outcomes, compliance, operational performance, and identified opportunities for improvement. • **Community Health Improvement Plan (CHIP):** Monitoring progress toward countywide public health priorities, objectives, and measurable outcomes established through the CHIP. • **External Affairs Committee:** Supports coordinated review of external communications, community engagement, partnerships, and Public Health representation to ensure activities align with Department priorities and messaging. • **DPH Bonadio Draft Report:** Review of findings and recommendations from Bonadio's assessment of Department of Public Health operations, with identification and tracking of opportunities for operational and organizational improvement. • **Community Health/Education Dashboard QI:** Development and implementation of a performance dashboard to measure Community Health and Education activities, including reach, productivity, strategic alignment, and program outcomes. Dashboard data will be used to identify trends, demonstrate impact, and guide ongoing quality improvement.	• **CHHA QAPI :** Quarterly quality meeting • **CHIP:** Completed, submitted and uploaded to SCDPH website under "Health Data and Reports". A "State of the County: Health Update" conference is being planned for the Fall. • **EAC:** is actively meeting and reviewing all external-facing Public Health materials and documents prior to distribution. This process supports consistent, accurate, professional, and accessible communication that aligns with Department priorities and standards. • **Bonadio:** Review of Bonadio feedback on DPH policies • **Dashboard:** Review and update of data collection, intent, and focus of data moving forward

Disease Surveillance and Investigation

- **Tick-Borne Illness:** Continued monitoring of increasing tick-borne disease activity and trends within the community**.**
- **Emerging Communicable Disease Monitoring:** Ongoing surveillance for measles and the current Borna disease virus (BDV) outbreak, with particular attention to potential travel-associated exposures and cases.
- **Medical Reserve Corps (MRC):** SCDPH has not had an active, operational Medical Reserve Corps since 2024. One of the barriers to maintaining and rebuilding the program has been the need to resolve County requirements and processes related to background checks for volunteers. Without a fully established process for appropriately screening, credentialing, training, and maintaining a deployment-ready volunteer base, the Department has not represented the MRC as an active response resource. SCDPH is reviewing these requirements and the infrastructure necessary to rebuild a functional and sustainable MRC, while also monitoring uncertainty surrounding future federal support for the national MRC program.

Goal / Area of Focus	**Key Performance Indicators**	**Update / Progress**

Immunization Program	• OFFICE CLINICS -VFC, VFA, FLU, COVID
	  ○ # PEOPLE IMMUNIZED
	  ○ # OF DOSES (VFC, VFA)
	• WALK-IN - VFC, VFA, FLU, COVID
	  ○ # PEOPLE IMMUNIZED
	  ○ # OF DOSES (VFC, VFA)
	• PUBLIC CLINICS
	  ○ # PEOPLE IMMUNIZED
	  ○ # OF DOSES in the PUBLIC
	• POD (Point of Distribution) CLINICS
	  ○ # of DOSES@ PH
	  ○ # of DOSES In public
	TOTALS
	• TOTAL # CLINICS
	• TOTAL #PEOPLE IMMUNIZED VFC, VFA, COVID office & walkin
	• TOTAL # DOSES @ PHS
	• TOTAL # DOSES (Public)
	• COMBINED TOTALS OF ALL DOSES
	
	Ages of vaccinated: Categorized by group
		• OFFICE CLINICS: 1
		  ○ # PEOPLE IMMUNIZED: 1
		  ○ # OF DOSES: 2
		• WALK-IN: 0
		  ○ # PEOPLE IMMUNIZED: 0
		  ○ # OF DOSES: 0
		• PUBLIC CLINICS: 0
		  ○ # PEOPLE IMMUNIZED: 0
		  ○ # OF DOSES in the PUBLIC: 0
		• POD (Point of Distribution) CLINICS: 0
		  ○ # of DOSES @ PH: 0
		  ○ # of DOSES In public: 0
		TOTALS
		• TOTAL # CLINICS: 1
		• TOTAL #PEOPLE IMMUNIZED: 1
		• TOTAL # DOSES @ PHS: 2
		• TOTAL # DOSES (Public): 0
		  ○ COMBINED TOTALS OF ALL DOSES: 2
		
		Ages of vaccinated:
		  • 1-6 yrs: 0
		  • 7-18 yrs: 1
		  • 19-35 yrs: 0
		  •

Rabies	• # of reported animal bites/incidents
	  ○ Domestic
	  ○ Wildlife
	• # animals tested
	  ○ Domestic
	  ○ Wildlife
	• # tested positive for rabies
	• # rabies vaccination clinics
	• # humans receiving post exposure prophylaxis (PEP)
		• # of reported animal bites/incidents: 24
		  ○ Domestic - Cat Incidents: 3
		  ○ Domestic - Dog Bites: 17
		  ○ Wildlife – Bat: 4
		• # animals tested: 5
		  ○ Domestic - Cat Incidents: 0
		  ○ Domestic - Dog Bites: 5
		  ○ Wildlife – Bat: 1
		• # tested positive for rabies: 0
		• # rabies vaccination clinics: 1
		  ○ 129 vaccinated
		• # humans receiving PEP: 4

Emergency Preparedness	• **PHEPRP & COOP Emergency Preparedness Plan Updates:** SCDPH is conducting a comprehensive review and update of its Public Health Emergency Preparedness and Response Plan (PHEPRP) and Continuity of Operations Plan (COOP). Updates include reviewing emergency roles and responsibilities, staff call-down and activation procedures, communication protocols, essential Public Health functions, succession and delegation of authority, continuity of critical services, and coordination with County and community response partners. The goal is to ensure plans are current, operational, and reflective of the Department's present staffing structure and responsibilities so that essential Public Health services can be maintained during an emergency or disruption.	
Medical Reserve Corp. (MRC)		N/A
Lead	• # of Lead Tests • # of Positive Cases • # of Visits with DOH	• Total labs drawn: 106 • # of Positive cases: 1 • # of visits with DOH: 1 • Lead Education: 0

Sexually Transmitted Infections (STI)	• # of lab reported cases
	• # of health care provider follow-up for + labs
	• # of confirmed disease type:
	  ○ Chlamydia
	  ○ Gonorrhea
		• # of lab reported cases: **15**
		• # of confirmed disease type:
		  ○ Chlamydia: 11
		  ○ Gonorrhea: 3
		  ○ Syphilis (primary): 1

	○ Syphilis • # of rapid HIV tests completed • # of referrals made for HIV related services	• # of rapid HIV tests: 0 • # of referrals made for HIV related services: 0
Hepatitis	• # of lab reported cases • # of health care provider follow-up for + labs • # of confirmed disease type:	• # of lab reported cases: **22** ○ ↑ 11 previous month • # of confirmed disease type: ○ Hep A: 0 ○ Hep B: 1 ○ Hep C: 9
Tuberculosis (TB)	• # newly reported, Active TB cases • # of latent TB cases • # of reported by pending TB cases	• # newly reported, Active TB cases: 0 • # of latent TB cases: 1 • # of reported by pending TB cases: 0
General Communicable Reportable Diseases	• # of lab reported cases • # of confirmed disease type (varies monthly)	• # of lab reported cases: 238 (168 Lyme Disease) ○ ↓ 51 from previous month

Outreach Location	**Outreach Topic**
Livingston Manor Trout Parade Outreach	• Topics of Outreach (paper materials): STI prevention, Tick borne illness prevention, Rabies prevention, outdoor safety • # People Reached: 241 Grant deliverable: • STI's – 30 sexual health kits (condoms, dental dams, education materials); Pamphlet given: 1 HPV, 1 Syphilis, 2 PID, 1 BV • Lead/Immunizations – 10 boxes of crayons, 8 immunization coloring books, 13 Lead Coloring books, 4 Lead Paint Safety pamphlets, 3 Wash the lead off magnets, 3 Get ahead of lead magnets • Tickborne illness prevention - 30 insect repellents, 50 tick kits • Skin cancer prevention – 14 pocket sunscreen tubes

	• Rabies prevention – 7 dog leashes, 5 small dog harnesses, 4 xs harnesses • Public Health Awareness – 45 Bobber stress balls **participants could only take an item if they answer a question regarding any of the above topics correctly. If they were incorrect they were told the correct answer and then given another question – this included use of the "Wheel of Misfortune" – drug/alcohol related questions – for little ones we made up questions regarding hand hygiene, tick safety, sun/summer safety, animal safety.*
Lead Outreach	Childhood Lead Prevention: During June, SCDPH conducted targeted outreach and technical assistance with local pediatric and healthcare providers, including Refuah Health, Catskill Pediatrics, Ahava, Dr. Gill, and Sun River Health, to review childhood blood lead level (CBLL) testing rates, reporting requirements, and use of NYSIIS to monitor testing. Follow-up is underway with providers to identify and address potential gaps in laboratory reporting. Community education was also expanded through distribution of bilingual lead poisoning prevention and nutrition materials at a Liberty food pantry and education provided to Healthy Families staff regarding lead testing recommendations and available resources for families.