OUR MISSION
We improve population health in Western New York by connecting diverse groups and aligning resources and expertise.

OUR VISION
Together we create connections for the healthiest Western New York

WE VALUE
Creativity  Dependability
Engagement  Integrity
Playfulness

Creating Connections for WNY Health

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BUILDING COMMUNITY CAPACITY

We add value to the community by building capacity to improve community health, helping improve the quality of healthcare and spearheading reforms that drive down the cost of healthcare.

Collaborating/Coalition Building and Leadership

We bring together various stakeholders for the purpose of working together in a more coordinated and effective manner than would have been the case without us.

Convening/Events

We bring together stakeholders from various sectors who adopt a common goal, shared metrics, and a willingness to share best practices.

Brokering

We bring resources to an audience or community that may not have otherwise had access to those resources.

Look for the above symbols throughout this report
Studies find that residents with greater access to supermarkets or a greater abundance of healthy foods in neighborhood food stores consume more fresh produce and other healthful items.

The focus of healthy retail work is to transform corner stores and small markets to healthy-options establishments. Our teams work with the store owners to improve access, availability, pricing and promotion of healthy options. In the last year, the healthy retail work has expanded into two additional counties, and plans for 2018 look to carry the work into two more. We anticipate working with 6 more stores this year. We are building relationships with corner stores across Western New York, using a team of key community partners to increase availability, improve pricing, placement and promotion of healthier foods and drinks.

We are uniquely positioned to connect stakeholders to resources and programs across multiple fields to improve the health and well-being of Western New Yorkers.

This is a great example of how we can collaboratively address needs articulated by local residents with low-cost, high-impact solutions.

Justin Booth
Executive Director
GObike Buffalo

**Workplace Wellness**

The majority of people’s time is spent at work. By creating an environment that promotes healthier eating and increased movement and physical activity throughout the day, chronic diseases caused by poor nutrition and a sedentary lifestyle can be reduced. In turn, healthcare costs will decrease and productivity will increase.

**Complete Streets**

Supporting urban design and land-use policies through “complete streets” work allows us to assist in community engagement for developing and implementing plans that support walking at a community level.

GObike Buffalo remains a strong partner, and through IMPACT support we have 6 projects in various stages. Project highlights include the development of complete streets recommendations for the City of Buffalo, which have become institutionalized through the adoption of the Buffalo Green Code and Bicycle Master plan. In Niagara Falls, collaboration with the City has led to the provision of many extensive improvements throughout the city, including the painting of crosswalks and bike lines.

**Healthy Retail**

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**DYK?**

More than half of WNY children are living in households that experience food insecurity.

Food Environment Index.
The National Diabetes Prevention Program (NDPP) is an evidence-based program that focuses on lifestyle change to prevent type 2 diabetes. Lifestyle change programs are identified in target areas, and participants from priority populations can be enrolled into workshops.

The NDPP class schedules are now online at Revesreyourrisk.org! In 2017 we posted class times, locations and registration information for all public National DPP programs around WNY. The site now helps participants find and register for the next open class in their area.

Motivational Interviewing

We partnered with Dr. MacLean to provide MI to 5 selected organizations in 2017. These organizations included Northpoint Council Inc, Independent Health, Buffalo Prenatal-Perinatal Network, Say Yes Buffalo and Alzheimer’s Association of Western New York. The training began in August 2017 and ended in November 2017 with 102 individuals participating in the training. The overall goal of the MI training is to give providers, clinicians and other healthcare professions additional tools to help patients adopt healthy behavioral. Additional goals involved collecting data related to process measures. Since the completion of the training, we are currently collecting data for 3 and 6 months post MI training.

National Diabetes Prevention Program

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DYK?

1 in 3 adults have prediabetes.

We have worked closely with the Population Health Collaborative to reduce diabetes and improve the health of Niagara County residents. Since our collaboration, we have helped 57 individuals to better understand how to prevent the disease and thereby reduce their risk of heart disease and stroke.

Cathy Donovan
Niagara County Department of Health
**Practice Facilitation**

This 13-week long program helps a health system build capacity for continuous quality improvement through the assessment of practice systems and processes, and the redesign of workflow to support meaningful change.

The Practice Facilitation scholarships have allowed practices to expand their skill sets and bandwidth for quality improvement processes. Student projects center on transformation efforts, and have resulted in processes that have streamlined the diagnosis and management of patients with chronic conditions. One practice focused on the proper diagnosis and coding for pre-diabetic patients. To make this a seamless process, the practice built the American Diabetes Association (ADA) prediabetes screening tool directly into their EHR. It was built into the workflow of the nursing staff to screen patients with the ADA tool when they are in the exam room, and do a separate outreach to patients who have been identified as “at risk.” Nursing staff would then offer lifestyle interventions to the patients including an appointment with a nutritionist and/or the National Diabetes Prevention Program class.

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**Mental Health First Aid**

This is an 8-hour course that gives people the skills to help someone who is developing a mental health problem or experiencing a mental health crisis. The evidence behind the program demonstrates that it builds mental health literacy, helping the public identify, understand, and respond to signs of mental illness.

We connected nearly 500 clergy members, healthcare professionals, and community members to the MHFA training. Organizations who hosted training sessions for their staff and community members include GBUAHN, Chautauqua County Health Network, Directions in Independent Living, Pilgrim-Saint Luke’s United Church of Christ, and Niagara County Department Of Health.

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**DYK?**

1 in 2 adults have a chronic health condition.

29 SCHOLARSHIPS
$112,000 IN SUPPORT
6 COUNTIES ParticIPATED

1 in 5 WNYers experience a mental illness each year.

500 PEOPLE TRAINED
$43,126 IN SUPPORT
4 ORGANIZATIONS PARTICIPATED

* CDC

* National Institute of Mental Health

MHFA training for Niagara Falls School District
Patient self-management of chronic hypertension has been shown to encourage lifestyle changes that mediate risks related to high blood pressure. Self-management of hypertension includes education around proper nutrition, physical activity and medication adherence.

Plans for the future include bringing BP cuffs into community pharmacies, engaging pharmacists in a management and education program, and also working with health systems to build sustainable cuff-loaner programs.

We have a complex patient, who is blind, has trouble walking and requires delivery services from our pharmacy. The patient stated that his doctor was very concerned about his uncontrolled blood pressure. It was obvious that our Blood Pressure Monitoring Program could help this patient get controlled but there were barriers. Once we supplied blood the pressure monitor he did not have the capability to read the monitor since he is blind. In order to enroll this patient, it was necessary that he could commit to reading his blood pressure on a regular basis.

Our pharmacist was able to speak with the nurse who managed his medications and ask for involvement in helping him read the monitor and log his blood pressure readings. The nurse was willing and able to help in this instance. We notified the doctor, who was very happy about this opportunity. This example provides insight to an uncommon problem and how we were able to creatively enroll this patient. This example also highlights the importance of the collaboration between healthcare professionals. Population health initiatives require collaboration and flexibility among practitioners to be successful.

Middleport Family Health Center
In The Community

When you take a step back and look across the community there is a tremendous amount of activity to improve the health of segments of populations of the community. We bring discipline and alignment of these existing efforts.

Project Rainfall is one answer to focusing on population health in Buffalo. Our hope is that while turning around this food desert, we can create a revenue stream that will improve access to health education and preventative health services. This will mean a great deal to the people who have been living in this community for the past 40 years, who are aging and who will benefit from convenient access to food and wellness activities.

Rita Hubbard-Robinson
NeuWater & Associates, LLC

Project Rainfall

Project Rainfall will be a food systems social enterprise in a low-income area. With 31% of the residents living below the poverty line, this area is historically underserved when it comes to access to fresh and healthy food options. This collaborative initiative will provide access to healthy food and employment opportunities by establishing a hydroponic and aquaponic food system with a year-round indoor farmer’s market, with opportunities for learning and incubation of food-related businesses that will create revenue streams to reinvest into community health and wellness services.

Igniting Hope

The African American Health Disparities Task Force is a grassroots initiative that has brought together community and academic individuals who want to address and improve the health disparities in the African American population in Buffalo.
Looking Forward

We are in the initial stages of adopting a chronic disease prevention campaign that would provide better coordination and collaboration of efforts to create improved health in Western New York.

Collectively, we will work towards building community capacity, sharing and replicating best practices, and adopting common metrics and visions to make the transformational changes our region needs to improve health outcomes for our community.

Financial Stability

We are grateful to each of our partners, sponsors, and supporters for entrusting us with their financial support. Our organization is committed to maintaining the highest standards of accountability for each dollar of funding received.

It has been and will continue to be our intent to maximize program spending to benefit Western New York. In order to improve the health of Western New Yorkers, we need help from our community to continue the great work of the Population Health Collaborative.

2017 Total Revenue

2017 Total Expenses

2017 Income, Expenses, & Restricted Funds will be available on the 990 report available for public disclosure

Thanks to Our Anchor Organizations!

Want to Get Involved?

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