

**Federal Reserve Bank of St. Louis
Investment Connection Proposal**



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Organization Name	Habitat for Humanity of Greater Memphis
Mission statement	Seeking to put God’s love into action, Habitat for Humanity brings people together to build homes, communities and hope.
Overview of Organization	<p>Founded in 1983, HFHGM has made it possible for 480 low-income families to build and buy their first home. Through restructuring and the expansion of services to include comprehensive neighborhood revitalization and Aging in Place (AIP) programs, the organization has grown from serving 20 families per year to 250+ in the last five years. Key strategies included upgrading technology, investing in staff training, and increasing the number of qualified staff to support the projected growth. Habitat’s AIP team includes 3 licensed contractors and 4 project managers, 2 social workers, an urban anthropologist, a medical anthropologist, a program manager and coordinator. Awards include: 2016 Governor’s Award for Innovative Programming for our Aging in Place program; 2017 HFH Tennessee Affiliate of the Year; 2017 HFH Tennessee Program of the Year for our Aging in Place program; 2012 Governor’s Environmental Award for Sustainable Building; CEO awards: 2017 Outstanding Executive Leader by the Association of Fundraising Professionals Memphis Chapter; Leader of the Year by Habitat for Humanity of TN. Licenses: General Contractors License. Accreditations/Certifications/ Degrees: Construction team—TN Contractors License; National Home Builders Association Certified Aging in Place (CAPS) certification; American Lung Association’s Master Home Environmentalist certification; Social Worker—Certified TN Ombudsman for Abuse, Financial Exploitation and Neglect;</p>

	<p>Court certified to represent abused individuals; Research team—Masters in Urban and Medical Anthropology; CEO—Masters of Public Administration with a concentration in Urban Affairs.</p> <p>Methodist Le Bonheur Healthcare (MLH), a regional not-for-profit healthcare system, includes 6 adult hospitals, the region’s largest pediatric hospital, Le Bonheur Children’s Hospital, and a large network of primary care physician offices and specialty groups, outpatient and diagnostic centers, and hospice and at-home care services. MLH is the largest provider of TennCare (Medicaid) in Tennessee, and in 2016 provided over \$200 million in charity care. In 2011, MLH sought to test targeted efforts focused on specific patient populations to identify new, effective ways to improve access to health resources. MLH utilized “geo hot-spotting” to identify the highest need community in its service region, and the 38109 zip code was identified. Patients from 38109 had the highest utilization of MLH Emergency Department services and the highest consumption of hospital charitable care. Moreover, 38109 is one of the poorest zip codes in the Mid-South. Before launching activities in 38109, MLH, in partnership with CHN churches, engaged community members to identify what they saw as the priority health and social needs of the community as well as the existing resources. Guided by the community’s voice, in 2013, MLH launched two “demonstration projects” in 38109 that continue today: “Wellness Without Walls” community-based wellness events that offer health screenings, referrals and access to social supports through partnerships with over 52 community agencies to about 400 community members each month and “Familiar Faces” tailored patient navigation that provides individualized, ground-level navigation to the highest need residents of 38109. Through the “Familiar Faces” navigation model, MLH navigators serve as a trusted support system to the highest need patients, not only connecting them to the healthcare system and improving their use of resources and health outcomes but also seeking to improve their overall wellbeing. The number of total hospital visits among the first cohort of 91 “Familiar Faces” patients was reduced by 56.93% from 126.3 to 54.4 hospital visits per year. The number of hospital visits among the second cohort of 82 “Familiar Faces” patients was reduced by 51.04% from 104.58 to 51.2 hospital visits per year.</p>
Website	www.memphishabitat.com
Location of project/activity	Memphis/Shelby County
Project/proposal title	Launching of CAPABLE in Memphis

Support request	Investment/Grant
Requested amount	\$800,000
Other significant partners in the proposal	Methodist Healthcare Foundation Methodist Le Bonheur Healthcare
Proposal narrative	<p>Habitat for Humanity of Greater Memphis (HFHGM) and Methodist Healthcare Foundation (MHF) are proposing to replicate the Johns Hopkins’ Community Aging in Place—Advancing Better Living for Elders (CAPABLE) program model in Memphis to reduce the impact of disability among low-income adults and to increase their wellness using the goals they set for themselves in conjunction with expert interventions—all to increase the potential for them to age in place and reduce healthcare costs. HFHGM will serve as the lead agency, fiscal agent, and general contractor. MHF will identify and qualify clients, provide a community health navigator, occupational therapist, registered nurse and data specialist.</p> <p>The community health navigator (navigator) will serve as the primary liaison between the client and CAPABLE team. The navigator will conduct the initial client home visit; identify health and home safety barriers; develop an in-home care plan to include a registered nurse and/or occupational therapist; and link clients to additional social services. HFHGM’s construction team and the occupational therapist will conduct a home environment assessment, along with the client, to determine what accessibility aids and home modifications/repairs are necessary. After the home modifications/repairs are completed, the occupational therapist will teach clients how to safely use accessibility aids and home modifications and how to improve their abilities to conduct the basic activities of daily living (ADLs).</p> <p>Green & Healthy Homes Institute will analyze the data and compile an in-depth impact report on the health cost savings.</p>
Issues addressed	Neighborhood revitalization and stabilization; Affordable housing; Community facilities and services
Geographic impact	Citywide; Neighborhoods
Population served	The program will serve 75 recently discharged MLH patients aged 60+ who are enrolled in Medicaid, earn less than 80% AMI, live within the 38109 zip code, and are assigned to MLH’s Home Health Alliance or are already served through MLH’s Familiar Faces community health navigation program, which provides support to patients with complex health needs as indicated by a frequent

	<p>number of hospital and Emergency Department encounters (11 or more annually).</p> <p>The 38109 zip code has been identified through research conducted by MLH and Shelby County Health Department as the area of Memphis most dramatically affected by health disparities, including disproportionately higher rates of chronic disease, Emergency Department and in-patient admittance rates, and use of hospital charitable care. The area has a total population of 46,260, of which 96.2% are African American, 31.5% have incomes below the Federal Poverty Level, 23.9% have less than a high school education, 21.6% are unemployed, 36.7% receive Supplemental Nutrition Assistance, and 19% are uninsured. The AMI is \$29,648.</p>
Income of population served	At or below 80% AMI
Anticipated outcomes/impact	<p>Through the proposed replication of the CAPABLE model between HFHGM and Methodist Le Bonheur Healthcare, the following measurable outcomes are anticipated:</p> <p>Among clients served, 100% will report improved feelings of health, stability and safety within their home. 50% of clients served will report improvement in depressive symptoms. 70% of clients will experience a reduction in the number of Activities of Daily Living (ADL) that they have difficulty with from pre to post intervention. The average number of instrumental ADLs that clients have difficulty with at baseline will be reduced by 30% . Among 75 clients served, 100% of clients' utilization of the healthcare system will improve based on decreased emergency department visits, in-patient hospitalizations, 30-day hospital readmissions, overall readmission, and total encounters (Observation and Outpatient visits to hospital). Healthcare costs will be reduced among 100% of patients served.</p>
Evaluation methods used to measure success	<p>To monitor and evaluate the impact of the intervention on healthcare utilization and costs, clients will be placed in a patient cohort that will be trackable within Methodist Le Bonheur Healthcare's (MLH) electronic medical record (EMR) system, modeled after the Familiar Faces community health navigation program. For this program, MLH will define a baseline of healthcare utilization for the cohort of patients, including emergency department visits, in-patient hospitalizations, 30-day hospital readmission rates, overall readmission rates, and total encounters. Baseline will be defined based on their utilization patters over a 365-day period prior to the implementation of the intervention. Then, on a monthly basis, at the conclusion of the five-month program period, and for 365 days</p>

	<p>following the conclusion of the intervention, MLH will evaluate the healthcare utilization of the clients served to identify changes in healthcare utilization patterns. In addition, MLH will utilize the EMR data to evaluate changes in the average cost of care for the clients served.</p> <p>MLH will also evaluate process measures including the number of clients served, the number of interventions provided (number of community health navigator, nurse and occupational therapist visits), and rate of referrals to healthcare and social support resources.</p> <p>To evaluate the impact of the program on the client's feelings of stability, safety, health and loneliness, the community health navigator, nurse and occupational therapist will conduct pre and post surveys utilizing a Simple Evaluation Tool to assess and evaluate changes in the clients feelings of stability, safety, health and loneliness. The clients will also complete a PHQ2 and PHQ9 depression screening survey pre and post intervention to evaluate changes in feelings of depression among clients.</p> <p>To measure the impact on positively changing the clients' abilities to perform essential Activities of Daily Living (ADLs) and instrumental ADLs, MLH will replicate the study method utilized by John Hopkins University through the Community Aging in Place, Advancing Better Living for Elders program, funded by the Center for Medicare and Medicaid Innovation. At the beginning of the intervention period, participants will be asked by the community health navigator to identify if they have difficulty performing one or more of the essential eight ADLs (walking across a small room, bathing, dressing the upper body, dressing the lower body, eating, using the bathroom, transferring in and out of bed, and basic grooming). Each task will be scored from 0 to 2 depending on whether the person does not have difficulty and does not need help (0), does not have difficulty but does need help (1), or needs help regardless of difficulty (2). At five months from baseline, the community health navigator will conduct a follow-up assessment of each client's ADLs score. A similar process will take place to evaluate the client's self-reported level of difficulty in performing instrumental ADLs (using the telephone, shopping, preparing food, doing light housekeeping, doing laundry, traveling independently, taking medications and managing finances). Performance on these tasks will also be measured using the 0 to 2</p>
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	<p>difficulty scale. As with the essential ADLs, the community health navigator will conduct a follow-up assessment of each client's instrumental ADLs at five months from baseline. The MLH Data Specialist will evaluate the baseline and quarterly ADLs assessments and categorize each participant as having improved, stayed the same or gotten worse. The evaluation of the program's impact on improving the clients' ability to perform essential and instrumental ADLs will be further analyzed and reported by comparing the average number of ADLs and instrumental ADLs that the clients reported having difficulty with at baseline compared to the number at the conclusion of the program.</p>
Project time frame	New Program