Impact Profiles

Health Foundation
for Western & Central New York

Since its inception, the Health Foundation for Western and Central New York has served as an advocate for continuous improvement in health and health care by investing in the people and organizations that serve young children and older adults in the 16 counties in western and central New York.

The Foundation has three focus areas: (1) improving the health and health care of children birth to age five who are impacted by poverty; (2) improving the health and health care of vulnerable older adults; and (3) ensuring that communities across the region have the capacity to effectively address health needs.

The Foundation has always recognized achieving meaningful, sustained change in these focus areas requires work beyond awarding grants. To this end, we work with our community partners to better plan for, and address the needs of, the most vulnerable and underserved populations in our regions.

Since 2004, the Foundation has invested almost $50 million in programmatic efforts across these three focus areas. The Foundation's work has helped improve health and health care along numerous fronts, including children's oral health, maternal and child health, falls prevention and care transitions for older adults, health leadership across the region, and the health safety net in numerous communities.

Along the way, the Foundation has developed a strong reputation in the community as a convener, often serving to help bring together stakeholders for a common purpose. The Foundation also has a strong legacy of innovation, and capitalizing on emerging opportunities, as well as a willingness to learn and the desire to consistently improve our ability to serve our community.

In 2013, the Foundation partnered with The Bridgespan Group, a nonprofit advisor and resource for mission-driven organizations and philanthropists. Their work was both reflective, and forward facing: to take stock of the Foundation's work to date and identify opportunities to sharpen the Foundation's efforts to maximize its impact. This strategic sharpening process culminated in a vision, and corresponding supportive strategies, for each of its three focus areas, to guide the work of the Foundation between 2014 and 2019.

VISION: All children impacted by poverty are physically, socially and emotionally healthy as they enter kindergarten.

STRATEGIES:

- Prevent common childhood problems and manage chronic diseases.
- Build strong, nurturing family and community environments that support healthy development and learning.
- Ensure healthy pregnancies and positive birth outcomes.
- Develop strong social and emotional skills.

VISION: All vulnerable older adults are able to plan for and maintain a dignified, independent, high-quality life in their community.

STRATEGIES:

- Prevent and minimize the effects of triggers of decline.
- Ensure caregivers can effectively support those who they care for and for themselves.
- Enhance access to high-quality, coordinated elder-competent care.

VISION: All communities are able to effectively plan for, and address, health needs of the most vulnerable and those in poverty.

STRATEGIES:

- Ensure communities have effective health planning tools and systems.
- Build the capacity of health, human service, and safety net organizations.
- Develop strong organizational and community leaders.

Programs for Children Impacted By Poverty

Health Foundation
for Western & Central New York

Prevent Common Childhood Problems and Manage Chronic Conditions

CHOMPERS: Portable Dental Care

Challenge: Tooth decay affects more than one-fourth of U.S. children aged 2–5 years. In New York State, approximately **44 percent of children experience tooth decay by the third grade.** Children from low income and minority families are particularly vulnerable because they are less likely to have their oral health addressed. An estimated 17 million low income children in the United States go without oral health care each year. This represents about one out of every five children.

Solution: The Foundation launched the Portable Dental Care program to address transportation and other barriers that can prevent children and their families from accessing needed preventative services and treatment. These school-based clinics offer a range of preventive services, including teeth cleanings, fluoride rinses, as well as providing educational information to caregivers.

Impact: Since the program began in 2011, the two portable dental clinics in Western New York served approximately 1,482 children, and the four portable dental clinics in Central New York have served approximately 5,143 children.

About
1 in 5
children
go without
oral health care
each year.

WNY

Since 2011,
Chompers has served

1,482 children | 5,143 children

for a total of
6,625
children served

CNY

Prevent Common Childhood Problems and Manage Chronic Conditions

From 2011–2018, over

40,533 kids

have participated in Cavity Free Kids

CHOMPERS: Cavity Free Kids

Challenge: Poor oral health has a negative impact on child health, wellness, and ability to succeed in school. Families need to see oral care as a health priority for children, an idea that early childhood educators and primary care providers have a significant role in reinforcing. Families need more knowledge on what good oral health care entails. The current system does not provide adequate access to oral health care for low-income children due to insufficient capacity and low rates of reimbursement. Bringing oral health care to places children already go will increase access.

Solution: Cavity Free Kids includes a large collection of lessons, activities, stories, songs, and other resources to engage young children in play-based learning about oral health, and help parents/caregivers practice good oral health habits at home. The Health Foundation has funded four Cavity Free Kids grantee cohorts in western and central New York. **There are currently three regional hubs, 82 Master Trainers and 882 Community Trainers.**

Impact: Over 40,533 kids have participated in Cavity Free Kids since its inception (2011–2018). The pilot suggested this program is effective in improving dental habits; the evaluation of the pilot found that 88% of children had increased the frequency of their teeth brushing, there was a 59% uptake in eliminating juice from classroom snacks, and parents reported increased knowledge of healthy oral hygiene practices.

88% of children

had **increased the frequency**

of their teeth brushing

There was a

59% uptake in eliminating juice

from classroom snacks

Cavity Free Kids is important because, for some of the families in the program, a toothbrush is a luxury item. Kids reported their Cavity Free Kids toothbrush is being shared by the family, and requesting additional supplies that they can give out.

"Anyone we work with is embracing the curriculum because they can pick and choose activities. The lessons fit in with their existing curriculum, so Cavity Free Kids is a way to re-energize what they are already teaching in the classroom, and it is cost effective and can easily be replicated in the future without a lot of cost," says Theresa Wells, coordinator of Health, Disparities and Nutrition for Cattaraugus Wyoming Counties Project Head Start.

"My classroom gets excited by the props and hands-on activities with the puppets, along with the big mouth that allows children to practice proper teeth brushing. The curriculum is right on their level, so they understand what they are learning. And with little classroom funding, I appreciate that we receive the props, activities, dental floss and tooth brushes for each child as a part of the kit at no cost," says Nadine Deluca a preschool teacher at North West Academy Head Start.

Build Strong Nurturing Family and Community Environments

Help Me Grow

Challenge: Developmental screenings are recognized as one of the most effective methods available to identify developmental delays and behavioral dysfunctions. When problems are identified early and followed by appropriate interventions, it greatly improves school readiness and the likelihood of future success in young children. Based on both state and national statistics, **15 percent of children will experience a developmental delay or disability, with significantly higher rates among children who live in poverty.** The positive effects of early intervention are well documented; however, **only 22 percent of children in New York State receive routine developmental screenings.** Consequently, for many children, their delay or disability is not identified until it is more complex and difficult to address.

Solution: Help Me Grow provides developmental screenings for children with the goal of increasing parent and caregiver knowledge of childhood development and important developmental milestones. These screenings are important for early detection and treatment of developmental delays; additionally, Help Me Grow provides referrals and linkages to essential support services when necessary. Help Me Grow provides a cross-systems framework that identifies and maximizes existing programs, funding, and data systems to improve resource allocation and create community connections in a family-centered service delivery system. This helps parents access the supports and services they need and improves developmental outcomes.

Impact: In the first cohort of Help Me Grow, 2,600 children received a social-emotional development screening. Of the children screened, 43% were identified as needing additional screening or support services, and 98% of those children and families received linkage to appropriate services.

In the first cohort

2,600

children received a social-emotional screening

43%

of those needed additional screening or support

98%

of those children and families received linkage to appropriate services

Develop Strong Social and Emotional Skills

PEDALS (Positive Emotional Development and Learning Skills)

Challenge: Research demonstrates children with well-developed social and emotional skills are more prepared for kindergarten, have better overall academic outcomes and a healthier physical and emotional trajectory throughout their lifespan. Children living in poverty are at greater risk for deficits in social and emotional skills.

Solution: Developed in partnership with the Peter and Elizabeth C. Tower Foundation, PEDALS is a two-year intervention for 3- and 4-year-olds that combines evidence-based curricula, classroom coaching, technical assistance and evaluation to create an environment in which children actively learn and develop self-regulation, attachment and communication skills. The program also identifies children with additional needs to ensure accommodations and appropriate referrals are made for them and increases teachers' skills to provide the optimal environment for a child's success.

From 2012 to 2017, PEDALS reached
150 CLASSROOMS, and at least
4,500 CHILDREN

year one: **HALF** as many kids rated as having **A NEED.**

year two: **3X** as many kids rated as having **STRENGTH.**

In years 1 and 2, PEDALS participants went from *below national average* for social-emotional protective factor scores, ***to ahead of the national average.***

Impact: From 2012 to 2017, the PEDALS program has been incorporated into 150 classrooms, and reached at least 4,500 children. The evaluation of the pilot found significant improvement on the Devereux Early Childhood Assessment (DECA); the DECA is a measure of protective factors and behavioral concerns. Children who are rated as low in protective factors and high in behavioral concerns are considered to have a need, and children who are rated highly on protective factors and low in concerns are considered to have a strength. During the pilot, after year 1 of PEDALS, there was a 50% decrease in the number of children who were rated as having a need (relative to their pre-intervention scores), and at the end of year 2, three times as many children who were rated as having strength. At baseline, across both years, these children had lower than national average social-emotional protective factor scores. At post, across both years, these children had moved ahead of the national average. PEDALS also incorporates developmental screenings, and 96% of teachers reported discussing these screening results with caregivers; teachers felt these screenings increased their knowledge of student social emotional needs and better prepared them to follow-up on these needs (e.g., through an intervention plan or referral).

Through PEDALS, early childhood educators learn how to use an evidence-based curriculum like Second Step to teach children how to manage strong emotions, communicate effectively and make friends. Lisa Fastonia Snell, a teacher at Bethel Head Start, shared an example of how kids manage their emotions. Standing together in a group, they put their hands on their tummies and said "stop." They then name what they were feeling and took deep belly breaths to calm down.

"When students came into my classroom, a few had already experienced some significant trauma in their lives. Others had never played with other kids before, so they didn't know how to share, or how to trade toys. They had to learn these things. It was a slow start, but over time, I began to see it (the PEDALS curriculum) was really working and I began to believe," Snell said.

"Early childhood programs can tailor the program to fit their specific needs to make it successful, and sustainable, within their organizations. Coaches are there to provide guidance and support, help teachers fit activities into their classes and deal with challenging behaviors," Jaimee Ferraro, a PEDALS coach, said.

Ensure Healthy Pregnancies and Positive Birth Outcomes

Priscilla Project

Challenge: Refugee women experiencing their first pregnancy in the U.S. experience tremendous barriers when interacting with the health system due to language and cultural differences. Poor communication between the women and their providers can result in poorer birth outcomes.

Solution: Refugee women who are pregnant for the first time since their arrival in the US are paired with mentors and doulas. Culturally-matched doulas provide physical, emotional and informational support to refugee mothers before and during labor and childbirth. They assist with creating individualized birth plans and provide interpretation services for refugees and hospital staff. Doulas also provide breastfeeding support within 48 hours of birth, and again at two weeks and one month post-partum. Education classes on subjects including breastfeeding, infant nutrition, and the birth experience in the U.S. context are offered to all participants in their native languages.

Mentors meet with the refugee mothers-to-be for at least an hour once per week, and continue until three months post-delivery. Mentors provide an additional critical social support to culturally isolated women, and also routinely provide transportation to and from prenatal appointments, as well as assistance with obtaining baby supplies.

Impact: Forty women participated in this project, and a qualitative evaluation found that the women appreciated the emotional support of the doulas in navigating an unfamiliar healthcare system, and the doulas were highly praised by care providers. Relative to the control group, Priscilla Project participants had fewer C-section deliveries (14% vs 41%), 68% of the women had their doula present at the birth. 81% were able to breastfeed in the hospital, and 83% planned to exclusively breastfeed after discharge.

40 WOMEN participated

THEY EXPERIENCED

GREATER EMOTIONAL SUPPORT

FEWER C-SECTION DELIVERIES
14% *vs 41%*

68% HAD A DOULA PRESENT AT THE BIRTH

81% ABLE TO BREASTFEED IN HOSPITAL
with 83% planning to continue

Ensure Healthy Pregnancies and Positive Birth Outcomes

Midwifery

Challenge: Babies who are born prematurely and/or are low birthweight are at higher risk for developmental delays and lifelong physical and mental health challenges. When mothers do not receive adequate prenatal care, they are more likely to have preterm and low birthweight babies. Women living in poverty are significantly less likely to get early and sufficient prenatal care, and are more likely to have preterm and low birthweight babies, who are then at higher risk for complications.

Solution: Numerous studies have shown that Licensed Midwives have excellent birth outcomes and can provide a safe and viable alternative to traditional maternity care in the United States, particularly for low and moderate risk women. Despite this evidence, the number of Licensed Midwives in the Western New York region was low, compared to other regions in the state. In addition to direct grant funding, the Foundation provided grantees with expert guidance on developing a sustainable midwifery business model, including guidance on billing, payer mix, patient and on-call scheduling, marketing, recruitment, and more.

Impact: Over the course of the project, 21 Midwifery practices were engaged in grants and received technical assistance to improve their business acumen. These practices served over 30,000 women, and reported premature and low birth rate statistics that were nearly 50% lower than regional and national averages. Additionally, the Midwifery Blueprint, created by the Foundation, was utilized as a model for the development of Best Practices by a national midwifery group.

21 *Midwifery practices engaged*

serving over

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WOMEN

with **premature & low birth rates**

50% LOWER

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the

Midwifery Blueprint

created by the Foundation used as a national model for

BEST PRACTICES

For OB-GYN & Midwifery Associates of Ithaca, a midwifery practice that received a grant for technical assistance, the number of Medicaid patients served in their practice increased throughout the duration of the grant period, with nearly half making up their payer mix. Forty seven percent of the practices' low-income patients are being seen by certified nurse midwives.

"This grant certainly wasn't intended to increase visibility and knowledge about what midwifery is, as we were already known to the Ithaca community and were seen as a positive. What we needed was to internally strengthen our practice, to increase communication and to improve teamwork," Lisa Benedetto, MS CNM, said.

"The business development plan provided us with a document from which to work from, and enhanced our understanding of and ability to market midwifery services with a focus on establishing our brand and customized communications," Benedetto said.

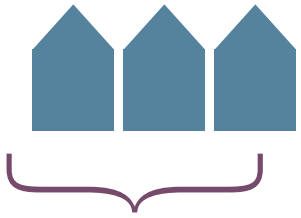
Ensure Healthy Pregnancies and Positive Birth Outcomes

Project WHEN (Women's Health Education Navigation)

Challenge: Women involved in the court system are at high risk of having poor birth outcomes and often have difficulty accessing services. For this group of women, traditional home visiting models are not always a good fit, and neither the justice system, nor the local health and human service provider networks are well positioned to support their unique needs.

Solutions: The Center for Court Innovation's Patient Navigator program provides support to court-involved, low-income women who are pregnant or parenting a child under the age of one. The navigator helps connect women to timely prenatal care, improves coordination among service providers and addresses any need for education and support around pregnancy and parenting. The Foundation collaborated with the March of Dimes to establish a new program site in Buffalo, and support and strengthen the existing sites in Niagara Falls and Syracuse.

Impact: Across the three sites, a total of 65 pregnant women received comprehensive case management services throughout their pregnancy, leading to very few pre-term births, and improved health outcomes for both mothers and babies. An additional 414 referrals were made to other services, with a very high rate of follow through (above 90% for the referrals that were tracked), and over 900 court involved women received educational information and materials about health and well-being, including sexual health and parenting.



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with a **90%+ follow through rate** on tracked referrals

over
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Ensure Healthy Pregnancies and Positive Birth Outcomes

DURING THE FUNDING PERIOD, THERE WERE

1,055 WELL-CHILD VISITS

531 *screens, for a screening rate of 50%*

70 *same-day appts for follow-up care*

BY SEPT 2018

1,000+ women

had been screened at well-baby visits

40–50% *screened positive for at least one risk factor*

400+ *received same- or next-day follow-up appointments*

Project IMPLICIT (Interventions to Minimize Preterm and Low Birth Weight Infants Through Continuous Improvement Techniques)

Challenge: Following pregnancy, the focus typically shifts from caring for the woman to caring for the infant, which means that the health needs of the mother are often ignored or not prioritized. Socioeconomic issues and family care can limit a mother's ability to focus on her own health needs, which, in turn, can impact the child's emotional and physical wellbeing. In the postpartum period, women may revert to risky behaviors, such as smoking or drug use, which can lead to increased depression, unprotected sex and unintended pregnancies. Early identification and support can help reduce these modifiable risk factors, and this is crucial for the wellbeing of the new baby, as well as preventing subsequent preterm and low birth weight babies.

Solution: The United Way of Buffalo & Erie County in partnership with March of Dimes, planned and implemented an "Interventions to Minimize Preterm & Low Birth Weight Infants through Continuous Improvement Techniques" Project. IMPLICIT is an evidence-based model that screens mothers of children ages 0–2 at well child visits for risk factors that cause preterm and low birth weight babies: smoking, depression, contraception use and multivitamin intake. If the mom has a positive screen, an immediate intervention and/or referral is made, with the goal of improving future pregnancy outcomes.

Impact: At the end of the grant funding period, Neighborhood Health Center successfully implemented Interconception Care screening at all four of their federally qualified health centers (FQHCs) located in Buffalo, Hamburg and Blasdell. They were able to negotiate a better price for their electronic health record build and were able to utilize the remaining funding to build onto the module to better suit their expectations and needs. Ensuring the electronic health record functions optimally has allowed the IMPLICIT model to become sustainable with minimal, if any, additional funding investment.

During the funding period, from January 24, 2018 through May 31, 2018, there were 1,055 well-child visits during which 531 screens were performed for a screening rate of 50%. Of those screened, 111 were positive for at least one risk factor, and 70 same-day appointments were scheduled for follow-up care.

By September 2018, over 1,000 women had been screened by Pediatrics at well baby visits, and 40–50% of the mothers screened positive for at least one risk factor. More than 400 women received same or next day follow-up appointments in OB-GYN or Behavioral Health for additional care and support services.

Additionally, the results of the project were accepted for a poster presentation at a national conference on maternal and child health, allowing for wider dissemination of the program.

Older Adult Programs

Health Foundation
for Western & Central New York

Prevent and Minimize the Effects of Triggers of Decline

Overall through Phase 2 projects,

28,675

older adults and **caregivers** were reached

2,079 in outpatient or home care therapy

1,538 in exercise

4,334 in home safety

16,977 through education programs

Step Up to Stop Falls

Challenge: Falls by older adults are a leading cause of injuries, hospitalizations, decreased quality of life and reduced independence. **They represent a key trigger of decline, and one that is preventable.** A fall can prompt a fear of falling again, often leading to a reduction in activity and the potential for more falls. This sequence of events produces increased medical care for injuries and nursing home admissions. One in three older adults falls each year, with one in ten of these falls resulting in injuries that require hospital care. The most important risk factors are muscle weakness, poor balance, medication usage, vision problems and fear of falling.

Solution: The Foundation's Step Up to Stop Falls program is a collaborative model built on the experiences of the WNY Falls Prevention Consortium and the 2009–2010 WNY Falls Prevention Collaborative, with the goal to both increase the depth of impact in Erie County and spread effective practices to new counties in western and central New York. In addition, the project employed social marketing strategies and broad community messaging to encourage behavior changes that can reduce the risk of falls.

Our Step Up to Stop Falls project was multi-faceted and included a variety of strategies such as developing common rehabilitation practices and competency in falls risk assessment and intervention, engaging pharmacists to review and modify medications based on the fall risk they pose, and integrating fall risk screening with follow-up referral to rehabilitation and to community practice by primary care practices or other clinical settings.

In total, Phase 2 of Step Up to Stop Falls (2012–2014) included 44 projects spread across the counties of Western New York, and three counties in Central New York.

Impact: Projects in Phase 2 worked to improve medication management, engage EMS personnel, reach therapy and nursing students, as well as to shift practice in rehabilitation services and primary care physician offices. As part of the work to change professional practice, two Erie County agencies implemented multi-factorial projects in certified home health agencies to move their work from stand-alone projects to processes that impact systems in the way they work with at-risk older adults. In total, almost 3,300 health professionals and students were reached with education and practice change.

Overall, 28,675 older adults and caregivers were reached through Phase 2 projects, including 2,079 in outpatient or home care therapy, 1,538 in exercise, 4,334 in home safety and 16,977 through education programs. Based on evaluation, it is anticipated that about 80% of those who participated were female. It is also expected that these projects continued to be successful in reaching "old-old" adults, and 30% of those who participated in exercise were over the age of 80. These community-based programs have been successful in reaching older adults before they experience the trauma of a serious fall.

Prevent and Minimize the Effects of Triggers of Decline

Step Up to Stop Falls (page 2)

Sustainability Report: Recently, the Foundation supported a sustainability evaluation to assess the degree to which Step Up to Stop Falls programs had been sustained by grantees following the end of funding in 2014. Many of the key components of Step Up To Stop Falls have been sustained, with community education, balance and exercise programs, and home safety activities being the components most likely to be sustained. Most of the coalitions reported scaling back the scope of their falls prevention work, e.g., offering community education classes three times a year instead of monthly.

1. Community education and balance and exercise programs were most likely to be sustained. While most coalitions have been able to sustain these programs to a certain level, many coalitions reported that they have significantly reduced the scope of these programs since funding ended in 2015. Sustainability of these programs has been threatened by staff turnover, loss of certified trainers in evidenced-based programs, and increasing fees charged by evidence-based programs. Additionally, the New York State Department of Health is no longer supporting some of the programs that were started under Step Up To Stop Falls, such as Stepping Out, which has eliminated a major source of funding for some agencies.

2. Programs engaging healthcare professionals have generally not been sustained. While coalitions were able to build these relationships, the loss of funding along with staff turnover and a decrease in routine coalition meetings resulted in several of these programs ending.

3. If a coalition built a relationship with an EMS provider, this relationship and their engagement in falls prevention activities has been sustained. Coalitions have become an asset to EMS providers who are struggling with sustainability and the impact of frequent calls for non-emergency situations. This has been especially beneficial in supporting volunteer squads in rural communities.

4. All home safety activities have been sustained. This is primarily the result of a County Office of the Aging policy change which incorporates home safety assessment into the intake and routine assessment of any older adult receiving services.

"It's been a life saver," explains Donna Jean Darling of the Tai Chi class in Ithaca she's attended for more than a decade. "I haven't fallen since I started taking the class."

"There was no great expense in any of the precautions I took," says Audrey. "Just common sense things I learned at Stay Well like removing my scatter rugs, plugging in night lights and moving my heavy dishes down to a lower cupboard so I wouldn't have to use a step stool. I never walk around the house in socks anymore. I wear sneakers or shoes with rubber soles all day long."

Prevent and Minimize the Effects of Triggers of Decline

Aging Mastery Program®

Challenge: People are living longer than ever; however, not all people are enjoying a high quality of life for the entire duration. Triggers of decline can precipitate a dramatic change in the health of older adults, and subsequently, in their quality of life. Preventing triggers of decline through modifying health behaviors, such as diet, sleep and physical activity can help improve the quality of life for older adults. Aside from changes to physical health, longevity can present new or different challenges related to finances, medication management, staying engaged with the community and advanced care planning.

Solution: The National Council on Aging created the Aging Mastery Program® to develop new expectations, norms and pathways for people aged 50 to 100, to make the most of their gift of longevity. **The Aging Mastery Program encourages aging mastery—developing sustainable behaviors across many dimensions that lead to improved health, stronger economic security,** enhanced well-being and increased societal participation. The program's core curriculum combines evidence-informed knowledge sharing with goal-setting and feedback routines, daily practices, peer support and small rewards. Classes are led by expert speakers who help participants gain the skills and tools they need to manage their health, remain economically secure and contribute actively in society.

Impact: Preliminary results from pilot projects conducted nationally show that Aging Mastery Program participants saw a significant increase in their physical activity levels, healthy eating habits, use of advanced planning, social connectedness, and participation in evidence-based self-management programs after taking the 10 week core curriculum. To date, the Aging Mastery Program has been introduced in all eight counties of Western New York, where 154 older adults have participated across 10 classes.

AGING MASTERY PROGRAM PARTICIPANTS **SIGNIFICANTLY INCREASED** THEIR:

- physical activity levels
- healthy eating habits
- use of advanced planning
- social connectedness
- participation in self-management programs

Prevent and Minimize the Effects of Triggers of Decline

Aging By Design

Challenge: Research revealed there is limited data and few evidence-based practices about community-based interventions to guide our work in addressing triggers of decline for older adults, in particular vulnerable older adults. The lack of substantial research and evidence-based practice is an unfortunate reality in the field of aging yet it also presents an opportunity for the Foundation to test new ideas and inform the field of practice. Previous work done by the Foundation indicated that designing sustainable programs and interventions that would succesfully meet the needs of older adults can be challenging. Service uptake is often low, resulting in programs that are underutilized and unsustainable.

Solution: The Aging by Design program used a human-centered design approach to developing programs and interventions. The project started by providing training on human-centered design to organizations in Western and Central New York, and then participating organizations were encouraged to submit proposals for using human-centered design to develop new service offerings for older adults. Over the course of the project, organizations engaged the older adult population they serve to identify their needs and then develop and test "prototypes" of solutions for those problems. By involving older adults at every stage of the process, the organizations were able to get ongoing feedback and refine their prototypes to ensure high quality, desirable programs and services that would meet the needs of older adults.

Impact: During the first phase of Aging By Design, 300 people were trained in human-centered design thinking. Thirty-five organizations submitted over 500 empathy maps from older adults, participated in street teams and organized stakeholder labs during the Learning Phase of the project, and 24 organizations submitted proposals to participate in the Planning Phase. Ten organizations were selected, and these organizations received additional training and technical assistance as they formed their design teams with older adults in their community. At the end of the Planning Phase, these organizations presented their prototypes at Design Day events and received feedback and suggestions from other members of the community. Following the Design Days, the organizations submitted proposals for funding for their prototypes, and 10 grants were awarded to fund development of these projects.

A full developmental evaluation of the project is ongoing, but initial insights indicate that Aging By Design has not only resulted in innovative solutions to needs identified by older adults, but has also resulted in significant culture shifts at some of organizations participating in the project. Some of the grantees have incorporated human-centered design into their organization more broadly, and continue to use the tools and principals of human-centered design when thinking about new services and programs.

LEARNING PHASE

300 **people trained** in human-centered design thinking

35 organizations participated

PLANNING PHASE

24 orgs submitted proposals

organizations were selected & developed project prototypes

10

grants were awarded to fund development of those projects

From the program Gather Around, by Central New York Aging By Design grantee InterFaith Works

"I can say 'how are you', 'goodbye' when I am out and about. I would not have done that before. My mobility is limited, so I don't get out a lot, but when I do, I use English greetings."

"I can't sleep at night (flashbacks are disturbing) - getting out of the house helps to process and coordinate/converse with others."

Ensure Caregivers Can Effectively Support Those They Care For and Themselves

This report generated the following recommendations to support caregivers:

- ACCURATE **IDENTIFICATION** OF **CAREGIVERS**
- PROVIDER **PAYMENT REFORMS**
- DEVELOPMENT OF **SUPPORT SERVICES** LIKE RESPITE
- ENACTING POLICIES FOR **ECONOMIC SUPPORT** FOR CAREGIVERS

Families Caring for an Aging America

Challenge: More than 35 million Americans are family caregivers for adults age 65 and older with chronic illnesses and functional, cognitive and sensory impairments that limit their ability to care for themselves independently. The term family caregiver can include relatives, but also partners, close friends and neighbors. In 2009, the estimated value of the care family caregivers provided for older adults was over $250 billion.

Family caregivers deliver extensive, ongoing help with daily activities to chronically ill and disabled older adults. Older adults who would have been in a nursing home years ago are now cared for at home, and family caregivers are expected to perform complex, medically related functions previously provided by nurses and other trained personnel. Yet family caregivers do not receive the assistance they need to perform their tasks, and they may experience high levels of stress, depression, and negative physical and financial effects due to their caregiving role.

Solution: We provided support to a project conducted by the Institute of Medicine to examine family caregiving for older adults by a committee of 15 individuals with varied expertise in family caregiving and related health care services subject matter. The committee gathered evidence from a variety of sources to create a comprehensive report that addresses the present state of family caregiving, needs for the future and policies to involve family caregivers in, and improve delivery of, services to older adults with chronic disease and disabilities, cognitive impairment and other frailties and to support family caregivers.

Impact: The report generated a series of recommendations for actions to provide better support for caregivers. Some of these recommendations focused on developing and implementing effective mechanisms to identify caregivers and implementing provider payment reforms to motivate providers to include caregivers in the service delivery process for their care recipients. Other recommendations were around development of explicit support services, such as respite, and enacting state and federal policies to provide economic support for caregivers.

In October of 2018, the Foundation held a “Connecting to Caregivers” breakfast in Central New York to present and discuss these recommendations with stakeholders. The breakfast also featured a keynote address from nationally recognized caregiver advocate Ramie Liddle, followed by a panel discussion of local experts in caregiving.

“This report raises serious concerns about the current state of family caregiving of older adults in the United States. The impact of caregiving on families should not be ignored. If the needs of caregivers are not addressed, we risk compromising the well-being of our elders and their families. Taking on these challenges means seizing an opportunity to discover the potential societal benefits of effectively engaging and supporting family caregivers in the care of older adults—both economic and otherwise.”

Ensure Caregivers Can Effectively Support Those They Care For and Themselves

ARCH National Respite Caregiver Research Report

Challenge: Respite care is an evidence-based best practice for supporting family caregivers of older adults; however, it remains underutilized by those most in need of it. Additionally, there are a number of questions about respite care that remain unanswered, which has hampered the spread of respite services. Some of these questions include the development of reliable outcome measures; cost-benefit analyses to justify future funding and sustain efforts; systems change to improve access; improving provider competence; and translating research findings into best-practice models.

Solutions: ARCH National Respite Network & Resource Center, in collaboration with the Administration for Community Living, has convened a consortium of funders to work together to build an evidence base for caregiver respite programs. The consortium, consisting of funders from government, private non-profit foundations, corporate foundations and other types of philanthropic organizations, is collaboratively developing a Request for Proposals for multi-year projects that evaluate and measure the short and long-term impact of caregiver respite. The goal of the consortium is to demonstrate the impact and cost effectiveness of respite programs, identify new best practices and ways to improve service quality and establish baseline outcome measures. This will ultimately allow community stakeholders to better plan, deliver and evaluate respite programs and services.

ARCH National Respite Caregiver Research project

is currently underway

Impact: The ARCH National Respite Caregiver Research project was approved in September of 2016 and is currently underway. Additionally, the ARCH National Respite Caregiver Conference will be held in Buffalo, New York in 2019.

ARCH National Respite Caregiver Conference

BUFFALO, NEW YORK | 2019

Ensure Caregivers Can Effectively Support Those They Care For and Themselves

In NYS, there are an estimated

131,000 GRANDPARENTS

WHO ARE CAREGIVERS

16.1 MILLION AMERICANS

PROVIDE UNPAID CARE

for loved ones with cognitive loss

Brookdale Foundation Caregiver Initiative

Challenge: The need for caregiver support has risen dramatically as our country ages. This is particularly true for two distinct populations; people caring for individuals with Alzheimer's disease or a related dementia, and grandparents or other relatives thrust into a caregiving role for a child due to the absence of a parent.

According to the National Alzheimer's Association, **16.1 million Americans provide unpaid care for people with Alzheimer's or other dementia.** Although caring for a loved one can be rewarding, it can take a toll on the caregiver, particularly when the care recipient has dementia. Compared with caregivers of people without dementia, caregivers of those with dementia are twice as likely to suffer from substantial emotional, financial and physical difficulties.

Nationally, more than **7 million grandparents lived with at least one grandchild under age 18 in the same household during 2010. In New York State, there are an estimated 179,000 caregivers, 131,000 of whom are grandparents,** while many others are aunts and uncles, according to the New York State Kinship Navigator. Locally, over 6,100 grandparents are raising grandchildren in Western and central New York, and over 33,000 of these grandchildren are under the age of 18. Reasons a grandparent or other relative are forced into a parenting role vary but may include: the parent is incarcerated or is incapacitated by mental illness or substance abuse, has died, has an unstable home life or is homeless. The growing opioid crisis is creating an urgent need for more community programs to assist grandparents and other relatives in caring for children of addicted parents.

Solution: The Brookdale Foundation is a national foundation that developed and funds two initiatives that provide care and services for family caregivers: (1) the Brookdale National Group Respite Program and (2) the Relatives As Parents Program. The Respite Initiative supports the development of social model adult day programs to provide at least four hours a week of appropriate activities for people with dementia and information on supportive services for their caregiver. The Relatives as Parents Program is designed to create or expand services to grandparents and other relatives who have taken over the full-time care for children whose parents are unable to care for their children. Each of these initiatives provide two years of funding to community based organizations, attendance at the annual orientation and training conference and on-going technical assistance.

The Foundation will fully support up to ten community-based organizations to participate in either one of these two programs, five in each of the two regions. Funding includes a two-year grant and travel expenses to attend the Brookdale Foundation's annual orientation and training conference. The Brookdale Foundation will provide technical assistance over the two years in order to develop, implement and sustain the program.

Impact: This program was approved in the fall of 2018, and is still in progress.

Enhance Access to High-Quality, Coordinated Elder-Competent Care

Conversation Project

Challenge: Many people avoid or delay having conversations with their loved ones about important, but difficult, topics such as end-of-life care. Without these important conversations, caregivers and loved ones may unintentionally transgress the wishes of someone at the end of their life, adding to an already emotional and stressful time.

Solution: In 2014, Erie County Medical Center (ECMC) launched its own public campaign dedicated to encouraging people to talk about their wishes for end-of-life care with their loved ones, before a health care crisis occurs. In 2015, The Foundation added their support for this program, The Conversation Project, which is focused on encouraging and supporting families to have meaningful and timely conversations about a person's values and wishes regarding their chronic and/or terminal condition and, by extension, palliative or end-of-life preferences. What is unique about The Conversation Project is that it is being co-led by the palliative care team from ECMC along with pastors and ministers who are members of the community being served. The project served some of the most impoverished areas of Buffalo.

Impact: Led by ECMC, the Conversation Project was able to deliver 107 community presentations that reached 4,915 people in 2016, focusing primarily on ECMC staff and members of the surrounding community in the following zip codes: 14204, 14206, 14208, 14211, and 14215. In addition, ECMC was able to leverage a number of community assets to further the goals of the Conversation Project including City Wide Crusade—an organization comprised of chaplains who are involved in community outreach, and Black Nurses Rock—a community organization where professional black nurses share, network and develop together.

Led by ECMC,

THE CONVERSATION PROJECT

DELIVERED

107

community presentations

REACHING

4,915 PEOPLE

in 2016 alone

and collaborating with

City Wide Crusade

+

Black Nurses Rock

"At the Alzheimer's Association, we work with people with dementia and their families to offer support, education and guidance for future care. One important piece of care planning that often gets delayed is what happens at end-of-life. For many people with Alzheimer's disease, the window of opportunity to have a discussion on values and wishes is small due to the progression of the disease, and needs to happen as soon as possible. While we talk to caregivers about the importance of these issues ahead of time, we can't always be with them for that intimate discussion. The Conversation Project Alzheimer's kit has the potential to help make these discussions less daunting and more concrete for the families that use them by recognizing the unique needs of people with dementia and aiming for the end-of-life outcomes that are preferred by each individual."

-Rachel Rotach, LMSW,
Program Director
Alzheimer's Association, WNY

Enhance Access to High-Quality, Coordinated Elder-Competent Care

Social Work Practice Fellows

Challenge: There is a critical need for enhanced continuing education for social work supervisors. Not only do they teach, manage, and oversee those that they supervise, they are the first people that staff turns to for guidance in their direct practice with challenging clients. Although the role of the supervisor as teacher is critical, the curricula of many schools of social work is often devoid of information that addresses this aspect of supervision.

The need for enhanced continuing education for Master of Social Work supervisors results, in part, from the setting-specific context of our health and mental health systems, which allows social workers and other clinical providers to view themselves as specialists in working with particular age groups, populations or problems. Many organizations in which social workers practice, particularly in health care, serve clients of all ages. Thus, effective supervisors must achieve advanced levels of skill in supervision as well as a broad scope of expertise about supporting teams in overcoming practice-related complexities involving individuals of all ages as well as families.

Solution: The Social Work Practice Fellows program includes six full-day workshops that address issues critical to supervision of social work in direct practice along with an implementation manual. The curriculum addresses a variety of situations clients of all ages encounter, including addictions, family abuse and dysfunction, mental illness and chronic illness. The curriculum gives balanced attention to older adults, families, individuals and children. In each of the four pilot locations, cohorts of about 20 supervisors convened every other week for six full-day workshops to receive a total of 36 hours of training and will be awarded 36 continuing education units to apply toward their ongoing state licensure for professional practice. The program utilizes a proven model of supervisor recruitment, training and peer support and establishes a sustainable business model of collaboration among schools of social work in distinct geographical regions. Graduates of the training are then invited to join a network of Social Work Practice Fellows who will profit from ongoing knowledge building and professional networking.

Impact: Four partner schools have been engaged, and the first cohort of Social Work Practice Fellows was scheduled to graduate between the early 2018 and early 2019. The cohorts varied in size, including 15 participants at Syracuse University, 17 at The State University of New York at Buffalo, 20 at the University at Connecticut and 24 at Adelphi University. The six workshops emphasized caring for clients across the lifespan and included two workshops focused specifically on health challenges and mental health across the life course. All four of the partner schools ran successful programs, recruited diverse cohorts of agency-based supervisors who completed the program, built strong professional networks, and earned continuing education credits for their licensure while engaging in this important curriculum and learning experience.

A preliminary evaluation indicated that the average confidence level in using 36 best practices of supervision increased from 2.69 to 3.28 on a 4-point scale (1="Not at all"; 4="Very"), an increase of 0.59 points or 22% (n=78). The greatest increases in confidence were associated with the learning achieved in the following two workshops: Teaching Social Work Assessment Skills (27% increase) and Advancing Knowledge of Health Challenges Across the Life Course (27% increase).

A more comprehensive evaluation of the project is not yet complete, but the interest and uptake of the pilot program supports that this kind of lifespan training is desired by, and beneficial to, social work supervisors.

"I found it a great sounding board to learn from colleagues in the field, pick up some useful tools and concepts, and receive validation/encouragement in my leadership role and the difficulties that accompany it. I have already implemented some changes, including incorporating specific tools and strategies from the handouts provided. I also anticipate being more intentional in my approach—tailoring my supervision to each of my staff member's needs/personalities."

"I thought the program was very helpful. Each instructor provided a lot of specific, easy to use tools that I can implement with staff, try out on my own, and adjust to meet any specific needs/issues that come up. Each was well-prepared and made good use of the time. Each of the topics was appropriate for my current role. I really appreciated having the specific tools, but also the bigger conversations about how to do supervision well."

Capacity Building Programs

Health Foundation
for Western & Central New York

Ensure Communities Have Effective Health Planning Tools and Systems

Partnerships for Healthy Communities

Challenge: In 2017, Governor Cuomo launched an initiative to advance "Health Across All Policies," (HAAP) which includes a pledge to make New York the first Age Friendly State. HAAP is a collaborative approach with the goal being **to make health improvement a focus of policies and regulations of every agency.** Given the strong connection of HAAP to the Foundation's emphasis on social determinants of health for children and older adults, the Foundation has an interest in helping this initiative to be successful.

The Health in All Policies model, which is the conceptual underpinning of HAAP, recognizes that a community's greatest health challenges are complex. To fully succeed in solving them, health improvement strategies must target social determinants of health, including factors that are often the responsibility of non-health partners, such as housing, transportation, education, environment, parks and economic development agencies. This approach identifies ways in which decisions in multiple sectors can improve community health and wellness while simultaneously advancing other goals such as promoting job creation and economic stability, transportation mobility and environmental sustainability.

Solution: New York State has committed $1 million to fund a statewide Request for Proposals, which will result in ten, $100,000 grants, one in each of New York's ten regional economic development zones. To support HAAP, the Foundation launched Partnerships for Healthy Communities; this has the goal of accelerating uptake of HAAP in our regions by supplementing the statewide effort with an intensive learning collaborative and supplemental technical assistance provided by experienced HAAP implementers.

A key component of the project will be Foundation-sponsorship of three additional communities in the learning collaborative. The selected communities will have made significant strides in establishing livable and Age Friendly environments and will serve as "anchor members" of the learning collaborative. This approach will allow more western and central New York communities to participate and offer leadership opportunities within the collaborative to our grantees. The learning collaborative will consist of all 13 teams from across New York State—anywhere from 5 to 8 teams will be from the Foundation's central and western New York counties. Together they will go through the process of operationalizing HAAP to align with state-level guidance from the Department of Health, the Office for the Aging, and the Department of State.

At the November 2017 board meeting, trustees approved Phase 1 of Partnerships for Healthy Communities, which included a $50,000 grant to support New York State in establishing a healthy aging framework within HAAP, and $50,000 to offer a pre-conference intensive at the Leading on Livability Summit, sponsored by AARP, to raise awareness of HAAP and its connection to Age Friendly New York State.

Impact: This work is still ongoing, but the Foundation has made a significant contribution to the goals of making New York an age-friendly state and advancing HAAP. After Cuomo announced that New York was committed to using the Health Across All Policies approach, Foundation President Nora OBrien-Suric was invited to sit on the New York State Ad Hoc Leadership Committee, which guides the integration of HAAP in the next Prevention Agenda.

In August 2018, the Foundation successfully hosted the Leading on Livability Pre-Conference Summit in Syracuse, New York.

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Leading on Livability

Pre-Conference Summit

SYRACUSE, NEW YORK

Build the Capacity of Health, Human Services and Safety Net

OVERVIEW: The fiscal landscape for nonprofits and community-based organizations (CBOs) has experienced rapid change over the last several years. Shrinking pools of federal and state grant dollars, increased legislation and red tape around the use of grant dollars and the enhanced importance and cost of updated technology and infrastructure have all contributed to creating a vastly different operating environment for CBOs. These organizations provide vital services to the community, but many of these organizations and agencies lack the tools and business savvy to be sustainable in the current environment. The recognition of the challenges posed by the current environment resulted in the creation of a series of programs designed to help local CBOs evaluate and increase their own capacity for service delivery, while emphasizing sustainability and engagement of their staff and boards. These programs were designed to meet the needs of organizations of varying sizes and resources, but all share a common purpose: Provide practical tools and strategies along with expert technical assistance to increase organizational capacity to meet the needs of the populations they serve.

Build the Capacity of Health, Human Services and Safety Net

Ready or Not

Challenge: Many vital community-based organizations (CBOs) lack the skills and resources to be able to prepare, plan and position themselves to be able to take advantage of opportunities and achieve future success in a rapidly changing health care system and fiscal environment. These organizations often find that their focus and energy is spent "putting out fires" that arise, leaving them without the bandwidth to address the underlying causes of these fires. Out of this realization came the identified need for a program that would provide financial and technical support to organizations serving young children and older adults to allow them to engage in self-assessment of their business practices and develop plans for a sustainable future.

Solution: *Ready or Not* was designed to give organizations the breathing room to plan for their future, and engage in self-assessment. The ultimate goal of the program was to build organizational and community capacity for health improvement using an organizational self-assessment model called *Nonprofit Lifecycles—Stage-Based Wisdom for Nonprofit Capacity,* developed by Susan Kenny Stevens. From November 2012 through June 2014, *Ready or Not* provided participating organizations with financial and expert assistance to strengthen the core of their organizations and improve capacity.

During the first few months, grantees were provided with expert assistance in organizational needs assessment and planning for capacity building. This process included site visits and strategy sessions with grantees to determine their greatest needs and goals for capacity building. Informed by organizational assessment findings, grantees developed *Ready or Not* work plans that included key activities, outputs and deliverables, due dates, assignment of responsibility and measures of impact.

Impact: Nine organizations participated in *Ready or Not.* Evaluation findings revealed that all grantees could identify significant achievements, such as greater organizational self- awareness, upgraded systems and infrastructure, improved financial strength, new business and service opportunities and increased management strength as a result of *Ready or Not* participation.

Some of the specific improvements included: **greater awareness of their organization's strengths, weaknesses, needs and opportunities for capacity building, achieving growth** in services offered and revenue, d**iversifying revenue streams, increasing patient census/volume of services** and otherwise **improving the organization's capacity to generate revenue.** Every grantee reported **gaining a better understanding of their profitability,** industry and of the organization as a whole. Grantees also gained a better understanding of market opportunities in a changing health care environment.

Most *Ready or Not* grantees **succeeded in creating new administrative infrastructures and major process improvements** to support more effective finance, billing and reimbursement operations, and data management systems.

"We've achieved tremendous growth as a WNY regional player. We're engaging in collaborative problem solving and collaborative enterprise—introducing new services CCOB services in new ways and to new audiences. We're reaching more people to fulfill our mission. All of this resulted from joining a regional forum and thinking outside the box in Ready or Not."

"We met all our capacity building goals in Ready or Not. As a result, we are more prepared financially and more strategic. We look at our business now from the standpoint of strategy and an analytic approach guides our action. Specific areas of achievement include staff development; our rebranding work is done and our name change; we expanded the Board, the role of the Board, and created new Board Committees; we achieved positive year-end financial results for the past two years (before Ready or Not we were losing money); and our programs and services are aligned to generate more revenue, contracts, clients and services…Through Ready or Not, [our Organization] has become a 'social enterprise.'"

Build the Capacity of Health, Human Services and Safety Net

Get SET (Success in Extraordinary Times)

Challenge: Although *Ready or Not* was a successful program for the participating organizations, it also highlighted the need for further capacity building resources for CBOs. *Ready or Not* used an individualized framework, with organizations working independently with consultants to conduct self-evaluations and make changes to their organizational structures. While this produced successful results, this limited the possibility for wider dissemination, and lacked systematic opportunities for collaboration. GetSET grew out of the lessons learned from *Ready or Not* by **adding a standardized curriculum with group education sessions, while still retaining the emphasis on individual organization self-assessment.** GetSET shares the same goals of helping organizations address the challenges of adapting to a changing fiscal environment and becoming more business savvy, with an eye on sustainability.

Solution: As noted above, GetSET grew out of the success and lessons learned from *Ready or Not.* The specific goals of GetSET were to increase the governance, financial, administrative and programmatic stability of health and human service organizations. By increasing organizational stability in these areas, organizations would have an improved ability to respond to the needs of the community and improve population health and community outcomes. GetSET retained some of the key elements of *Ready or Not,* including the board and staff assessment and creation of a capacity building plan, as well as providing expert consultants for technical assistance throughout the program.

Some of the main learnings from *Ready or Not* were that grantees could potentially benefit from a standardized curriculum, as there were common "pain points" across organizations. GetSET offered this in the form of group education sessions on topics such as developing a value proposition, navigating change, using data, enhancing cash flow, and aligning operational and financial data. The group education sessions also allowed grantees to have more communication with one another, with the potential to foster future collaborations.

Impact: There have been three cohorts of GetSET to date; cohort 1 had 8 agencies (11/2013–10/2015), cohort 2 had 6 agencies (3/2015–8/2017), and cohort 3 had 8 agencies (3/2017–3/2019).

In October/November of 2016, one year following the end of formal GetSET activities for Cohort 1 agencies, an evaluation revealed that GetSET had a significant positive impact for all the participating agencies. Agencies reported **paying greater attention to business practicalities, without sacrificing attention to their mission,** having **more sustainable business models** and **embracing key elements of the organizational development skills** included in GetSET.

Some of these key organizational development practices included: better hiring practices and matching of staff member skills to their role in the organization; integration across programs/services; a more outcome-oriented approach that includes greater accountability for results; and increased attention to outreach focused on the right audiences, the right messages and the right mechanisms.

The cohort 2 evaluation echoed these results, and also found that participating agencies reported: greater engagement by their Boards, stronger internal structures and communication, decreased staff turnover, having established goals and/or implemented data collection and analysis to provide accurate information for decision-making and for assessing/improving quality and outcomes, enhanced branding, marketing, and staff recruitment (based on refreshed mission, vision) and feeling more prepared for the realities of value based care.

"It was perfect timing: GetSET changed the life of the organization. GetSET was a catalyst for agencies to take the time and the effort to focus on themselves and what they need…We are feeling very good that we have begun this work and we were the only ones in the room that far ahead!"

Build the Capacity of Health, Human Services and Safety Net

Hitting the Mark

Challenge: *Ready or Not* and GetSET provided in-depth technical assistance, self-evaluation and significant resources to participating organizations; however, these programs also required a substantial time and resource commitment from participants. For organizations that did not need that level of support, or did not meet the criteria to participate, there was a lack of resources on how to meet the challenges of the changing healthcare and fiscal landscapes. There was an identified need for high quality, engaging workshops that provided concrete tools and strategies to community organizations to better equip them to deal with their common challenges, without requiring the significant time and resource commitment of more intensive programs.

Solution: Hitting the Mark was a series of events including speakers, workshops and panels that shared valuable information and practical tools that providers and agencies could use to prepare for the future in a changing fiscal reality. The kickoff sessions included four short, practical workshops on meeting customer needs, creating a customer-driven culture, understanding your current organizational and financial stability and options for long-term organizational structures.

At the second event, experts shared strategies that organizations can use to successfully contract with Managed Care Organizations. It also included panels on the perspective of consumers and health plans, as well as discussions focused on three main influences on an organization's future: clients/consumers/patients/customers, "buyers" of services and their own organizational attitudes and strategies for managing change.

Impact: The first workshop, "Achieving Success through High Quality Services and Financial Sustainability," was held in November 2013 in Buffalo and Syracuse, New York; combined attendance for both workshops was over 200 people. The second event, "Succeeding in a Managed Care Environment," was held in February of 2014 in Buffalo and April of 2014 in Syracuse. The workshop was held twice in each location, once for primary care providers and once for a behavioral health audience. Response to all the workshops was extremely positive; participants reported finding them very helpful and appreciated the practical tools offered.

The first workshop,

Achieving Success through **High Quality Services** and **Financial Sustainability**

WAS ATTENDED BY OVER 200 **people** in Buffalo and Syracuse

The second event,

Succeeding in a **Managed Care Environment** *consisted of*

4 sessions

two for **primary care providers**

two for a **behavioral health audience**

BUFFALO + SYRACUSE

Build the Capacity of Health, Human Services and Safety Net

StoryGrowing

Challenge: *Ready or Not* and GetSET have both been highly successful and popular programs that provided expert technical assistance and concrete tools to help strengthen organizations, build their capacity and plan for the future. However, these efforts were foundational in nature—focusing on building the core strength of the organization from the ground up. This narrow focus was instrumental to the success of the programs but omitted any emphasis on communications. For the organizations in our region that are now in a stronger place institutionally, there is a need for a program to help increase their communications potential. Organizations that lack the capacity for communicating effectively with their community may struggle with articulating their value, making them less effective at reaching their target service population, less successful at fundraising, and ultimately, be in danger of closing their doors.

Solution: Building upon the successful frameworks of *Ready or Not* and GetSET, StoryGrowing was developed specifically to meet a shared need of many community-based organizations: how do we effectively communicate our value and tell our story? StoryGrowing uses a structure similar to that of GetSET, with group education sessions that provide practical communications tools, along with individualized expert coaching. The group sessions cover a wide range of topics, including how to collect stories of clients, donors, and programs, and how to structure, edit and share those stories with different audiences. Sessions also include how to effectively utilize social media, video and photography, as well as budget-friendly strategies for using these tools. There is a strong emphasis on organizational branding, and using stories to convey an organization's value and mission. Between sessions, participating organizations have access to expert technical assistance in the form of "Sherpas," who provide guidance and support throughout the program.

Impact: There have been four cohorts of StoryGrowing so far, two in each region. The first Central New York cohort had 11 organizations, the second had seven participating organizations. The first Western New York cohort had eight organizations, and the current ongoing cohort has nine organizations participating. The evaluations for the three completed cohorts have supported the value of StoryGrowing for participating organizations. A survey of the first Central New York cohort found that all organizations reported increases in all 19 skills included in the program, with the biggest increases in incorporating stories into their ongoing communications strategies, and establishing a brand. Additionally, 77% of respondents said the combination of the group sessions and coaching resulted in an established process to collect stories from their staff and clients. All participants rated the program as "good" or "very good" and 87% were very satisfied with the coaching they received (the remainder were "satisfied").

Evaluations for the second Central New York cohort and the first Western New York cohort were qualitative in nature, and consisted of narrative reflections of the program. The second Central New York cohort seemed to struggle more, with some organizations not taking advantage of the coaching that was offered to them. Some also expressed frustration with the time commitment, feeling not all workshops were as valuable as they could have been, and wishing there had been more time dedicated for processing as teams. Despite these challenges, all participating organizations reported some positive changes around how to use stories and create a storytelling culture in their organization, as well as how to better utilize branding and social media.

The first Western New York cohort reported high levels of satisfaction with the program, and noted significant positive impacts on their organizations. Many participants said the program changed the way they frame their organization and reported already integrating storytelling methods and techniques into many of their communications mediums including websites, social media, fundraising events, presentations and even conversations with stakeholders. In particular, the workshop on branding was highly praised by participants as the utility and relevance of the one page branding document the teams created was viewed as immediately useful. Many participants noted the workshops more interactive and less lecture in nature were the most effective, and provided an opportunity to get to know other attendees. The video workshop was universally criticized by participants, who viewed it as too sales-focused and felt that the presenters did not understand the budget concerns of most nonprofits. This feedback from participants has informed the redesign of StoryGrowing for Western New York Cohort 2, which is currently ongoing.

"Andy's expertise pushed us to a new level of storytelling. Overall, it was very effective for us. I do things differently now—I tell stories in a different way instead of just listing facts."

"During a staff meeting, we tried [a StoryGrowing] activity, with great success. It was a wonderful opportunity to have every staff member share a story about their own experience with the organization. These stories were very powerful, and each person shared something that reflected their own values, why they worked with our organization, a great experience with helping families, failed experiences helping families, the strength of our teams, and personal experiences while with our organizations."

Build the Capacity of Health, Human Services and Safety Net || **Networks**

In 2007, the Foundation made a commitment to strengthening the "safety net" of healthcare providers for vulnerable populations in our region. This commitment was driven by the recognition that safety-net providers are often the only source of care for children in poverty and older adults--other than emergency rooms. Unnecessary emergency room visits account for a significant waste of financial resources, and can slow down care for critical patients. Additionally, most providers were at capacity and unable to accept new patients, and communication and collaboration among safety-net providers was minimal to non-existent. Compounding these problems was a lack of adequate reimbursement for safety-net providers, with the exception of Federally Qualified Health Centers (FQHCs) which are reimbursed at significantly higher rates by Medicaid and Medicare. However, at the time, Western New York had significantly fewer FQHCs than communities of similar size and demographics.

In 2010, the Foundation took action to strengthen the safety net by providing support to increase the capacity of existing FQHCs and assist other safety-net providers in becoming certified as FQHCs. The goal was ambitious—double the number of patients seen by FQHCs in our region between 2010 to 2015. This investment by the Foundation also demonstrated foresight and an awareness of impending changes to the healthcare landscape, with a shift away from fee-for-service, while moving towards reimbursements related to positive health outcomes.

These early investments positioned FQHCs and providers in our region to respond effectively when changes to Medicaid reimbursement began in 2014, and led to increased communication and collaboration between safety-net providers.

Safety Net Association of Primary Care Affiliated Providers of WNY (SNAPCAP) and SNAPCAP IPA

Challenge: As previously noted, the Foundation has long seen the value in strengthening the safety-net of providers that care for the most vulnerable members of our community. At the outset of this work, the initial challenge was a lack of communication between the various safety-net providers, which severely limited the sharing of resources and best practices.

Over time, the most pressing challenge has become the changes to the healthcare reimbursement system because of Delivery System Reform Incentive Payment (DSRIP) and the Medicaid redesign, announced in 2014.

Solution: When the Foundation first became interested in facilitating the development of closer relationships between safety-net providers in the Western New York region, our role was as a convener—bringing together key stakeholders from FQHCs and other safety-net providers together to explore areas of mutual interest. These initial efforts were fruitful, and led to these providers creating their own organization, SNAPCAP: Safety Net Association of Primary Care Affiliated Providers of WNY.

After a few years, SNAPCAP took over responsibility for its own meetings and the future of the organization, and have been increasingly active and engaged in shaping the safety-net in Western New York. With relatively small grants from the Foundation, they supported new FQHCs and Access Points in underserved parts of the region, became a voice for the underserved and began a data collection process to both benchmark and pursue best practices. Also, in 2014, when the State Department of Health announced the DSRIP project, SNAPCAP leadership emerged as both an important voice for the Medicaid enrollee and a strong force in shaping the Performing Provider Systems in Western New York. SNAPCAP has continued to leverage the collective resources of its members, including ongoing learning collaboratives to facilitate the spread of best practices.

Also, SNAPCAP partnered with the University at Buffalo and HEALTHeLINK to strategically design a value-based reimbursement structure with the goal of achieving continuous quality improvement, reducing administrative burden for providers, and ultimately, maximizing reimbursement and improving patient outcomes.

Impact: In 2017, SNAPCAP engaged in strategic planning to explore the best mechanism for continuing to work together clinically, financially and structurally to improve patient outcomes and succeed under value-based payment models. SNAPCAP membership concluded moving to an Independent Practice Association (IPA) would provide the ideal corporate structure within which to develop joint capacity for managing populations and performance and secure value-based payment contracts.

In 2018, the Foundation provided funding to support the formation of the corporate governance structure for the SNAPCAP IPA, including development of a three-year financial model with a sustainability plan. All 12 SNAPCAP members have signed on to be part of the SNAPCAP IPA, and the organization is now an LLC in New York.

Becoming an IPA will allow the members of SNAPCAP, who are Western New York's safety net primary care providers, to achieve greater financial sustainability and higher quality of care through clinical integration, shared monitoring and accountability for health outcomes, while also protecting each member's independent organizational integrity.

Looking forward to 2019, SNAPCAP will build their collective capacity to secure Value-Based Payment contracts. This process will include building the operational infrastructure of the IPA as an independent organization, including technical infrastructure and data sharing and working together to improve positive health outcomes for patients across all IPA members.

UCHC

has become

a leader statewide

serving as a model of how

COLLABORATION

can increase efficiency while

lowering cost.

Upstate Community Health Collaborative (UCHC) IPA

Challenge: In 2013, the FQHCs in Central New York recognized Delivery System Reform Incentive Payment (DSRIP) and the upcoming Medicaid redesign in New York state offered both significant challenges and opportunities to safety-net providers in the region. By working collaboratively, they could leverage their collective resources to improve patient outcomes and operational efficiencies, as well as negotiate for better reimbursement contracts.

Solutions: In 2014, the Foundation provided funding for Federally Qualified Health Centers (FQHC) in Central New York to explore options for collaboration that would maximize the opportunities provided by DSRIP. After considering a number of options, it was determined an Independent Practice Association (IPA) model would best meet the needs of the four Central New York FQHCs: East Hill Family Medical, Family Health Center of CNY, Northern Oswego County Health Services and Syracuse Community Health Center.

The Foundation provided additional funding in 2015 to support the development of a complete business plan, and to offset initial costs of implementation while revenue streams were negotiated and secured.

Impact: As one of the early IPAs to incorporate, UCHC has become a leader statewide, serving as a model of how collaboration can increase efficiency in service while lowering cost. Through the IPA, members are working collaboratively and positioning themselves to take advantage of the market reforms based on the value they bring to payers.

To support the continued success of UCHC, in 2018 the Foundation provided ongoing bridge funding for operational support. This funding has helped UCHC to continue to grow its influence in Central New York, leading to the addition of a new member in August 2018. Additionally, UCHC has participated in meetings with the two other IPAs (SNAPCAP IPA and the Finger Lakes IPA) to explore possible future collaborations, as well as share valuable lessons learned from the process of launching an IPA.

UCHC has also recently taken critical steps towards sustainability, having successfully negotiated and executed two Value-Based Payment contracts, one with Fidelis that began in January of 2018, and one with United HealthCare that began in January of 2019. These contracts will provide a source of revenue that will allow UCHC to become self-sustaining, and continue to serve as a role model for other IPAs throughout the state.

WNYICC HAS SECURED

American Association of Diabetes Educators accreditation

AND

a 5-year contract with NYSDOH to deliver caregiver services

GENERATING $7.5 MILLION IN FUNDING

Western New York Integrated Care Collaborative (WNYICC)

Challenge: Turning the curve on rising health care costs requires addressing the social determinants of health, which has largely been the responsibility of CBOs and public sector agencies that rely on federal and state grant funding. Efforts to build sustainable alternative revenue streams for these organizations have been underway and some progress has been made, including the introduction of Medicare reimbursement for certain evidence based interventions such as Data Safety Monitoring Plan. However, CBOs have been slow to draw down these reimbursements because they simply do not have the infrastructure in place to do Medicare billing or to do the work necessary to contract with insurers and other consumers of services. Many report that they are not sure the effort is worth it because anticipated revenue is not high enough to warrant investment.

Solutions: The Western New York Integrated Care Collaborative (WNYICC) is a community-based integrated care network that brings together Area Agencies on Aging and CBOs to provide a vehicle for participating in new revenue-generating opportunities while reducing costs to individual organizations. Similar to physicians' Independent Practice Associations, these networks allow participating organizations to remain independent while serving as a contracting and billing vehicle for a group of partners. The Foundation has supported this Collaborative since 2013, and it grew out of several members' participation in the Foundation's *Ready or Not* program.

Due to the growing momentum of WNYICC health reform efforts, interest in partnering with the new Collaborative has been brisk, with several payers seeking partnership opportunities. Insurers, hospital systems, physician groups, and others that wish to tap into community-based services also benefit from community-based integrated care networks. They allow buyers to work with a single point of contact for business development and contracting, while meeting requirements to have a sufficient provider network that can provide geographic reach. Integrated care networks help by providing a mechanism to draw down alternative sources of revenue, such as Medicare dollars, which are long term funding solutions.

Impact: In 2016, the Collaborative officially incorporated as a taxable not-for-profit organization, and received 501c3 status in 2018.

While model exploration and development was underway, members of the Collaborative were simultaneously undertaking service line development. This work led to two accomplishments:

1) securing American Association of Diabetes Educators accreditation for the delivery of the Diabetes Self-Management Program, which is required for Medicare reimbursement; and

2) securing a 5-year contract with the New York State Department of Health (NYSDOH) to deliver caregiver support services under the state's Alzheimer's Disease Caregiver Support Initiative with Catholic Charities of Buffalo serving as organizational lead on behalf of the network. This contract generates $7.5 million in funding across five years (2016 through 2020).

Just as important as the contracts they've been awarded is the leadership provided; WNYICC serves as a model for other CBOs looking for a way to collectively leverage their expertise and resources to better address the social determinants of health and improve the health of their communities.

"CHW training gave us tools to grow personally and as a team to empower those we support to maximize their goals."

Community Health Worker Network of Buffalo

Challenge: In the United States, community health workers (CHWs) have been used primarily in the past 60 years in low-income and minority communities to address health disparities and social justice issues.

CHWs are frontline public health professionals who are trusted members of, or have an unusually close understanding of, the communities they serve through shared ethnicity, culture, language and life experiences. This trusting relationship enables them to bridge social/cultural barriers between communities and health or social service systems. CHWs help build individual and community capacity through a range of activities such as outreach, health education, home visiting, community organizing, informal counseling, social support, translation/interpretation and advocacy. There is extensive research to support CHW's ability to improve quality and access to health systems, as well as reduce cost and address health equity issues.

Despite evidence to support the utilization of CHWs, the workforce remains fractured and poorly organized. Much of the work that these CHWs do is about "connecting"—helping families to work together, introducing them to their neighbors or resources within their community, assisting them in navigating health and social services systems, etc. Complementary to this, institutions are realizing they need to garner community buy-in, as this leads to greater access and use of the institution in a more meaningful way from a quality and cost standpoint. However, larger systems often do not have the relationships to or trust with the individuals they serve in order to effectively engage the community. Because CHWs are often not defining themselves as such and often work in isolation (versus being connected to others in similar roles in other organizations, sectors, or neighborhoods), their impact is not as great as it could be if there was a hub through which to organize and advocate through.

Solution: In 2011, the Foundation began funding the Community Health Worker Network of Buffalo, an organization whose goal was to build community health capacity through training and mobilizing CHWs using a social determinants of health and asset-based community development framework.

The network has used a broad spectrum of strategies to equip and mobilize CHWs throughout the Western New York region. Some of these have been focused on training the CHWs; the network developed a Buffalo-based CHW training program with support on curriculum development and training of trainers from the CHW Network of NYC and the CHW National Education Collaborative, which is a national consortium of CHW practitioners and academics.

Other strategies have focused on outreach to raise the profile of CHWs and their role in community health, such as a "stakeholder seminar" for organizational and institutional leaders, which included 15 academics and medical doctors working in health and health care. They have also engaged in community-based participatory research to assess and evaluate programming with academic partners at the State University of New York at Buffalo (from Family Medicine, the Civic Engagement and Public Policy Research initiative), as well as the Buffalo-based policy think-tank Partnership for the Public Good and the Asset-Based Community Development Institute at Northwestern University. This research informed a white paper and an evaluation tool that was designed to serve as template for future project design around both qualitative and quantitative indicators of success using CHWs.

Additionally, the Network has engaged in policy and advocacy efforts such as a training, credentialing and reimbursement initiative for CHWs, and advocating for inclusion of CHWs in New York State Medicaid Redesign.

Impact: Over the past four years, the Network has worked diligently to establish themselves as the premier training and technical assistance provider for CHWs, with a particular emphasis on issues of inclusion and diversity. The only entity of its kind in western or central New York, the Network has trained and mobilized more 500 CHWs and engaged more than 2,000 people through workshops, community forums and conferences, meetings, and speaking invitations. These activities promote more compassionate and just health, education, and human services systems for people most impacted by health equity issues, especially those in poverty. The Network has engaged in outreach, advocacy and research activities, as noted above. These activities have significantly raised the profile of CHWs in the region, resulted in a white paper, and an evaluation tool, as well as building valuable relationships with stakeholders in the community. In addition, the Network has also provided more than 100 presentations to groups such as the Minority Health Coalition, Buffalo Prenatal and Perinatal Network and the State University of New York at Buffalo School of Public Health and Health Professions, furthering their goals of highlighting the valuable and critical work of CHWs. The group has also received nationwide recognition for their accomplishments, and was named the winner of the 2017 American Public Health Association's "CHW Group of the Year."

Build the Capacity of Health, Human Services and Safety Net

Advocacy

Challenge: To affect real systems-level change in our community and better the health of the whole population, it is not enough to simply fund programs and services. Systems-level change often necessitates changes in policy at the local, state and federal level. The Foundation's Board of Trustees has recognized in order to best serve our community, especially young children impacted by poverty and older adults, we need to be an advocate for these vulnerable populations and give them a voice. The Foundation's Board has charged the staff with advocating for policies that support the health and well-being of our target populations. As part of this, the Board set a goal of achieving high quality, affordable healthcare for all New Yorkers by 2027, demonstrating the commitment of the Foundation to our belief that healthcare is a human right.

Solutions: The Foundation has a multi-pronged advocacy strategy that leverages communications through social media, blog posts and other communications efforts; relationship building with elected officials; and networking with advocates who share our priorities. Foundation staff, in partnership with our Board of Trustees, developed a plan for achieving our goal of ensuring healthcare for all New Yorkers; the plan includes defending and strengthening what works, improving access to existing programs and supporting efforts to close the coverage gap. Foundation staff has also developed a list of other advocacy priorities in each of our vision areas.

In addition to the advocacy work being conducted by Foundation staff, we have also provided funding to advocacy groups to support large-scale campaigns around targeted issues relevant to our target populations. Specifically, the Foundation provided support to the Children's Agenda to advocate for increased access to early intervention services for young children, such as physical and occupational therapy and speech services. Funding was also given to the Schuyler Center for Analysis and Advocacy to support a project to advocate for the implementation of universal screening, referral and treatment for pregnant women and new mothers to address the potentially devastating impact of maternal depression.

PRODUCED
eight advocacy blogs + 104 social media posts

MET WITH
four elected officials and eight other advocates

HELD *20 additional phone calls and meetings with advocates and stakeholders*

&

FUNDED *two reports detailing underutilization of existing programs*

Impact: Throughout 2018 and the early part of 2019, Foundation staff have done significant work towards building our capacity for advocacy, while engaging in relationship building with elected officials, stakeholders and other advocates, as well as honing our advocacy priorities and messaging. Our communications team produced eight advocacy related blogs and 104 social media posts, which have helped raise our profile as an advocate for the public health and access to healthcare. Foundation President Nora OBrien-Suric, working with our advocacy consultant, met with four elected officials and eight other advocates, and our advocacy consultant had more than 20 additional phone calls and meetings with advocates and stakeholders.

Additionally, the Foundation funded two reports examining individual level factors that lead to under-utilization of existing public health insurance programs, as well as the best practices for increasing enrollment in existing programs. These reports generated valuable data and stories that are informing our ongoing discussion of the best strategies for ensuring all New Yorkers have quality, affordable healthcare.

Finally, the National Imperative report that was co-funded by the Foundation led to a productive meeting in Central New York around the recommendations in the report, and the importance of advocacy for supporting the work done by community-based organizations. A similar meeting is planned for Western New York for 2019.

Develop Strong Organizational and Community Leaders

Health Leadership Fellows Program

Challenge: Former president of the Foundation Ann Monroe observed that although there were leadership training programs for emerging talent, there was not a program for established leaders that would foster collaborative opportunities. Within the healthcare and nonprofit sectors, "silos" have always been a problem. Silos are people and organizations working in parallel, trying to tackle the same large-scale issues facing their communities, without awareness of other similar efforts to address the same problems. These silos fail to leverage shared resources, limit the spread of effective programs and often lead to the duplication of efforts.

Solution: The Health Leadership Fellows Program is an 18-month program designed to unify organizations working in parallel sectors, and to bring together established leaders from local nonprofits and healthcare organizations with the goal of fostering future collaborations. The program begins with in-depth personality assessments that help each Fellow to understand his or her own strengths and weaknesses as a leader. The structured components of the program are the four residential sessions, "The Individual Leader," "Results-Based Leadership," "Leading Change," and "Communicating as a Leader." In between these sessions, Fellows work in teams to develop and implement team projects that impact the health and well-being of either young children impacted by poverty, or older adults living in the community. These projects are supported with small grants, and teams are assisted by faculty coaches and research assistants.

The program culminates in a graduation ceremony, during which each team presents the results of their project to the entire cohort of Fellows, their bosses, members of the Foundation's Board of Trustees and alumni of the program. Following their presentations, teams receive feedback from a panel of expert coaches.

Impact: To date, there have been 318 leaders accepted into the Fellows program, representing 208 organizations supporting their participation, with 56 organizations having multiple Fellows. Fellows occupy leadership positions in the non-profit sector, government, health systems, philanthropy and academia. However, the true impact of the Health Leadership Fellows Program on the community ranges far beyond the number of Fellows and organizations. It is a story of lives changed, partnerships forged, and projects—large and small—that have meaningfully changed the communities served by the Fellows. With eight completed cohorts of fellows and around six teams per cohort, there have been more than 45 projects that have significantly enhanced the well-being of young children and older adults in the community. In the most recent cohort, the projects tackled a variety of issues including rising suicide rates among older men in rural counties and engaging Arabic-speaking families to foster healthy behaviors in young children. These projects used innovative approaches to address emerging health challenges they identified in the community—a hallmark of Fellows projects.

From the very beginning, the Fellows have used their projects to leverage existing resources and expertise to meet the needs they see in their communities. One of the earliest, and most long-standing examples of this is the Trauma-Informed Community Initiative of WNY Coalition. The coalition grew out of a team project from Cohort 1; this earlier foray into addressing issues around childhood trauma lead a small group of Fellows to begin developing ideas for a volunteer network that would provide trauma-informed and trauma-specific services. With funding from the Foundation, the group has grown into a network of individuals from a wide range of organizations who are working to develop and implement a Greater Buffalo Trauma-Informed System of Care Community. The coalition continues to help lead and assist individuals, organizations and communities by mobilizing resources in education, prevention and response to deal with the multi-dimensional aspects of trauma.

"We needed a real-world, in-depth program that would help the decision makers—the CEOs, agency directors and other health leaders—effect more immediate change"

"I came into the program… as a younger fellow and without much knowledge of the medical field. Through the core competencies and gaining more confidence with senior leaders, I became more comfortable with that landscape. Not only did I strengthen my leadership skills, but I also learned from my new peers about the myriad issues, lingo, processes and resources associated with social and health services."

➔ *FANning the Flames: From the Fellows to the FAN*

When the Health Leadership Fellows Program was developed, it was envisioned as an incubator for collaborations, rather than a "one and done" leadership training program. The hope was that projects and ideas seeded during the course of the program would take root and grow because of the relationships built through participation in the Fellows program, and subsequently in the Fellows Action Network.

One of the projects from the fourth cohort of Fellows was originally called T-Bear: Transforming Belief/Behaviors to Elevate Achievement Realization. This project focused on the long-term care needs of older adults, specifically those who want to be able to remain at home and "age in place." Most older adults need some level of caregiving and support services to be able to continue to live in their homes, and as the average age of Americans increases, there is a projected to be a 200% increase in the demand for home healthcare services in the near future. This is problematic because the home healthcare system faces chronic challenges in recruiting and retaining employees, which may lead to a significant shortage of service availability for older adults.

Retention and turnover stem from the fact that the home care workforce often earns very low incomes, and consequently, much of this workforce is dealing with the variety of stressors common to those living in chronic poverty. This team of Fellows had the goal of reducing turnover and improving workforce retention by providing specialized training for individuals working in organizations that employ home health aides; the training focuses on providing home healthcare workers with life skills acquisition and support from an identified retention specialist.

Their pilot project was successful and well-received by home healthcare agencies. Now members of the Fellows Action Network, Team T-Bear was awarded additional Foundation funding to support continued expansion of the program, now called SuperSkills. Evidence supports that this training can reduce turnover rates substantially; one participating agency reports that turnover rates after participating in the training went from 40 to 27 percent, and have stayed close to that level.

Develop Strong Organizational and Community Leaders

FAN (Fellows Action Network)

Challenge: The goal of the Health Leadership Fellows Program was to foster collaborative partnerships between strong community leaders, and ultimately to improve the health of the community as a whole. However, the Fellows program lasts 18 months, and the Foundation recognized the need for an organized network to further nurture these partnerships, and provide opportunities for collaborations between Fellows from different cohorts. Many alumni of the Fellows program expressed a desire to stay connected, and to build upon what they had learned from their participation.

Solution: The Fellows Action Network (FAN) was created in 2007 to foster ongoing collaboration, with the recognition that change can only happen if leaders work together. The FAN was implemented to provide a "home" for Fellows, in which they could continue to network, participate in learning opportunities, skill development trainings and pursue community goals through advocacy, networking and mutual support.

Early on, the FAN existed as a group of former fellows supported by a steering committee that offered retreats and other face-to-face leadership and networking programs. The Central New York contingent of the FAN has been very active in creating a strong mentoring program that extends into Western New York. It has developed a strong series of leadership development workshops and seminars attended by members and mentees of their mentoring program. This effort has been led by FAN members that include graduates of Ladders to Leadership as well as the Fellows program. The Western New York FAN members have developed advocacy training and actual advocacy planks, taking their efforts to Albany on behalf of vulnerable populations.

Throughout 2017, the FAN worked to refresh its structure to meet the demands of a growing number of Fellows with different programming preferences from earlier cohorts. This work included reconfiguring the Steering Committee to include representation of at least two people from each of the graduated cohorts after Cohort III; revisiting principles and values in order to embrace new learning (person-centered care, cultural competency, Triple Aim); offering new programming including a residential retreat; and exploring communication technology for committee communication and webinars.

Impact: A social network analysis of the FAN confirmed what anecdotal evidence had previously suggested—the Health Leadership Fellows Program and the FAN have resulted in meaningful collaborations across the region, with many Fellows sharing information and resources. There have been several notable projects associated with the FAN. These include projects that began as Fellows projects and were expanded, such as the SuperSkills project to support retention of in-home care workers, and the Trauma-informed Community initiative. The Fellows do considerable work with one another outside of the confines of the formal FAN structure as well. This includes projects like the WNY Integrated Care Collaborative, which involves no fewer than nine Fellows.

However, some of the Fellows alumni have felt the FAN has not been engaged or utilized to the full extent of its potential. This has led to some restructuring of the FAN in 2018, with the Foundation providing support for outreach to engage inactive fellows and learn how the FAN might better support collaboration among Fellows.

Additionally, some Fellows expressed a desire for a Foundation-sponsored opportunity to collaborate, with the idea that this could foster partnerships and create projects with broad-reaching impact. To provide a more intentionally designed opportunity to work together, the Foundation developed the Health Leadership Fellows CALL to Action, which will kick-off in June of 2019. Through this project, the Foundation and the FAN will identify up to eight multi-organizational teams in western and central New York. Teams will be asked to develop system-realigning projects that hold the potential to produce better health outcomes and sustained system change. These projects will leverage the resources of multiple organizations, with the goal of improving the health of our community as a whole.

FAN PRECIPITATED NOTABLE PROJECTS SUCH AS:

SuperSkills | Trauma-Informed Community initiative | WNY Integrated Care COLLABORATIVE

and the new HEALTH LEADERSHIP FELLOWS **CALL TO ACTION** *program kicks off June 2019*

In Summary

The Health Foundation for Western and Central New York believes that making an impact on our community requires going "beyond the grant," and we believe that real, sustainable change requires collaboration and partnerships.

We believe that communities are in the best position to tell us what they need, and our role is to be supportive, rather than prescriptive.

We believe that in order for communities to be fully healthy, everyone needs to have access to high quality, affordable, equitable healthcare, and that healthcare is a human right.

We believe all children, especially those impacted by poverty, should enter kindergarten physically, mentally, and emotionally prepared for success.

We believe older adults are vital, valuable members of our community, and that everyone has a right to live the length of their life with dignity. We believe that aging does not have to mean a lower quality of life.

We believe in being responsive to the needs of the community and open to opportunities that are presented, while maintaining our focus on our vision areas.

We believe in innovation—in taking risks, and trying new solutions to big problems. We also believe that learning is an ongoing process. There are no "perfect" solutions, and sometimes, good ideas take iteration and trouble-shooting to become great ideas.

These beliefs are central to the work we do, and reflect our commitment to improving health and ensuring well-being for all members of our community.

Reflecting on the past—Looking to the horizon

Reflecting on the past is an important part of planning for the future. As we take stock of where we have been over the last five years—the investments that we've made and the impact we've had—it becomes clear that our impact cannot be entirely quantified in numbers, and the impact of our work extends beyond the end of the grant period. In reviewing our past investments, we are encouraged to see programs like PEDALS and Step Up to Stop Falls continue following the end of the grant cycle; it is our commitment to the community to work with grantees to develop plans for sustainability and to continue to foster progress. However, we don't value sustainability to the exclusion of flexibility and innovation, so when something isn't working, we support our grantees in their efforts to make improvements.

The Foundation has a process of how we examine new ideas and conceptual models to guide our work: explore, commit, and deepen. As we reflect on our past work and plan for the future, this framework continues to guide us. These are some of the ways our past explorations have become our current commitments, and where we're ready to take a deeper dive. We believe long-term investments in our fields of interest help to plant seeds of sustained growth, and this is when we begin to see major shifts in the health of our community.

Capacity Building

Changes to the healthcare system, because of the Affordable Care Act (ACA), have driven much of the work in our capacity building vision area in recent years. A key conceptual underpinning of the ACA was the Triple Aim, which emphasized improving the healthcare system through better patient care and better population health management, which ultimately results in lower per capita health care costs.

The pursuit of the Triple Aim has led to important system changes. How we pay for clinical care is moving from fee for service to value-based payments driven by patient outcomes. Increasingly, there is recognition that better patient care and better population health is not possible without addressing social determinants of health.

The Foundation has been on the cutting edge in our response to these changes, first by exploring how and why providers were not communicating. Then, we committed to opening those lines of communication by serving as a convener to bring together groups of providers who share a common purpose. Finally, we deepened that commitment and invested in building the capacity of both clinical and social care providers to work in a Triple Aim driven environment.

We have supported the development of new business models that bring FQHCs together to achieve better collective impact through IPAs, such as SNAPCAP IPA and UCHC IPA, and integrated community care networks, such as Western New York Integrated Care Collaborative, which provide a vehicle for community-based organizations to do the same.

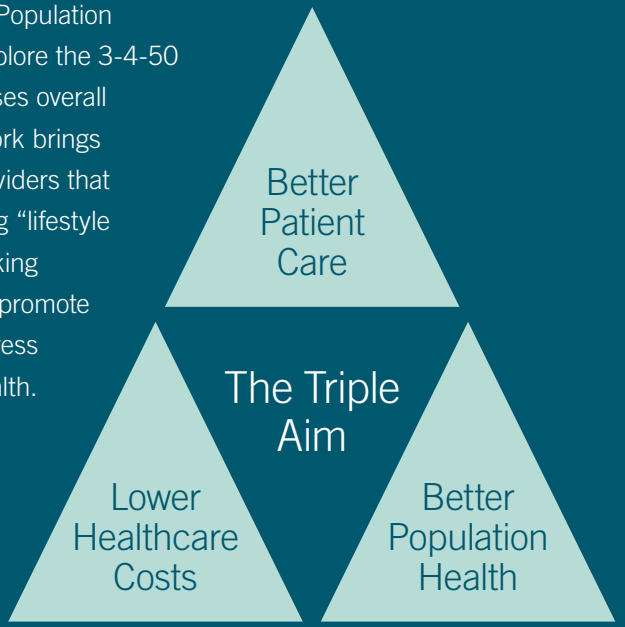
This work—helping similar types of care providers work in closer collaboration—has laid the groundwork for the critical next step: building bridges between clinical and social care. Creating these bridges between clinical and social care providers will be essential for addressing the social determinants of health and improving positive health outcomes for our whole community.

As we work with our community partners to take this next step, we are exploring innovative strategies to build and strengthen connections between different types of care providers to address the social determinants of health. Some examples include:

- A pilot project between Erie County Department of Social Services and Jericho Road to utilize Community Health Workers to improve service, as well as community relationships between Child Protective Services and the City of Buffalo's growing immigrant and refugee population.

- A soon to be released study by Capital Impact Partners that looks at the growing number of older adults served by FQHCs. This study will be used as a springboard for exploring ways FQHCs can partner with organizations like WNYICC and community-based organizations to achieve better patient outcomes by addressing social determinants of health.

- A planning grant to the Population Health Collaborative to explore the 3-4-50 framework, which addresses overall population health. This work brings together primary care providers that are increasingly embracing "lifestyle medicine" with those working at the community level to promote healthy lifestyles and address social determinants of health.



Older Adults

Our work in the older adult area has been heavily guided by the Triggers of Decline model and exploring how the Foundation can better promote healthy aging. Our most significant investment between 2014–19 was Aging by Design. Through this program, community-based organizations and older adults are working together to identify better ways to help people stay healthy and independent as they age. During the Aging by Design learning phase, older adults told us what they worry about and what they need help with.

This exploration provided rich insights, and these are some of our current commitments informed by those insights:

› Older adults continue to be concerned with falls. A soon to be released study by the State University of New York at Buffalo looks at fall risk assessment practices of primary care providers. This exploratory work will inform future fall prevention programming. In particular, how can we strengthen the relationships between the primary care providers, who assess the risk for falls, and the community-based providers that deliver interventions to address the risk of falling.

› The leading concern of older adults is loneliness and social isolation. Another current study being conducted by the State University of New York at Buffalo is examining how primary care providers address depression in older adults. Concurrently, we are also monitoring and supporting efforts of community based organizations to expand evidence-based interventions that address depression, such as Healthy IDEAS.

Children Impacted by Poverty

Our work in the children's vision area has been guided by our belief that creating well-being for children is an active and ongoing process, and a process that can be especially challenging for families impacted by poverty. Wellbeing is more than simply the absence of "negatives," such as abuse or toxic stress, so we continue to work with our community partners to develop programs that nurture and support children and their families.

We also recognize that a child's wellbeing begins before birth, and we continue to invest in maternal health with the goal of improving positive birth outcomes. Some of our prior explorations have supported the value of midwives and doulas for improving mothers' experiences before, during, and after childbirth, and we recently committed to a new project to train doulas in Cayuga County.

We are continuing to explore how to best support communities in ensuring all children are emotionally, physically, and mentally prepared for kindergarten. These explorations, and our subsequent commitments, are guided by our understanding that wellbeing is broad, and that ensuring children requires starting early, and remaining engaged. These are a few highlights:

› We're exploring ways to turn the curve on maternal mortality rates; the United States has higher maternal mortality than any other developed country. In New York, 20.9 women die in childbirth of every 100,000, and among African-American women, the rate is even higher: 54.6 for every 100,000.

› Some of our prior work has explored the effects of maternal depression on children, and we recently committed to supporting the Schuyler Center for Analysis and Advocacy in their advocacy work to promote universal screening for maternal depression. Maternal depression is a stronger predictor of school readiness than even poverty, and early identification and treatment are essential for positive outcomes for both mother and child.

› Building on the Foundation's tradition of exploration, last year we launched the Innovations in Children's Health and Wellbeing project. The goal of this project is to identify and support innovative and exploratory programs that have the potential to deliver new and better ways to address existing or emerging needs, and will lead to better health outcomes for children impacted by poverty.


Health Foundation
for Western & Central New York