

Fahe 2021 Annual Meeting


SWVA and NETN Regional Collaboration and the Social Determinants of Health

Panelists:

Andy Kegley – HOPE Inc., Executive Director, Moderator

*Rebecca Dillow – Clinch-Powell RC&D, Director of Strategy &
Development*

*Rachel Stiltner - Ballard Health, Senior Community Engagement
Specialist*



How did we get here?





Fahe is a network of Appalachian leaders working
to build the American Dream.

Since 1980, Fahe has invested \$1.05B, generating \$1.61B
in finance. Channeled through Fahe's Members and
community partners this investment has changed the
lives of 698,183 people.



HOPE's 30-year collaborative work across 6 SW Va localities:

- **60 SF homes developed/sold in 2 subdivisions and scattered site**
- **2 LIHTC projects—Southridge, Woodlawn School**
- **4, 4-BR group homes for IDD; 9 units PSH housing**
- **Bookkeeping services for 12 local non profits**
- **In FY 19, 20: 380 households served by Rent and Mortgage Relief Program**
- **2 food security programs:**
 - **HOPE Packs provided 38,500 total weekend supplements last school year to 900 students**
 - **Open Door Café, served 44,000 lunches since opening 11-1-18, 75% paid forward by others**
- **Over \$40 million total housing/food program investment**



Urgent Need Fund

Wythe Bland Foundation - March – July 2021

BREAKDOWN OF APPLICANT NEEDS

26 grantees

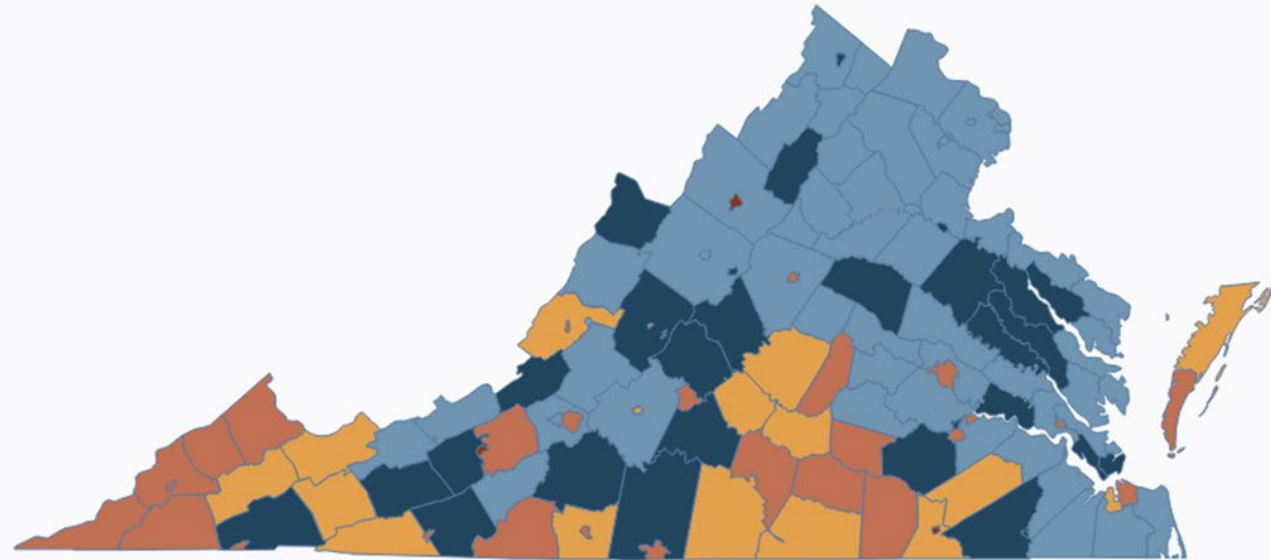
6	\$1620.54	Trouble affording rent or bills due to medical procedures, not eligible for other assistance
4	\$1962.50	Difficulty paying bills due to COVID-19 related sickness or job loss**
4	\$646.19	Water or sewage access
2	\$547.98	Domestic abuse situations requiring short-term motel housing
4	\$2497.55	Home repairs for water, sewage, or electrical**
4	\$1403.00	Temporary housing from domestic issues or unemployment
3	\$994	Between housing situations with no place to go/Homeless
1	\$53.59	Mental health issues made it difficult to work or afford bills
1	\$294	Recently released from prison with nowhere to go
1	\$227	Aquired permanent housing but can't afford the deposit
1	\$126	Help requested by church on behalf of individual (with promised reimbursment)

*Note that some of these values contain overlaps and therefore repeated values meaning summing these categories will not give you the total amount distributed during this time period.

**These totals cannot be averaged out because they contain one individual each representing \$1000 and \$1500, respectively, skewing the average payment higher than normal.

VIRGINIA

← BACK



POVERTY RATES

Population in Poverty (Percent)



0.0-11.9



12.0-16.9



17.0-19.9



20.0-29.9



30.0-53.5

Housing Affordability Problems, 2018



County
% Cost Burdened Homes

- ≤24.9
- ≤29.0
- ≤39.9
- ≤57.3

Clinch-Powell's 32-yr & current impact on housing in NE TN:

Development

- 29 Energy Star Certified new construction homes
- 11 acquisition/rehab/resale homes
- 38 single family rentals of which 34 reserved for low and very low-income families

Counseling/Coaching

- HUD approved counseling agency serving more than 2,000 families since 2002 with pre and post-purchase, rental, high cost mortgage and foreclosure prevention
- Rural LISC Certified Financial Opportunity Center providing in-depth, long term coaching in financial literacy, workforce development and access to income supports

Housing Financing

- \$5 million in construction financing as a CHDO since 2002
- \$5.4 million in housing financing since 2016
- \$865k in home repair loans

Emergency Housing Services

- \$1.4 million in mortgage, rent and utility assistance to 400 COVID 19 impacted families
- \$500k in rent and utility assistance to combat homelessness



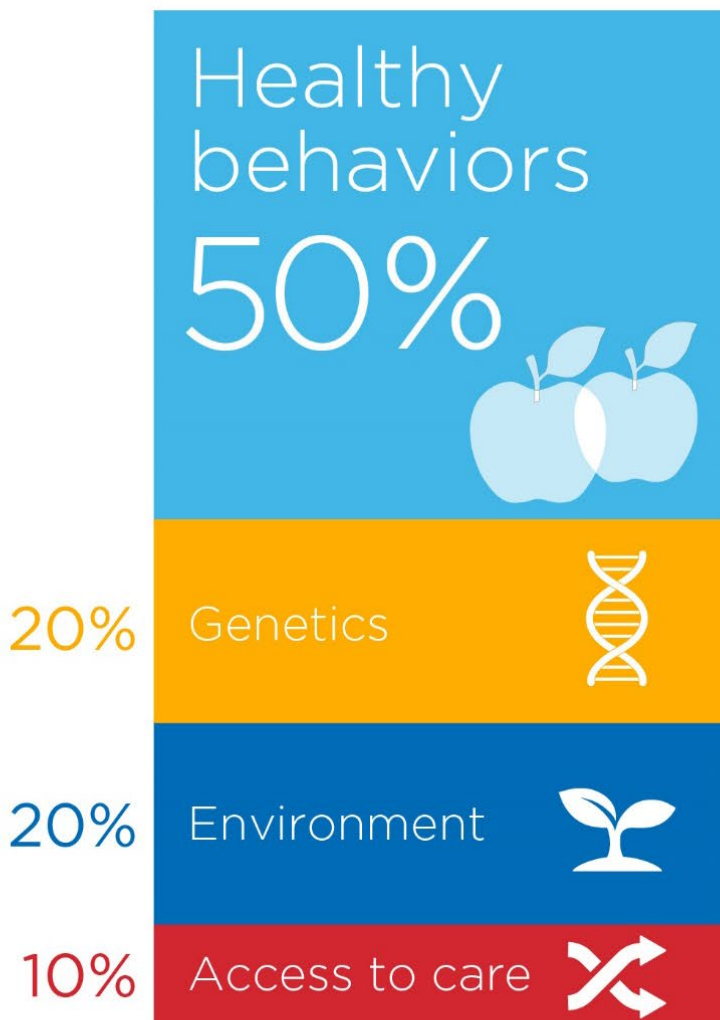
**Why should a health system care
about housing and why should
housing care about health?**



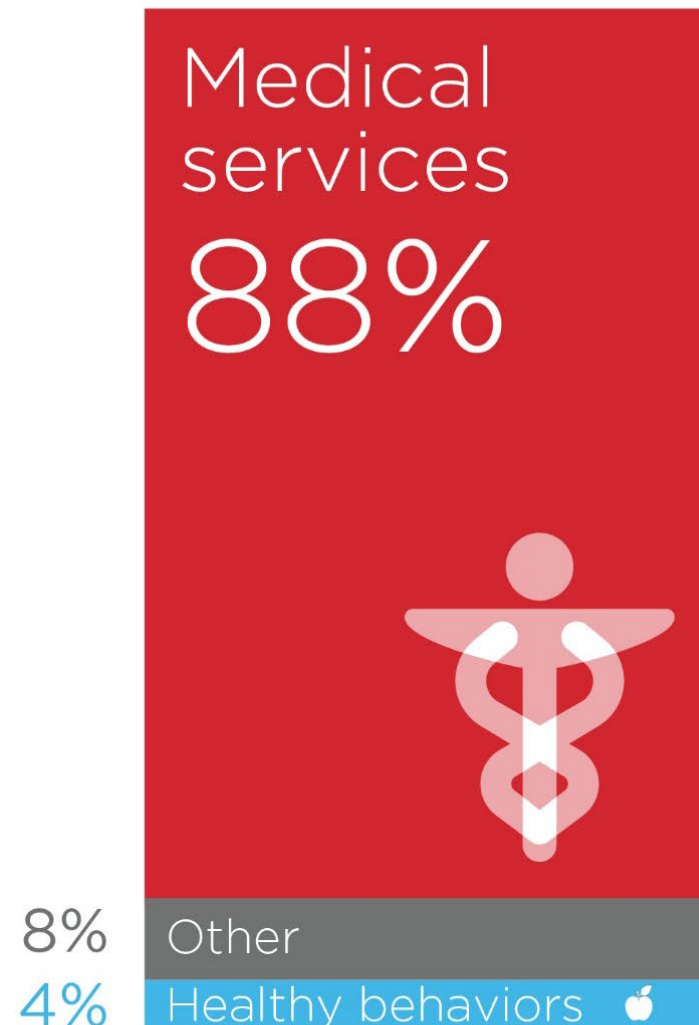
Ballad Health Population Health

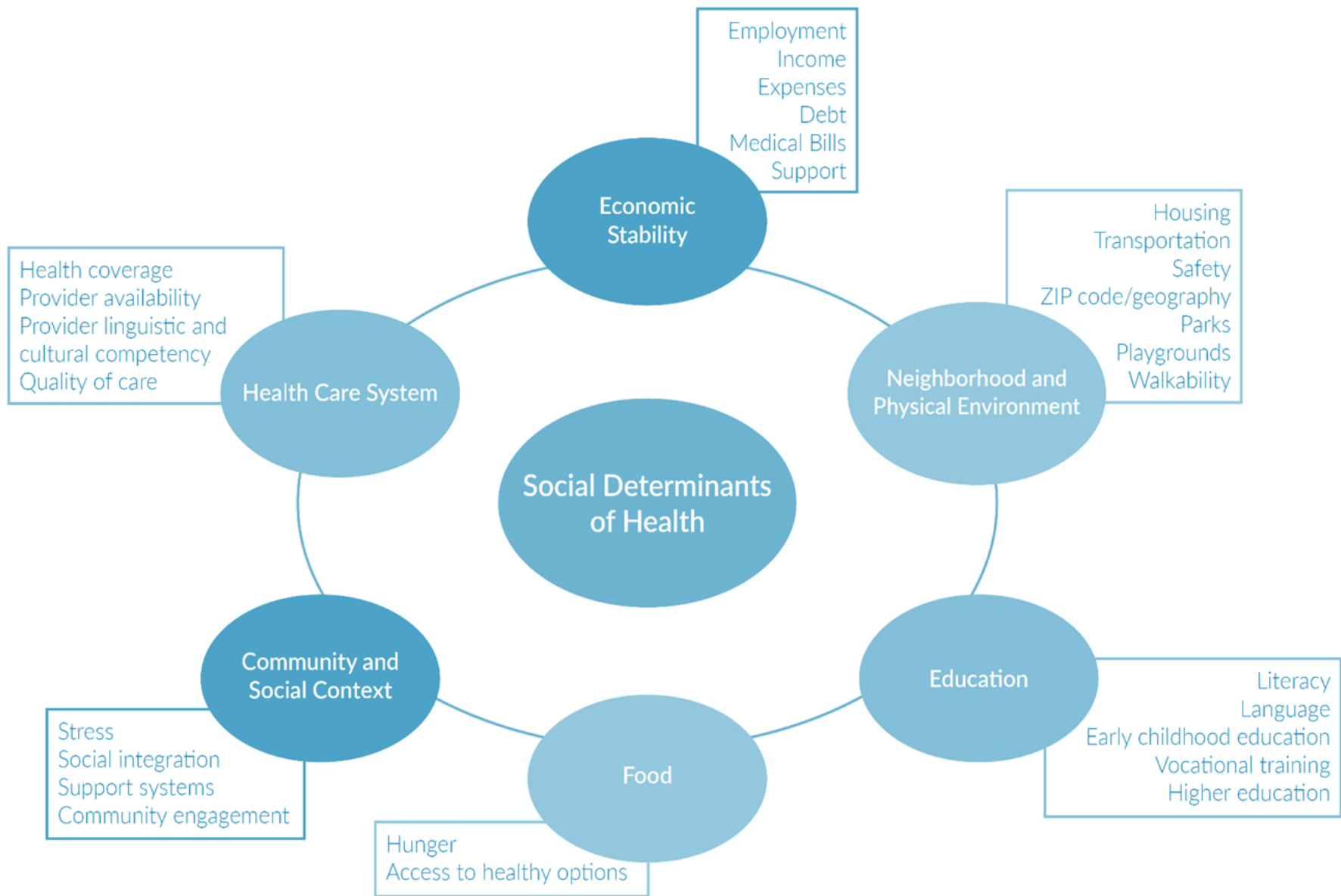


What **makes** us **healthy**



What we **spend** on being healthy

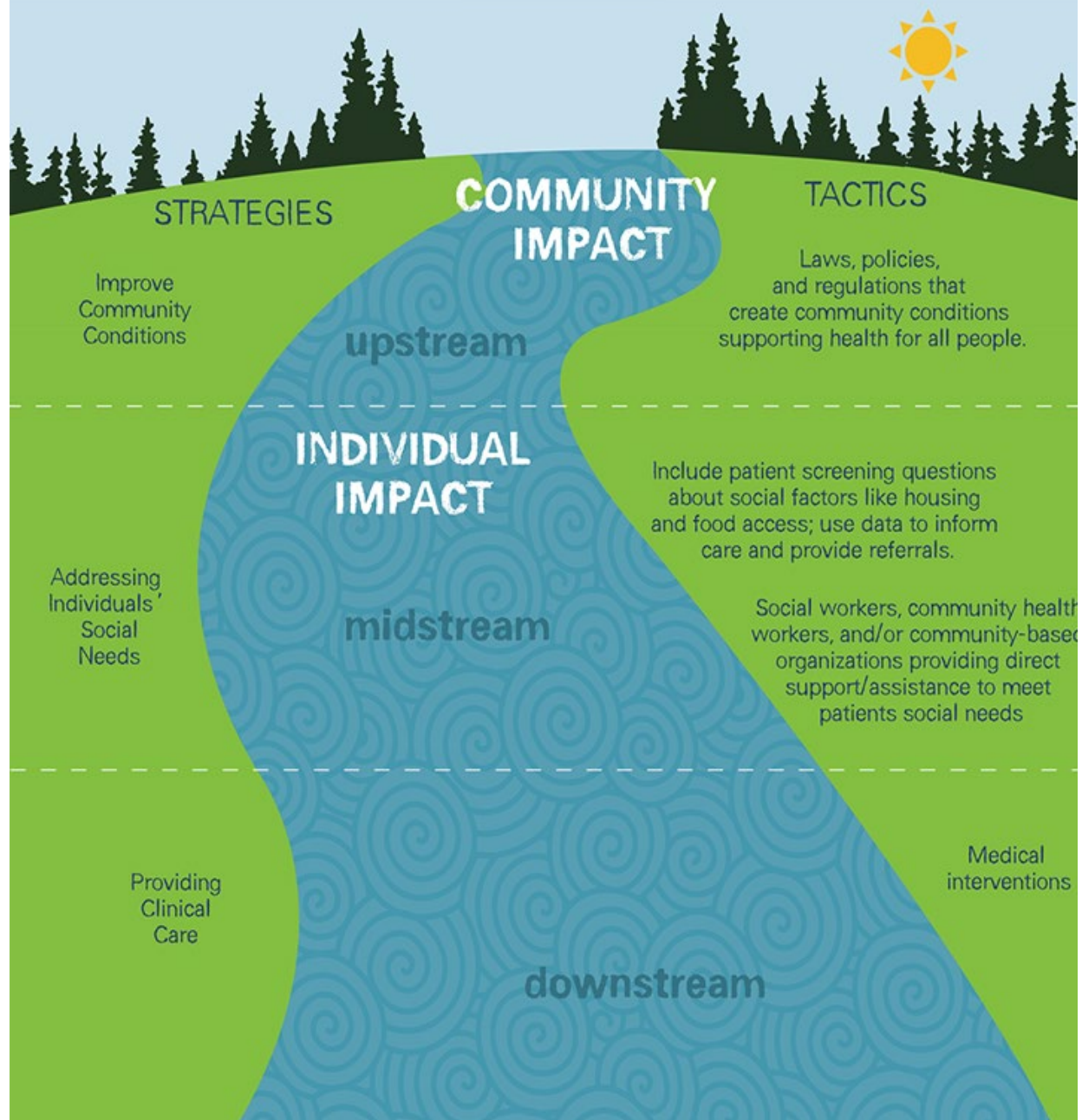




Health Outcomes

Mortality, Morbidity, Life expectancy, Health care expenditures, Health status, Functional limitations

SOCIAL DETERMINANTS AND SOCIAL NEEDS: MOVING BEYOND MIDSTREAM



**Not an either/or-
All must be
addressed**

Accountable Health Communities Overview

November 17, 2018 through August 31, 2021

262,724 Offered Screenings

148,368 Answered Screenings

44,089 Identified Needs

25,890 Community Referral Summaries Given to Patients

1,924 Resources in Community Resource Inventory

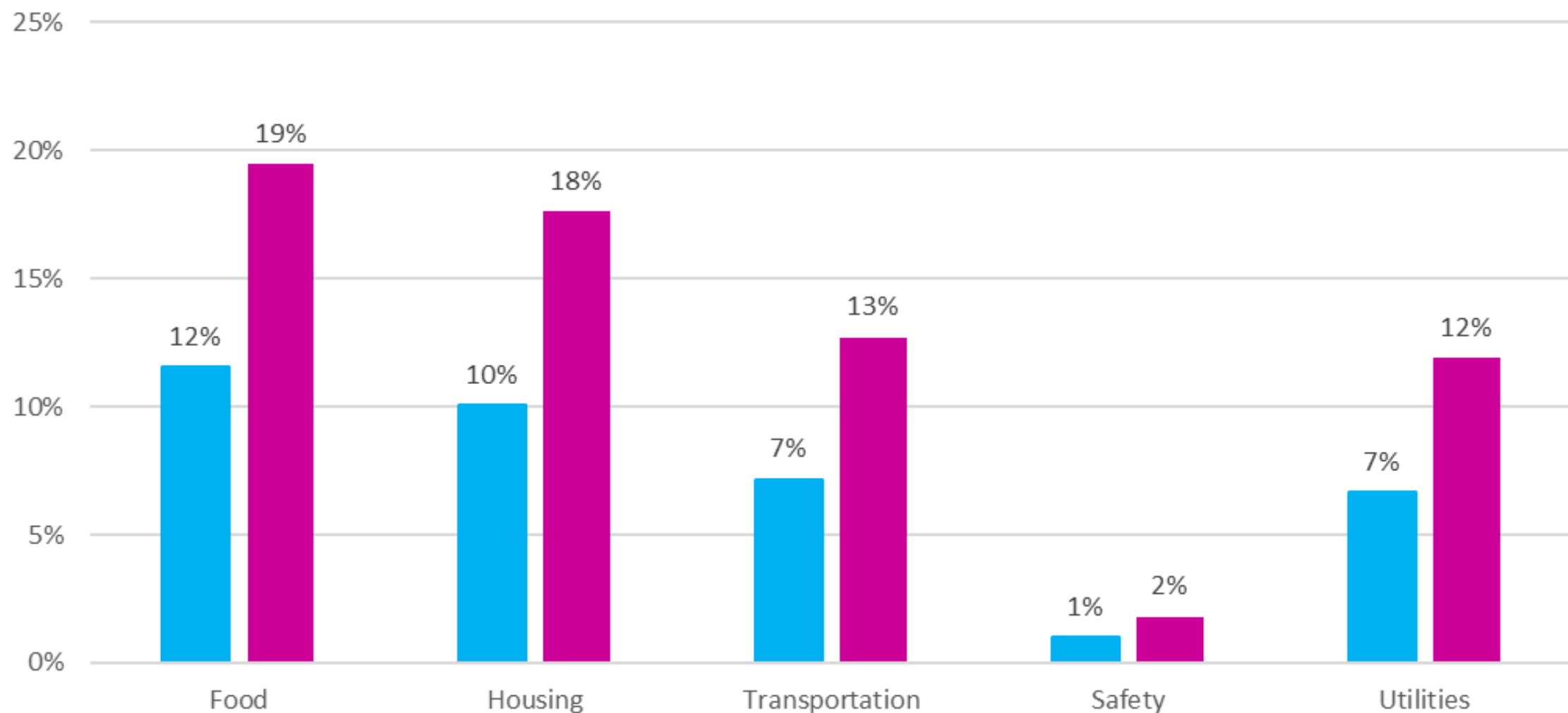
7,030 Navigated Patients

57,768 Outreach Attempts by Navigators

	Number of Individuals Screened with Needs	
Food	10,934	(7,504 with 2 or more ED visits)
Housing	9,512	(6,789 with 2 or more ED visits)
Transportation	6,787	(4,897 with 2 or more ED visits)
Safety	958	(697 with 2 or more ED visits)
Utilities	6,299	(4,595 with 2 or more ED visits)

Frequency of unique beneficiaries with HRSNs
(11/17/2018 - 8/31/2021)

■ All Unique Beneficiaries ■ Unique beneficiaries with 2+ ED visits





Striving Toward Resilience & Opportunity for the Next Generation

Accountable Care Community (ACC)

What is an ACC?

Impacts population health by **integrating:**

- Public health
- Health care delivery
- Social services
- Business



Uses multisector **partnerships**

- To emphasize shared responsibility for the health of an entire community.
- To design systems that are successful at both:
 - addressing social and economic factors
 - improving population health.

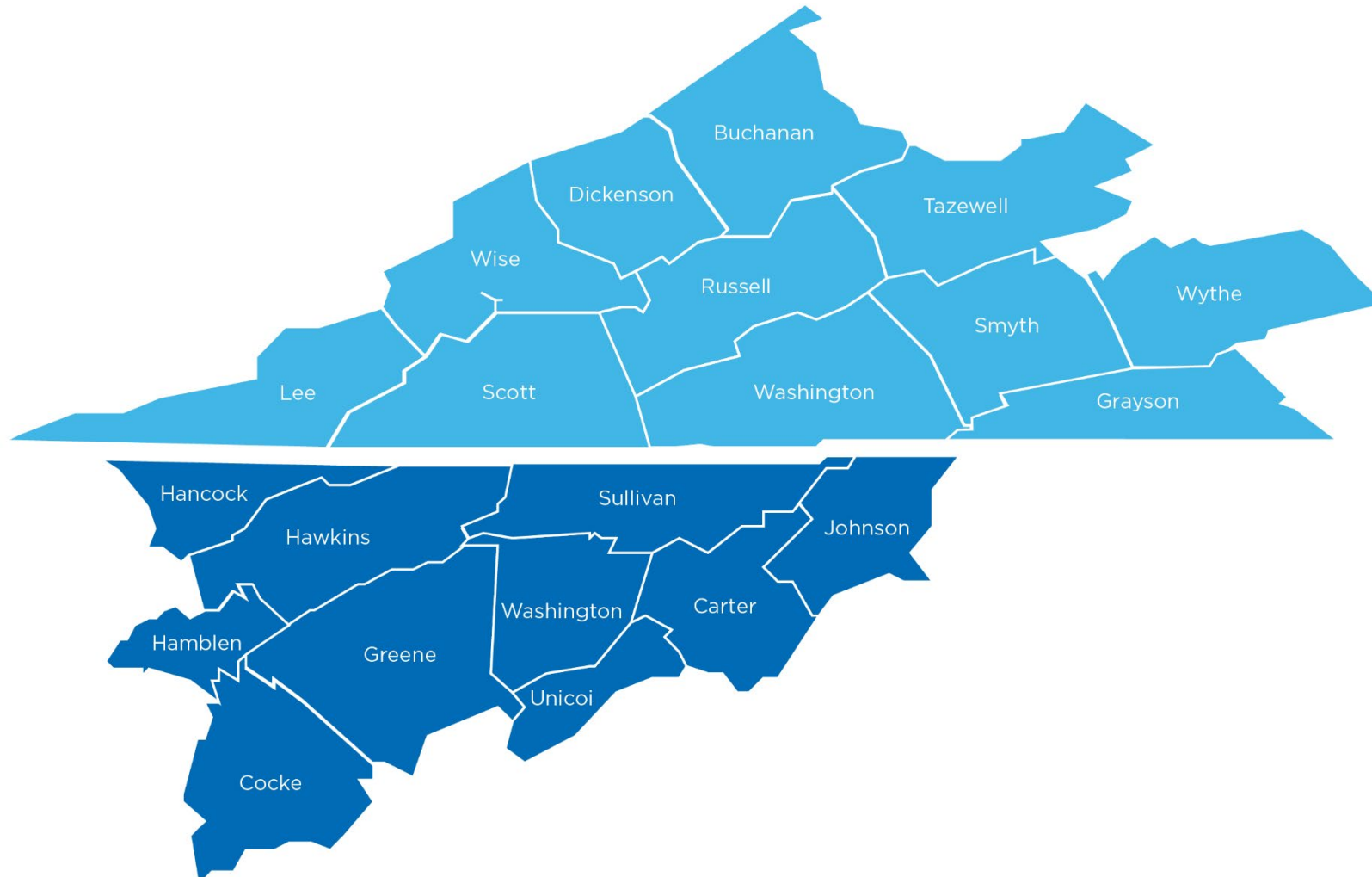
5 conditions of collective impact

1. Common agenda
2. Shared measurement
3. Mutually reinforcing activities
4. Continuous communication
5. Backbone support

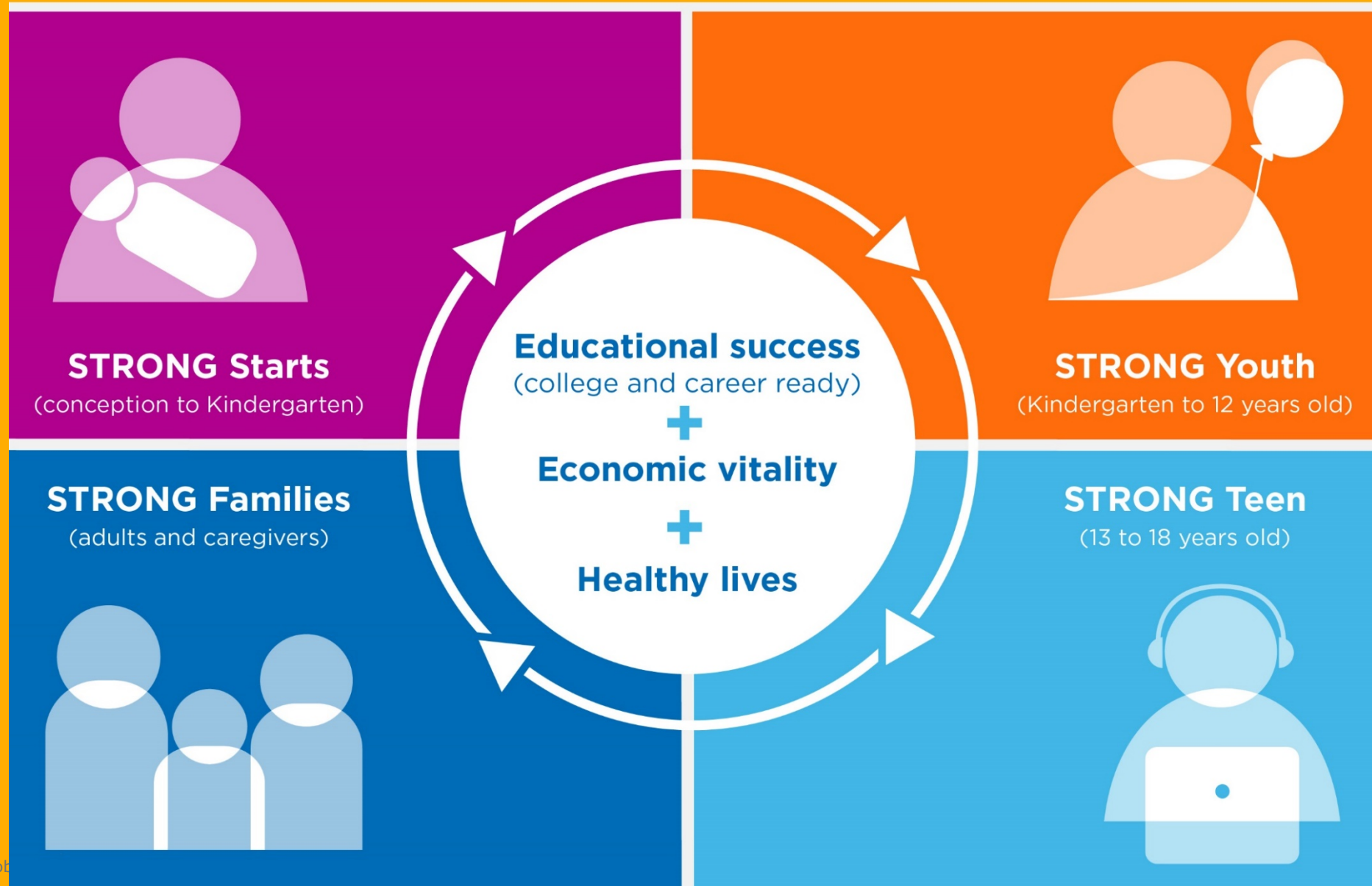


- STRONG ACC will identify, align and leverage regional wellbeing efforts aimed at recognizing the connection between education, income, and health; and seek to create a healthy population by serving people of all ages, making sure to include those who are at-risk.

“Think regionally, act locally”



S.T.R.O.N.G. model



What does the collaboration look like?

- We communicate monthly and as needed.
- We share data and best practices as they arise.
- We receive health screening referrals.
- We are improving relationships with our other community partners.
- We are focused on housing as a health determinant.
- Ballad has approved funding for a proposal from Fahe to further support the intersection of health and housing and to capture narrative to tell this story.



Where are we going?

- **Co-investment opportunities**
- **Leveraged grant applications**
- **Invest in best practices around housing**
- **Continue screenings and referrals**
- **Maintain regular dialogue**
- **Cost sharing programs with Fahe networks**
- **Expand learning collaborative beyond Ballard footprint into broader Fahe service area**



Fahe Proposal Funded by Ballad for Member Support in work we are doing:

- **HOPE Inc.**
- **Appalachian Community Action and Development Agency**
- **Bristol Regional Housing Authority, prospective Member**
- **Appalachia Service Project**
- **Clinch Powell RC&D**
- **Eastern Eight CDC**
- **Kingsport Housing Redevelopment Authority**



Activities supported by the Ballard funding:

- **Housing Rehab Activities**
 - **Weatherization Activities**
 - **Utility/Rent Assistance**
 - **Food Scarcity**
 - **Financial Capability Counseling**
 - **Homelessness Prevention**
 - **Permanent Supportive Housing**
 - **Rapid Re-Housing**
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- A decorative graphic at the bottom of the slide consisting of several overlapping, wavy horizontal bands in various shades of blue, creating a layered, mountain-like or water-like effect.

What do we learn?

- **Identify narratives that tell the story of the intersection of health and housing for Fahe and Ballard Health**
 - Clinch Powell client who had lost their job came in for COVID Emergency Assistance – CP was able to help her gain employment at Ballard Health and get back on her feet.
 - Single mother housed in KHRA Supportive Housing was able to complete a 4 year nursing degree and is now employed full time as a nurse.
- **Members will have access to UniteUs as a data and referral system**
- **Members including health questions with housing intake**



May – July 2021

ACTIVITY MEASURES <i>(People Served)</i>	ASP	App CAA	Bristol RHA	Clinch Powell	E8	HOPE	KHRA	Total
Homeowner Rehab	376	-	-	8	-	-	-	384
Weatherization Services	-	21	-	-	-	-	-	21
Utility/Rent Assistance	-	-	313	-	-	16	4	333
Financial Capability Counseling	3	-	12	201	134	67	40	457
Homeownership Delivery	3	-	-	-	23	2	-	28
Homelessness Prevention	-	-	-	6	-	56	66	128
Permanent Supportive Housing	-	-	-	3	-	33	-	36
Rapid Re-Housing	-	-	-	6	-	20	45	71
EnVision Center Services	-	-	107	-	-	-	-	107
Family Self-Sufficiency Program (FSS)	-	-	21	-	-	-	74	95
Resident Opportunities & Self Sufficiency Program	-	-	28	-	-	-	-	28
Food Insecurity Activities	-	-	210	-	-	6,178	144	6,532
# of Households Served	32	6	691	224	835	3,901	373	6,062

Next steps?

- **Additional collaboration work and expansion within the Fahe service area**



Q & A

Thank you!

