NEED
Heart disease is a leading cause of death in Albany County, New York. Among adult residents, 30.8% have physician-diagnosed hypertension. The 2017 National Diabetes Statistics Report indicated that 9.8% (24,065) of Albany County adult residents were diagnosed with diabetes. It is projected that 33% (81,852) of adult residents have prediabetes with only 4.9% diagnosed. Obesity is a significant risk factor for chronic diseases. The latest Behavioral Risk Factor Surveillance System (BRFSS) survey conducted in Albany County estimates that 21.7% of adults do not participate in leisure time physical activity, 10% of adults do not have adequate access to locations for physical activity, and an estimated 62.8% of adults are overweight or obese, a significant increase from the 2003 estimate of 54%. These challenges are disproportionately occurring in communities experiencing socio-economic hardship and minority health disparities.

ACTIVITY
The Albany County Department of Health (ACDOH) collaborates with the local YMCA, National Diabetes Prevention Program (NDPP) providers, a regional supermarket with pharmacist services, and area primary care practices (PCP) to build capacity for prediabetes and hypertension evidence-based self-management programs. Collaboration includes sponsoring the training of NDPP and YMCA-Blood Pressure Self-Management (Y-BPSM) facilitators, developing a calendar of upcoming programs, increasing referrals to the programs, and utilizing community health workers (CHWs) to support participants.

OUTCOMES
The Collective Impact model provides a successful framework for implementing an innovative approach to delivering evidence based interventions (EBIs) while also addressing health equity issues. In 2018, 32 NDPP and 4 Y-BPSM facilitators were trained to build the capacity for respective programs. Five NDPPs were delivered and 62 residents (primarily experiencing social determinants of health) attended; 80.7% (n=50) successfully completed the NDPP classes with CHW support. Thirty-one residents were enrolled in the Y-BPSM from August 2017 to December 2018. Two community pharmacists engaged one PCP to enroll 40 hypertensive patients into various hypertension intervention initiatives. Four PCPs utilized prediabetes and hypertension registries to identify patients that would benefit from NDPP, Y-BPSM, pharmacist and/or CHW support. Three CHWs provided support (i.e. addressing housing, transportation, and food access challenges; providing health coaching) for healthy behavior change to 268 residents diagnosed with prediabetes, diabetes, and/or hypertension.

LESSONS LEARNED
Success in this cross-sector initiative is attributed to partnering with community organizations that have an aligned vision to improve the health of community residents, promote health equity and EBIs (i.e. NDPP, Y-BPSM, CHWs). The community benefits from this Collective Impact approach as organizations commit to mutually reinforcing strategies that foster shared use of resources, skills and expertise; maintain ongoing communication about challenges, successes and responsibilities; and evaluate performance metrics.
GOAL
Columbia County Department of Health (CCDOH) has been working to provide prescription and illicit drug education has part of their 2016-2018 priority area, to all residents and community partners.

SUCCESSES
2,596 individuals during drug education community events!

CHALLENGES
DEA no longer weighs lbs. collected from drop boxes throughout the community or on national and local Drug Takeback Days.

TECHNICAL ASSISTANCE
HCDI Public Health Planners and data team have provided assistance in the development of a Drug Take Back Maps, Capital Region Guide for Mental Health and Addiction Services, and have provided ongoing support for the Controlled Substance Awareness Task Force, Prevention Workgroup, and other CHIP related activities.

NEED
Prescription and illicit drug prevention has been identified as a major area of concern for Columbia County. As of 2016, over 289 million prescriptions were written nationwide for opioids. While these prescriptions are intended as temporary relief from pain, their highly addictive nature has had devastating effects on a local, state, and federal level. From 2013-2015, Columbia’s opioid-related overdose mortality rate was 11.5% compared to 8.5% for the Capital Region.

ACTIVITY
CCDOH, in collaboration with community partners such as Catholic Charities, local law enforcement, Columbia and Greene Counties’ Departments of Human Services, Columbia Memorial Hospital, Twin County Recovery Services and more, worked to provide community-wide education and services to reduce prescription and illicit drug usage. School and community group events, Drug Takeback Days, Medication Drop Boxes, and Naloxone trainings are just a few of the successful community activities for addressing drug use among residents.

OUTCOMES
In 2018, there have been a total of 16 school and community events on addiction and education, reaching upwards of 2,600 individuals. In addition, 3 Drug Takeback Days took place throughout the communities in 2018 along- a marked increase from the years prior. Lastly, 30 Naloxone trainings were held for community members and relevant staff, reaching almost 80 people. Trainings and Takeback days took place in libraries, schools, pharmacies, local grocery stores and even among special populations, such as prisons.

LESSONS LEARNED
Columbia County has learned firsthand the importance of building relationships with community partners to determine the unique demands and strengths of each population served. Nothing gets done alone!
Greene County

NEED
Obesity is a complex and multifaceted problem effecting individuals and families across the country. Many major causes of being overweight and/or obese are related to lifestyle choices, such as poor diet and lack of exercise. From 2012-2014, Greene County had the lowest age-adjusted percentage of adults who engaged in leisure-time physical activity in the Capital Region at 69.8%. In parallel, Greene County also had the second highest obesity percentage in the Capital Region at 31.4% from 2013-2014.

ACTIVITY
GreeneWalks is a popular walking program created by the Greene County Rural Health Network in 2010. Since the program’s conception in 2010, over 1,250 people have participated. GreeneWalks was developed as a result of a growing volume of research indicating the positive impact community walking programs can have on individuals who are overweight or obese. GreeneWalks is a free, 8-week contest that is open to all Greene County residents.

OUTCOMES
Through television and radio ads, billboards, and bank statement and utility bill inserts, the Greene County Rural Health Network was able to recruit over 200 participants. The 2018 GreeneWalks Program saw almost a 200% increase in the number of participants since the program began in 2010 (69 participants to 203 participants). Of the 203 participants who began the program, 78 had finished with competed activity logs. Eight cash prizes were awarded through a random drawing of the 78 participants—four $250 prizes and four $125 prizes were awarded.

LESSONS LEARNED
The GreeneWalks Program has seen firsthand the power of incentive. GreeneWalks has seen a significant jump in participants from the start of the program to now. GreeneWalks found that an increase in the number of prizes, in addition to the amount of prizes distributed had a tremendous impact on participation. In addition to incentive, GreeneWalks has found community input to be a valuable asset to the program, especially when locating popular or under-utilized loops and trails throughout the community.

GOAL
Greene County is working to create community environments that increase physical activity in the county’s residents.

SUCCESSES
GreeneWalks had a 200% increase in participation!

CHALLENGES
Getting the word out to community members is challenging even with various methods of advertising.
NEED
According to CDC, the number of drug overdose deaths continue to rise in the United States with an average of 130 Americans dying every day from an opioid overdose. Rensselaer County has not been spared with this Opioid Crisis. From 2012 - 2018 Rensselaer County has had 110 opioid related deaths and 24 additional deaths pending toxicology related to Opioid overdoses. One of the needs that were identified through our County’s Heroin Coalition was the lack of information on adequate services for our residents with this disease of addiction that needed help. Although there is a NYS Hotline for Addiction services, the coalition members wanted a more local approach where local services could be identified for our resident’s needs.

GOAL
Rensselaer County Heroin Coalition would develop a helpline where residents who needed help with substance use could call for information, resources and referrals to area providers.

SUCCESSES
Through television, social media and newspaper interviews, the Rensselaer County Recovery Helpline was able to recruit and train 57 volunteers, 9 of which are leads.

CHALLENGES
The Rensselaer County Recovery Helpline is operated by volunteers and there is no funding stream. This becomes a challenge to advertise other than TV, newspaper and social media. Even with these three methods of advertising, the awareness of the helpline should be stronger than it is now.

TECHNICAL ASSISTANCE
HCDI shared Rensselaer County’s Recovery Helpline posts on Social Media.

ACTIVITY
A committee was formed in collaboration with Chatham Cares of Columbia County who mentored and guided the group through 1 ½ years of development. Chatham Cares developed their own helpline and was able to give the committee the knowledge and resources for this development. The helpline process is made up of a two tier system, where the resident calls a toll free number and a volunteer answers through their own smart phone. The volunteer uses their computer and inputs all the information from the caller to a web based program. This information will be sent to the lead on duty. The lead will take over and try to help the caller. The phone line is open every day from 9am to 9pm.

OUTCOMES
The helpline was launched on October 15, 2018. We continue to advertise the helpline through various TV interviews and newspaper articles. We have gone to many community events and have begun to train our local law enforcement on the helpline and its importance. By the end of December we had received over 40 calls and have helped place 7 people in treatment.

LESSONS LEARNED
Billboards, newspapers, radio and brochures are areas of advertising that we need to use in order to maximize the awareness of our residents about the helpline and its importance.
NEED
Saratoga County is home to over 700 backstretch workers who care for thoroughbred horses at the racetrack, as well as many migrant farm workers. These workers often face barriers to care that result in health disparities, such as lack of insurance, linguistic and cultural differences, and lack of documentation. In particular, infectious disease threatens the health of both migrant workers and those with whom they come in contact. According to the Office of Disease Prevention and Health Promotion, viral hepatitis, influenza, and tuberculosis (TB) are among the leading causes of illness and death in the United States. Unfortunately, the Migrant Clinicians Network reports that migrant workers are six times more likely than the general population to develop TB and tend to have low immunization rates, especially for pertussis and influenza.

ACTIVITY
In 2010, Saratoga County Public Health Services (SCPHS) partnered with Saratoga Hospital and the Backstretch Employee Assistance Team (B.E.S.T.), to include free immunizations and TB screening at the backstretch clinic. Two SCPHS nurses attend each clinic to administer immunizations, the cost of which is covered by the New York State Vaccines for Adult Program (VFA) for uninsured and underinsured adults, and conduct monthly TB screening. In 2014, SCPHS initiated field clinics at local dairy farms, offering immunization services at no cost through the VFA and Vaccines for Children (VFC) programs. B.E.S.T. and the Migrant Education Identification/Recruitment Program provide interpreters.

OUTCOMES
Over the course of nine years at the backstretch, SCPHS has held more than 153 clinics, seen 678 patients, and administered 1,042 vaccines. In fact, SCPHS exceeded its 2018 goal of increasing backstretch clinic vaccination rates by 5% by a factor of four. Moreover, in the four years since starting the dairy farm program, SCPHS has treated 215 migrant dairy workers and administered 376 vaccinations. As a result, many of the backstretch and migrant dairy farm workers have completed their vaccine series over the past several years, permitting SCPHS to hold fewer clinics over time. By partnering with other organizations focused on addressing regional migrant worker social and health disparities, SCPHS is creating sustainable interventions that maximize limited resources and facilitate integrated delivery of primary and public health care.

GOAL
Given their high risk and isolation, the U.S. Centers for Disease Control and Prevention recommends increasing vaccination rates among migrant farm workers through targeted outreach. By partnering with the backstretch clinic and visiting local dairy farms, SCPHS has increased the number of migrant workers who are fully immunized, receive regular flu vaccinations, and receive testing and treatment for tuberculosis. Moreover, SCPHS’ manpower and access to government-funded vaccines contribute to the sustainability of the backstretch clinic.

SUCCESSES
In 2019, SCPHS will celebrate its 10th year of participating in backstretch clinics during an extended racetrack season that will host more clinics than ever, maintain its migrant dairy farm clinics, and build relationships with local orchard operators so as to extend on-site vaccination clinics to migrant orchard workers in the county.

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Saratoga County Collaborative Effort to Increase Vaccination Rates Among Migrant and Seasonal Farm Workers

hcdlny.org
Population Health Improvement Program

2017 County Success Stories
LESSONS LEARNED

ACDOH's success can be attributed to creating mutually beneficial partnerships with key stakeholders (i.e. healthcare providers) to implement reinforcing strategies. Sustainable strategies included:

- Promoting a calendar of Y/NDPPs to both the community and PCPs;
- Providing technical assistance to implement health system processes for developing prediabetes registries, referral systems and multi-directional feedback between the health care team members and patients;
- Engaging CHWs to provide ongoing support to participants, PCPs, and Y/NDPP providers;
- Using CHWs to link participants to resources for healthy food and physical activity opportunities.

GOAL

Albany County promotes culturally relevant chronic disease interventions that promote self-management to delay the onset and/or reduce the risk of diabetes and hypertension.

SUCCESSES

“The CHW builds relationships and identifies barriers that limit the participants’ ability to manage their health. She connects them to other community programs to help with these barriers—which is a very valuable resource!” - Marcy Pickert, RD, CDE

CHALLENGES

One of the key challenges is addressing equity issues (i.e. transportation, food access, etc.) that interfere with participants’ ability to implement and maintain healthy behavior changes.

TECHNICAL ASSISTANCE

HCDI Public Health Planner provided support by facilitating the Albany-Rensselaer Diabetes-Obesity Task Force which connects providers, and community based organizations to prevention initiatives. This Task Force assisted in promoting NDPP throughout Albany County.
Columbia County

NEED

Prescription drug abuse prevention—specifically, opioid overdose reduction has been identified as a major problem in Columbia County and also a growing problem nationwide. Unlike many health indicators, prescription drug abuse is seen in diverse populations. In 2014, 20% nationwide aged 12 and older reported using prescription drugs for nonmedical purposes (National Institute on Drug Abuse, 2016). Prescription drugs are often easily accessible, and abuse of those drugs can lead to severe health consequences and even death. From 2011-2013,

ACTIVITY

CCDOH partners include Catholic Charities of Columbia and Greene Counties, Greene County Public Health, Columbia-Greene Controlled Substance Task Force Prevention Work Group (The Prevention/Education Work Group is made up of members of Catholic Charities of Columbia and Greene Counties, Columbia and Greene Counties' public health departments, Columbia and Greene Counties' Departments of Human Services, representatives from Columbia Memorial Health, Twin County Recovery Services, Inc.), as well as others. These partners work together to support activities which address prescription drug abuse issues. The activities include increasing the number of medication drop boxes in Columbia County, coordination of school based community forums addressing opiates in the community, increase the number of Narcan trained community members, and track Narcan administration in Columbia and Greene Counties.

OUTCOMES

There has been one medication drop box added in Columbia County this year, totaling the number of drop boxes in the county to three. In addition to National Drug Take Back Day, CCDOH hosted individual drug take back days at all senior centers in the county, which were very well received. There was a shortage of Narcan statewide in the beginning of 2017 which made the number of available kits in the community low for the greater part of 2017. The shortage is no longer in effect and there are plenty of kits county-wide through Project Safe Point. The dosage of Narcan in the kits handed out has also been increased from 0.4 to 4. Project Safe Point continues to do monthly Narcan trainings in the county throughout 2017.

LESSONS LEARNED

Columbia County has seen that it can take multiple approaches and funding to take on the prescription drug abuse crisis in the region. It is critical to have the engagement and support of the community to move progress forward toward prevention.

GOAL

Columbia County Department of Health (CCDOH) is working on preventing nonmedical use of prescription and illicit drugs by all residents of Columbia County.

SUCCESSES

The Controlled Substance Awareness Taskforce has been committed to meeting regularly to reach the goals of the group. There has been an increase in medication drop boxes, many community events, trainings, and prescriber education.

CHALLENGES

Statewide Narcan Shortage and the DEA no longer are weighing lbs. collected from drop boxes on National Drug Take Back Day in the spring of 2017.

TECHNICAL ASSISTANCE

HCDI Public Health Planner has provided assistance in the development of a Capital Region Guide for Mental Health and Addiction Services, and has provided ongoing support for the Controlled Substance Awareness Task Force, Prevention Workgroup, and other CHIP related activities.
NEED
Obesity, considered a chronic disease, is a significant risk factor for other chronic diseases and conditions, which for youth, means dangerous health risks across their lifespan. This includes high blood pressure, type 2 diabetes, asthma, high cholesterol, stroke, heart disease, certain types of cancer, and osteoarthritis. Overweight and obesity may also contribute to psychological distress, depression, discrimination, and prejudice. Of Columbia County public school district students, 18.7% are obese (New York State: 17.3%). Among Columbia County children, overweight and obesity rates vary by school district. Hudson City School district has the highest percentage of students who are obese (23.1%; Student Weight Status, 2012-2014).

ACTIVITY
The Columbia County Department of Health (CCDOH) partners with Hudson City Youth Center, Cornell Cooperative Extension of Columbia and Greene Counties, Columbia Memorial Health, and Healthy Communities NY to establish relationships within the community to promote 5-2-1-0 guidelines in afterschool programs. The 5-2-1-0 program focuses on working with children in after school programs to encourage and support healthy behaviors. CCDOH began working with Hudson Youth Center staff on implementation of the 5-2-1-0 program. CCDOH reviewed the “Getting Started Checklist” for the program with Hudson Youth Center staff; collected BMI’s for participants; chose three focus areas (of 10) 5-2-1-0 strategies to implement within the community; completed the 5-2-1-0 survey with Hudson Youth Center. CCDOH is beginning implementation of 5-2-1-0 in two other afterschool programs in the county.

OUTCOMES
Due to staff overturn at Hudson Youth Center afterschool program, CCDOH has not been able to get new staff on board to implement the 5-2-1-0 program. The Columbia County Health Educator is working towards building better relationships with school administrators based off advice received from Rochester’s successful 5-2-1-0 initiative. CCDOH is also contracting with Mentor Foundation USA to house someone from their Living the Example program to help forge a relationship with Hudson City School District Administrative Staff.

LESSONS LEARNED
Columbia had been able to understand the importance of working on relationship building with school administrators to find out their wants and needs. CCDOH learned to meet school administrators where they are before trying to get the school on board to implement a new program. It takes time!

GOAL
Columbia County is working to create community environments that promote and support healthy food and beverage choices and physical activity for youth.

SUCCESES
Columbia County DOH has successfully started a Chronic Disease Coalition which aims to further the activities of the Chronic Disease CHIP priority.

CHALLENGES
Getting school administration on board to support the 5-2-1-0 initiative in the Hudson Youth Center afterschool program.

TECHNICAL ASSISTANCE
HCDI Public Health Planner has connected CCDOH to the Rochester 5-2-1-0 for best practices, created a guide for where to be physically active in Columbia and Greene counties and provided ongoing support for the Chronic Disease Coalition and other CHIP related activities.
GOAL

Columbia County Department of Health (CCDOH) is working on preventing nonmedical use of prescription and illicit drugs by all residents of Columbia County.

SUCCESSES

The Controlled Substance Awareness Taskforce has been committed to meeting regularly to reach the goals of the group. There has been an increase in medication drop boxes, many community events, trainings, and prescriber education.

CHALLENGES

Statewide Narcan Shortage and the DEA no longer weighing lbs. collected from drop boxes on National Drug Take Back Day in the spring of 2017.

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NEED

Prescription drug abuse prevention—specifically, opioid overdose reduction—has been identified as a major problem in Columbia County and also a growing problem nationwide. Unlike many health indicators, prescription drug abuse is seen in diverse populations. In 2014, 20% nationwide aged 12 and older reported using prescription drugs for nonmedical purposes (National Institute on Drug Abuse, 2016). Prescription drugs are often easily accessible, and abuse of those drugs can lead to severe health consequences and even death. From 2011-2013, Columbia’s opiate-related drug hospitalizations were 32.2% compared to 23.2% for the Capital Region.

ACTIVITY

CCDOH partners include Catholic Charities of Columbia and Greene Counties, Greene County Public Health, Columbia-Greene Controlled Substance Task Force Prevention Work Group (The Prevention/Education Work Group is made up of members of Catholic Charities of Columbia and Greene Counties, Columbia and Greene Counties’ public health departments, Columbia and Greene Counties’ Departments of Human Services, representatives from Columbia Memorial Health, Twin County Recovery Services, Inc.), as well as others. These partners work together to support activities which address prescription drug abuse issues. The activities include increasing the number of medication drop boxes in Columbia County, coordination of school based community forums addressing opiates in the community, increase the number of Narcan trained community members, and track Narcan administration in Columbia and Greene Counties.

OUTCOMES

There has been one medication drop box added in Columbia County this year, totaling the number of drop boxes in the county to three. In addition to National Drug Take Back Day, CCDOH hosted individual drug take back days at all senior centers in the county, which were very well received. There was a shortage of Narcan statewide in the beginning of 2017 which made the number of available kits in the community low for the greater part of 2017. The shortage is no longer in effect and there are plenty of kits county-wide through Project Safe Point. The dosage of Narcan in the kits handed out has also been increased from 0.4 to 4. Project Safe Point continues to do monthly Narcan trainings in the county throughout 2017.

LESSONS LEARNED

Columbia County has seen that it can take multiple approaches and funding to take on the prescription drug abuse crisis in the region. It is critical to have the engagement and support of the community to move progress forward toward prevention.
NEED
The burden of substance abuse, regionally and in Greene County, is well recognized and has received considerable attention. Greene County has higher rates of drug-related hospitalizations than Upstate NY, while Greene and Columbia counties had the highest rates of opiate-poisoning related hospitalizations in the Capital Region. Greene County also did not meet the Prevention Agenda Objective of 18.4% of adults reporting binge drinking in the past 30 days. The Columbia-Greene Controlled Substance Awareness Taskforce is committed to working on the Prevention Agenda priority area of promoting mental health and preventing substance abuse for the 2016-2018 CHIP.

ACTIVITY
The Greene County Public Health Department partners include, but not limited to, Rural Health Network, Law Enforcement, Twin County Recovery Services, Healthcare Consortium, Columbia Memorial Health, Pharmacists, Project Safe Point, MCAT, Project Need Smart Sharps Collection Program, Greene County Public Health, Columbia County Department of Health, Mental Health Association of Columbia and Greene Counties, Catholic Charities and Greene County Family Planning. The activities to address the need are based off of the evidence-based practice Project Lazarus. Activities include: community activation and coalition building, prescriber education and behavior & pain patient services and drug safety, supply reduction and diversion control, drug treatment and demand reduction, harm reduction (including naloxone training), and community-based prevention and education. Of the activities listed above, community activation has been a strong focus of the Controlled Substance Awareness Taskforce in 2017.

OUTCOMES
There have been many events that have been held throughout both Columbia and Greene Counties in an effort to raise more awareness and action including: Drug Take Back Days, Community Forums, Presentations at Senior Centers, “Rebound” the Chris Herren Story Presentation, a Zumba Fundraiser, CPR at Hudson City School District, the opening of two Youth Clubhouses, naloxone trainings, Hope Rocks Festival, Harvesting Hope in Recovery event, and school resource nights. These events and community forums have been well received by its residents.

LESSONS LEARNED
Greene County has experienced that one activity will not fix the entire issue, it takes multiple approaches with a lot of community action, support and involvement to fight the growing substance abuse issue in our region.
Greene County

NEED
Many of the major causes of morbidity and mortality in the United States are related to poor diet and physical inactivity. Being overweight and/or obese is defined as falling into a range of weight that is greater than what is considered healthy for a given height. Greene County has the second highest obesity percentage in the Capital Region at 31.4% based off of NYS EBRFSS for age-adjusted percentage of adults who are obese, 2013-2014. Greene county also has the lowest age-adjusted percentage of adults who are engaged in leisure-time physical activity from 2012-2014 in the Capital Region at 69.8%.

ACTIVITY
The Green County Public Health Department partners with Greene County Rural Heath Network, the Greene County YMCA, the Greene County Chamber of Commerce, and others to promote weight loss and increase community-based physical activity. This is achieved through the Rural Health Network Biggest Loser Contest and maintenance program, outreach to primary care providers regarding obesity counseling protocol and guidelines for obesity counseling a reimbursable service, as well as the GreeneWalks Community Walking Program.

OUTCOMES
The 2017 Biggest Loser Contest had the highest number of participants to date with 557 participants. Of which, 218 participants completed the contest, 102 were eligible for the maintenance program and 32 finished the maintenance program. Since the start of the contest in 2013, a weight percentage loss category to be eligible for prizes has been added, to accompany the original weight loss in pounds category. In addition, community coordinators have been included to support worksite coordinators, and a new weigh maintenance program for those who lose 5% or greater of their starting weight has been developed. Top winners for the 2017 contest lost about 60 lbs. and/or 15-20% of starting weight.

LESSONS LEARNED
The Rural Health Network has seen that money talks, since there was a large increase in contest participation when the amount of money to be won in the contest along with the overall number of prizes that were given out increased. As well as, don’t underestimate the power of camaraderie (cited as #1 reason people continue in the Biggest Loser Contest), there is no such thing as too much publicity, and weight loss is an ongoing journey and one contest of program is not enough. There needs to be support offered throughout the year to encourage people to be self-motivated to sustain weight loss.

GOAL
Greene County is working to create community environments that promote and support healthy food and beverage choices and physical activity.

SUCCESSES
2017 has had the highest participation since the contest started with the largest prizes, longest contest duration and most importantly most weight and weight percentage losses!

CHALLENGES
Maintaining participation and keeping partners motivated throughout the contest.

TECHNICAL ASSISTANCE
The HCDI Public Health Planner provides ongoing support for the Greene County MAPP Committee and Columbia-Greene Chronic Disease Coalition.
NEED

In 2016, Rensselaer County saw an increase of 32 deaths: claiming the lives of 26 males and 6 females, ranging in age from just 22 up to 64. These numbers are up from 25 deaths in 2015. The deaths in 2017 are 33.

ACTIVITY

With the increase of Heroin related deaths identified on our county for the past several years, the County Executive felt it was imperative to address this public health crisis with the formation of the Rensselaer County Heroin Coalition in March of 2016. With the assistance and leadership from the Sheriff and the Public Health Director as co-chairs, the coalition has met every six weeks and has participated in over 4 community wide events. With roughly 700 active participants and members, the coalition is comprised of county departments such as: Sheriff, Health Department, Mental Health, Probation, District Attorney’s Office, Employment and Training, Veterans, County Executive’s Office, Social Services, Public Safety, Legislature, Public Defender and Department of Youth. Some of the outside organizations are the DEA, NYS Senate, CEO, Law Enforcement Agencies, Hudson Valley Community College, Russell Sage, RPI, Siena, Questar, Unity House, Local School Districts, libraries, addiction and recovery centers, local hospitals, shelters in our community as well as those in recovery and family members who have lost loved ones. This coalition has worked very closely with the other 5 community coalitions in the county along with the US attorney’s Office.

OUTCOMES

* Distributed over 100 educational posters to the Rensselaer County School Districts. * Participated in a state wide Dental Symposium. * Sheriff’s Department held over 7 Drug Take Back Days in 2017. * Continue to develop a 24/7 Helpline for our residents in need of help. * Coalition hosted several meetings with guest speakers. * Coalition has divided up into 6 subgroups-data, legislation, medical, treatment and harm reduction, community education and law enforcement to work on various goals and objectives.

LESSONS LEARNED

The Rensselaer County Heroin Coalition is not the total answer to ending the opioid deaths in the county. It is only one spoke of the wheel for this very complex epidemic. The main aspect of this coalition is for people both professionally and personally to network with each other. Much work has been completed by the members beyond this coalition through learning and collaborating with each other.
NEED
In 2016, Saratoga County committed its focus to improving mental health and substance abuse due to the opioid epidemic and increasing mental health needs throughout the county. In relation to the priority of substance abuse, Saratoga County Public Health Services (SCPHS) identified the Neonatal Abstinence Syndrome (NAS) infant discharge rate as a major issue. The National Institute on Drug Abuse indicated that the risk of stillbirth is 2-3 times greater in women who take prescription pain relievers or use illegal drugs during pregnancy.

ACTIVITIES
SCPHS created a detailing campaign using the 5P’s Screening tool, which involved an in-person visit to nine obstetrics and gynecology offices. They were given a packet of information to express the purpose of the campaign and to receive an agreement to participate in the pilot program. The packet included: an infographic that describes symptoms of NAS, calming methods for treating NAS infants, treatment methods, a list of what providers can do, a list of resources for the county, and an NAS informational brochure that was developed by the NAS Subcommittee.

Partners include, but are not limited to, SCPHS, Saratoga Hospital, Glens Falls Hospital, Warren County Public Health, Washington County Public Health and the NAS Subcommittee of Hometown vs. Heroin.

OUTCOMES
The NAS Family Resource Guide Brochures have been distributed to four providers, three primary care offices, five Ob/Gyn practices, and five buprenorphine provider practices. Saratoga Hospital also implemented validated NeoAdvance training materials to develop policy, procedures, and training for treatment of NAS infants by staff, therefore reducing the need to transfer infants and mothers to Albany Medical Center.

LESONS LEARNED
In order to increase awareness of services to mothers, SCPHS will continue to work with partners to distribute informational brochures at maternal/child health nurse visits, WIC and lactation consultation meetings, and on hospital discharge paperwork.
**MISSION**

The Suicide Prevention Coalition of Saratoga County is a consortium of partners dedicated to preventing suicide in our community by:

- Increasing awareness
- Providing trainings on suicide prevention
- Connecting families, communities and individuals to resources
- Providing postvention response teams

**NEED**

Saratoga County identified that middle-aged men (45 to 60 years old) experienced a 43% increase in suicide from 1997 to 2014. The age-adjusted suicide death rate per 100,000 is higher in Saratoga County (13.0) than both the NYS average (8.0) and the NYS Prevention Agenda Objective of (5.9). To address these concerns, Saratoga County Public Health Services (SCPHS), in partnership with Saratoga County Mental Health and Addiction Services, implemented the Suicide Prevention Coalition of Saratoga County (SPCSC).

**ACTIVITIES**

The SPCSC has formed two subcommittees; one focused on prevention education, for providing the community with opportunities for suicide prevention training, and the second group focused on postvention education.

To raise community awareness about the SPCSC, the group created marketing materials including a brochure, flyer, and community resource list. Materials are circulated through stakeholder agency distribution both on-site and online and at health fairs and community events. Additional coalition outreach activities include the development and distribution of coffee sleeves displaying coalition information, the Suicide National Lifeline number, and the message “You Matter to Me.”

The SPCSC will also be hosting the Parents Open Forum to have a conversation about the Netflix Series 13 Reasons Why, and to discuss issues teens face. The event will be held Tuesday, April 17, 2018, 6:30 to 8PM at Saratoga Springs Public Library, Dutcher Community Room.

**OUTCOMES**

2,000 coffee sleeves have been distributed to eight different local coffee shops throughout Saratoga County and several partner agencies. The SPCSC also had a 10-minute TV Spot on a local station to talk about the coalition and provide prevention education.

**SUCCESSES**

A strength of having a trained SPCSC postvention team is building community capacity for multi-agency response in the event of a suicide.

**CHALLENGES**

Expanding the utilization of resources by community partners.

**TECHNICAL ASSISTANCE**

The HCDI planner assisted the coalition by designing the coffee sleeve and helped with distribution.

**LESSONS LEARNED**

There is a lack of evaluative techniques to assess how the community and stakeholder groups are using suicide prevention trainings. SCPHS can implement a short-term outcome measure, such as a survey distributed at the end of trainings to collect the number of participants who report they will use the training.
NEED

In 2014, the New York State Behavioral Risk Factor Surveillance System (BRFSS) indicated that over 15,000 adults living in Saratoga County were diagnosed with diabetes and 7,000 with prediabetes. Taking into consideration the threat that diabetes poses to their community, Saratoga County Public Health Services (SCPHS) and key partners formed the Saratoga County Prediabetes Coalition (SCPC) with the intent to create awareness, and prevent the onset of diabetes through the creation of a social and physical environment that encourages healthy lifestyles.

ACTIVITY

The Nourish Your Neighbor Initiative promoted healthy food drives and provided free materials, on-site education, and an evaluation of types of foods contributed. Ongoing work is being accomplished to support the prediabetes packet campaign. Free resources are being distributed to primary care offices that support the initiation of a discussion on individual patients’ risk factors for prediabetes.

Coalition partners include, but not limited to, Saratoga County Public Health Services, Saratoga Hospital, Cornell Cooperative Extension, MVP Healthcare, Franklin Community Center, Price Chopper, Capital District YMCA, Saratoga Lions Club, Shen School District, and Moreau Community Center.

OUTCOMES

Nearly 40 organizations and 12 food drives received Nourish Your Neighbor outreach. Additional materials provided included sample shopping lists, pledge posters, informational sheet, canvas, and plastic bags. Over 30 primary care offices requested prediabetes outreach and over 300 booklets have been dispersed.

LESSONS LEARNED

Follow-up for prediabetes booklet distribution to primary care offices should be started earlier to maintain engagement. Developing a system for determining which offices are using the prediabetes resources and which need more to share with patients would be helpful for tracking.

GOAL

The Saratoga County Prediabetes Coalition (SCPC) will incorporate the Nourish Your Neighbor Initiative within at least three food drives. PCSC will create and distribute informational prediabetes packets with evidence-based and local resources that are culturally sensitive and developmentally appropriate.

SUCCESSES

The number of prediabetes booklets distributed well-exceeded goals set for the first year and five provider clinics are actively using booklets.

CHALLENGES

A continuing challenge is obtaining provider feedback about the prediabetes resources. Data collection and paperwork required of the Nourish Your Neighbor program was a barrier.

TECHNICAL ASSISTANCE

The HCDI planner for Saratoga County provided sample logos to represent the coalition. A follow-up provider survey for the prediabetes booklet distribution was also developed and distributed in the prediabetes resource packet.
NEED
In 2015, members of the Schenectady Coalition for a Healthy Community conducted a food insecurity survey with 393 adults within the City of Schenectady and forty percent of respondents indicated a high level of food insecurity. According to New York State Behavioral Risk Factor Surveillance System data (2013-2014), 63% of Schenectady adults are either overweight or obese. With the known connection between obesity and food insecurity, SCPHS implemented strategies to Prevent Chronic Diseases and applied funds from the Partnerships to Improve Community Health (PICH) grant, funded by the Centers for Disease Control and Prevention, to develop and implement a community-wide food plan. The action plan leveraged local resources accessible to food-insecure residents and provides evidence based interventions for increasing availability of and access to healthy foods. The PICH grant also supported training for three lifestyle coaches who could implement the Diabetes Prevention Program (DPP) through Ellis Medicine.

ACTIVITY
To increase availability of affordable healthy foods, particularly for those with limited access, food pantries are now offering healthier options. Simultaneously, work is being done increase the number of Community Based Organizations that offer or promote the DPP and Diabetes Self-Management Education (DSME) throughout the community.

Partners include, but not limited to, Ellis Hospital, Sunnyview Hospital and St. Peter’s Health Partners, Cornell Cooperative Extension, County Food Pantries, Price Chopper, United Way of the Greater Capital Region, Bethesda House, YMCA, CDPHP, and MVP.

OUTCOMES
Six food pantries are utilizing policy and environmental strategies to offer healthier options in the county. For those in need, Ellis Medicine offered three DPP classes since October 2016, and twenty-six individuals have participated in the DPP with a total weight loss of 112 pounds.

LESSONS LEARNED
The Diabetes Prevention Program monthly meetings were changed to biweekly meetings to increase participant engagement and retention.

GOAL
SCPHS aims to create community environments that promote and support healthy food and beverage choices and physical activity; to expand the role of health care and health service providers and insurers in obesity prevention.

SUCCESSES
Diabetes Prevention Program participants have lost weight, increased physical activity and adopted lifestyle changes. In addition, there is an increase in awareness about prediabetes and diabetes.

CHALLENGES
Diabetes Prevention Program participants’ attendance and retention is an ongoing challenge as well as program promotion.

TECHNICAL ASSISTANCE
The HCDI Public Health Planner provides ongoing support for Schenectady County Public Health Service diabetes/obesity work group, Schenectady Coalition for Healthy Community, and other chronic disease related activities.