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Executive Summary

The Community HealthCorps (CHC), through the National Association of Community Health Centers (NACHC), will place 575 full time AmeriCorps members (ACMs) in frontier, rural, and urban communities in 18 states and Washington, DC between August 2013 and July 2016 to improve health care for the medically underserved, increase financial literacy related to making informed health care decisions, and address barriers (language, transportation, etc) that affect the economically disadvantaged, older adults, individuals with disabilities, veterans and their families, and currently overweight children. Over the three years, 90,000 individuals will improve attitudes toward use of health care; 67,500 individuals will increase financial knowledge related to economic impacts of health care decisions; 8,100 older adults and individuals with disabilities, 1,800 veterans' families, and 900 veterans will increase social ties/ perceived support. The CNCS focus areas met include Economic Opportunity, Healthy Futures, and Veterans/ Military Families, and requested investment of \$7,331,250 annually will be matched with \$7 million.

Rationale and Approach

1) PROGRAM DESIGN -- A) NEED: The devastating economic impacts of illness and lack of access to quality, affordable health care cause millions of Americans to make decisions between their health care and housing or food. Several facts highlight these impacts due to the changing health of U.S. residents and the rapid changes to the health care system: (1) U.S. health expenditures neared \$2.6 trillion in 2010, ten times the \$256 billion spent in 1980 (Centers for Medicare and Medicaid Services (CMS), January 2012); (2) for every uninsured person, over \$900 of unpaid medical bills per year is shifted to higher premiums for the insured (Families USA, 2005); (3) individuals are living longer with multiple chronic illnesses (e.g., diabetes, high blood pressure) and placing tremendous demands on the system, estimated costs account for over 75% of U.S. health expenditures (Centers for Disease Control (CDC)); (4) the estimated medical costs attributable to obesity reached almost 10% of all medical spending (Commonwealth Fund, May 2012); and (5) the recession over the past decade resulted in higher unemployment, loss of employer health insurance, and lower incomes for millions, of which recent veterans, minorities, and individuals in previous industrial regions all had higher rates than the general population.

The economically disadvantaged, veterans, older adults, the overweight and obese, new Medicaid and other coverage-eligible individuals, will need to identify and access healthcare services, and manage chronic conditions among limitations like lack of transportation, geographic isolation, or

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limited English proficiency (LEP). CHC will utilize ACMs to address the following: (1) The knowledge gap of the link between health choices and their impacts on credit worthiness, overall health, and economic opportunities; and (2) the access gap between eligibility for services and effective utilization of the health care system, including social determinants of health (where one lives, access to healthy food, public transportation, etc).

Federally qualified health centers (FQHCs)-community owned, neighborhood-based, and federally supported nonprofits that began providing health care to medically underserved people over 45 years ago and now serve over 22 million patients annually - will continue to serve as the primary community partners and service sites for ACMs through CHC to address the gaps mentioned above.

The racial and ethnic demographics of FQHCs nationwide (compared to the US population) in 2010 are as follows: Hispanic/Latino 34% (16%); African-American 26% (13%); Asian/Pacific Islander 4% (5%); American Indian/Alaska Native 1% (1%); and White 42% (64%). Socioeconomic indicators show FQHC patients are poorer, more rural, and more likely to be uninsured or insured through government support: At or below 100% of FPL 72% (21%, US); at or below 200% of FPL 93% (40%); uninsured 36% (16%); Medicaid 39% (16%); Medicare 8% (12%); and rural 48% (16%).

FQHCs' expansive reach into the nation's most medically underserved areas stems from their federally-mandated program requirements: have a consumer-majority governing board, at least 51% are users of the FQHC; serve all without regard to ability to pay; provide a high level of primary and preventive care; conduct community needs assessments; customize services to meet the specific needs of their communities; and serve federally-designated medically underserved populations.

Community HealthCorps' proposed sites are 53% urban, 29% rural and 18% suburban or split between rural and urban service sites (referred to as Blended Operating Sites). Four new regions/sites are proposed: Sonoma County, CA; Hawaii; Dover, NJ; and Harrisburg, PA.

URBAN OPERATING SITES: From the coast-to-coast, CHC sites in urban areas exhibit many of the same diverse populations and changing demographics of the communities they represent. City centers that were once victims of urban sprawl with populations moving away and high crime rates are now seeing their most marginalized populations and their poorest become more concentrated in pockets of the city served by FQHCs.

Across the western and mountain regions of the country, CHC is located in major urban centers in California (CA), Colorado (CO), and Washington (WA). In CA, sites in Los Angeles serve high concentrations of Hispanic and Asian communities that have developed over decades in the eastern part of the city, predominantly African American populations in Watts, and pockets of homeless

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populations across the county. Over half of these populations have LEP and the county is home to nearly 380,000 veterans and over a million elderly people over the age of 65. In San Francisco, sites see 80% of their patient populations as low-income and thousands of veterans' access homeless outreach programs where the CHC serves side-by-side with AmeriCorps VISTAs at St. Anthony's Foundation and GLIDE in San Francisco (faith-based organizations). Across the Bay in Berkeley and Oakland, CHC sites provide a higher than normal amount of care to the elderly (35% of patient base) and the homeless (69% reside in the FQHC's service area). In CO, the Englewood area just east of Denver and home to a CHC site, includes over 219,000 uninsured residents, 24% of which live at or below 200% of the FPL. The corridors that line the routes out of the city are home to motels that have become temporary housing for thousands of homeless families seen each day by ACMs providing outreach and health education. Finally, in WA 33% of the CHC site's service area (Seattle and Tacoma) and 92% of patients served had an income below 200% of the FPL, 89% of patients have public insurance or were uninsured, and 18% were best served in a language other than English.

Moving eastward, the Central part of the country is home to urban-based CHC sites in Missouri (MO), Michigan (MI), and Wisconsin (WI). Beginning in MO, St. Louis' eastern part of the city is home to high crime, poverty, and lacks access to healthy food options. The CHC site provides services to over 41,000 individuals (31% are children, 24% homeless, 55% uninsured, and 18% live in public housing). In MI, CHC has built a strong presence in and around Grand Rapids, the state's second largest city behind Detroit and home to the largest CHC site in the country. Of the site's 41,000 patients: 27% are uninsured; 92% have public health insurance; and 17% are LEP. Finally, in Milwaukee, WI the CHC site sees the patients from predominantly Hispanic neighborhoods. The service area has the highest rate of uninsured individuals (36%) in Milwaukee and some of highest health disparities in WI.

The Northeast and mid-Atlantic regions of the country are home to the largest concentration of CHC sites and ACMs in urban centers in Massachusetts (MA), Connecticut (CT), New York (NY), Maryland (MD), and Washington, DC. Beginning in MA, Boston and the immediate surrounding communities are home to three CHC sites. Overall, FQHCs in MA saw over 760,000 patients and provided over 3.6M visits. Increased demands for outreach and helping new patients understand the services available through FQHCs is a primary activity for all ACMs. Additionally, ACMs assist people living make proper nutrition and exercise choices to reduce their weight with a new national partner, Weight Watchers. Also, one site will focus primarily on the city's homeless populations (including veterans) who struggle to access health care and social services because of societal problems as well as

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their personal struggles with social isolation and being disenfranchised. In CT, CHC sites are in the state's largest and poorest cities (Fairfield, Hartford, New Haven, Meriden, and New Britain) and are situated then in the city's poorest census tracts. Several of these once larger industrial cities have seen their main manufacturing and ports close over the years, while becoming home to large new immigrant populations. In CT, Latino children at FQHCs have a 20% uninsured rate compared to the state average rate 5.2% for all children. In NY, CHC sites within Manhattan, Brooklyn, and the Bronx encompass a large number of racial and ethnic minority communities that lack high quality and culturally competent health care. In recent years, a large influx of immigrants from Haiti, Southeast Asia, Africa, and Central and South America have established themselves in these service areas. These populations face significant health problems, including high rates of HIV/AIDS, obesity, and depression, as well as low literacy and education levels, and high unemployment. In Brooklyn, the CHC site is also located near the U.S. Army Garrison at Fort Hamilton and provides wellness programs to the many military families and veterans. In Syracuse, the CHC site in this mid-size urban center contains over 1/3 of the city's minority population, over half of the city's population with incomes 100% below FPL and 1/3 of the city's Medicaid population. In NJ, Camden is one of the poorest cities in the U.S., overall 36.3% of residents live below the poverty line. Also, 39.89% of the households are single parent; the violent crime rate is higher than the national rate by 476% (2010); and the unemployment rate was 19.6% (2011), twice that of the national average. In MD, the site primarily will place ACMs in service sites in Baltimore and just outside of Washington, DC. Of the 261,875 patients served by MD FQHCs overall in 2009, 4,190 were veterans, and 86% of the patient population is at or below 200% of FPL. In MD, the infant mortality rate, teen death rate, and AIDS diagnosis rate all rate worse than the US average. Finally, DC's uninsured rate is between 8-15% (55-80,000), 30-50% of residents suffer from chronic diseases, and DC leads the nation in per capita of people living with HIV/AIDS. The CHC site will targets placements to Columbia Heights, Anacostia, and areas east of the Anacostia River.

RURAL OPERATING SITES: In several of the states where CHC has an urban presence there are also placements in some of the most rural parts of the state. This occurs in CA, CO, NY, and WA. In all of these regions, FQHCs populations are made up of larger portions of migrant farm workers.

Beginning in CA, the unemployment rate in the Central Valley and Inland Empire has remained above 15% since 2009. The region is home to Tulare and Kings Counties ranked 48th and 57th out of 58 counties in CA for the prevalence of deaths due to diabetes. The vast majority of residents live in remote rural areas and over 47,000 patients per year are migrant farm workers. About 40 miles north

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of San Francisco, Sonoma County is known for their wine and lush estates, but is less known for the poverty of many who work in the vineyards and surrounding farms. In the county, residents living below 200% of the FPL grew from 24% (2006) to 30% (2010) and 42% of its school children are food insecure or hungry. Further north, CHC sites serve low-income and LEP populations unable to navigate paperwork necessary to receive benefits for which they may be eligible. Communities in this service area such as Laytonville and Willits are all considered 'frontier' and lack access to health care even more vastly than 'rural' communities. In CO, the CHC site in the northeastern part of the state provides health care to 65,225 low-income patients annually along the Rocky Mountains' eastern valley of which 55% live 100% below the FPL and another 25% live 100-200% below the FPL. In NY, the FQHCs across the Hudson River Valley operate in communities where portions of the population struggle with poverty, lack of insurance, and linguistic/cultural isolation. Nearly all patients have incomes at or below 200% of the FPL, and more than half are best served in a language other than English. The migrant farm workers seen at FQHCs in the area face psychological, domestic violence, and substance abuse related to the stresses surrounding migration, and working and living conditions that have serious health consequences. Finally, in WA the CHC site is in Yakima County, an economically disadvantaged region with 21.8% of the population below 100% of the FPL; 29.2% aged over 25 is without a high school diploma or GED; and more than one in four uninsured patients cannot afford to pay for prescription medications.

CHC proposes additional rural sites in Idaho (ID) and Maine (ME). In ID, due to the economic downturn more families find themselves without health insurance and premiums for working families have increased by 122%. CHC continues to partner through the Institute of Rural Health at ID State University who places ACMs at FQHCs and non-profits in southeastern Idaho. In ME the operating site is the largest of the state's FQHCs, serving 50,000 patients, and the only FQHC in the largely rural area. Roughly 65% of their patient population is at or below 200% of FPL.

BLENDING OPERATING SITES: CHC proposes seven additional operating sites that serve communities and regions that have a combination of urban and rural service sites. Beginning in Hawaii (HI), a consortium of FQHCs will place ACMs in two rural FQHCs in Wai'anae and Kailua-Kona and two urban FQHCs in greater Honolulu. All four FQHCs serve predominantly Medicaid, low-income Medicare, or uninsured populations. This is the first year CHC will place ACMs in Hawaii. In Louisiana (LA), the efforts of CHC in the state grew out of the recovery following Hurricanes Katrina and Rita in 2005. Today, LA is ranked 47th in the nation's health rankings. CHC will support sites consistent with the needs rural and urban and FQHCs across the state. In Northwestern NJ, the

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operating site's target population includes migrant farm workers, public housing residents, and the homeless. In 2011, their patient base was 68% Hispanic compared to 9.5% in Northwest NJ, 60% were LEP compared to 17.7% region-wide, and lastly, 68.5% were uninsured in comparison to 9% for the region. In Ohio (OH), the state has seen extreme downsizing of its manufacturing sector over the last 20 years, resulting in higher unemployment and uninsured rates. CHC's partner in the state will place ACMs in urban areas like Cincinnati, Columbus, and Cleveland and in more rural areas like Chillicothe, Ironton, and Zanesville. Together, the service sites reported of the 162,000 patients they see, 35% are uninsured, 40% receive Medicaid, and 35% were under the age of 19. In Central Pennsylvania (PA), the FQHC primarily serves the areas representing the highest number of prominent socio-economic barriers to health: income, language, educational, insurance, and housing. The unemployment rate for these areas was 12%. In 2011, 33.5% of the patients were uninsured - higher than FQHCs in the state as a whole (25.8%). While the number of individuals served increased by 28% between 2008 and 2011, the number of uninsured went up by 56%. Finally, in Waco, TX the poverty rate among the CHC operating site's 48,000 patients is 27.6%. Also, every year thousands of veterans and their families who come to and/or live near Ft. Hood Army Base choose to get their services at the FQHC. At the southernmost tip of the state (Brownsville), one mile from the U.S.-Mexico border. The health status of the CHC site's patient population is one of the poorest in the nation; of over 23,000 adult visits, 29% were for diabetes and 37% were for high blood pressure. Furthermore, only 62% of all adults are uninsured and only 76% of children.

B) ACMs AS HIGHLY EFFECTIVE MEANS TO SOLVE COMMUNITY PROBLEMS: Between Aug, 2010 and Dec, 2012 (over 75% of the current 3-year AmeriCorps grant cycle), CHC helped over 143,887 individuals determine eligibility and/or enroll in health insurance/benefit programs; provided translations to over 81,998 individuals; and aided over 260,416 individuals to utilize health care services and programs that had previously not done so and who were uninsured. This proposal builds upon these successes and new ACM services include: (1) delivering financial literacy education related to health care choices; (2) reducing inappropriate use of emergency rooms (ERs) through patient coaching, adhering to treatment regimens and conducting self-care management; and (3) delivering programs with community and faith-based organizations that provide health-facilitating resources beyond the doors of the FQHC and are designed to meet the needs of older adults, disabled individuals, veterans and military families, the economically disadvantaged, and obese or overweight children.

Community HealthCorps requests 575 full-time ACMs, whose activities will be diverse, complement the communities they serve, and lift barriers experienced in accessing health care. The

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following examples highlight key proposed ACM activities: (1) FINANCIAL LITERACY EDUCATION: In Idaho, ACMs will educate on the differences between name-brand and generic medications, factors to be considered along with the potential economic consequences of one's selection. At Institute for Family Health in NY, ACMs will provide education focused on diabetes, nutrition issues to increase health literacy around health disparities in the Bronx and financial implications for patients living in this area without fresh produce options. (2) ER DIVERSION/ SELF CARE MANAGEMENT: In Camden, NJ, ACMs will coach patients how to efficiently access the healthcare system, determine when to seek emergency and hospital care, and to self-manage their chronic conditions (i.e., understanding the financial impact of healthcare decisions). At Hudson River HealthCare in NY, ACMs will deliver the Stanford Chronic Disease Self-Management Program, providing an opportunity to work with patients learning chronic conditions management skills. (3) PARTNERSHIP CULTIVATION/ PROGRAMS & SERVICES DELIVERY: ACMs at LifeLong Medical Care in CA will assist veterans and military families to find housing and support with organizing child care, health services, and employment assistance as part of a collaborative supported by the US Dept of Veterans' Affairs (VA). At East Boston Neighborhood Health Center in MA, ACMs will connect patients to support their overall health and financial stability, including links to transportation, housing, food and weight management services. ACMs will also implement the Elder Service Connective Living Program - a new web-based program designed to increase social ties and support for older adults by connecting them to each other and their communities. At Community Health Integrated Partnership in MD, ACMs will bring an existing, evidence based obesity prevention program to scale at more FQHCs.

Without ACMs, CHC sites would not be able to meet the growing needs, especially of patients with chronic conditions who need additional support to meet health care goals.

C) EVIDENCE-BASED/EVIDENCE-INFORMED AND MEASURABLE COMMUNITY IMPACT: The major contributors to the high costs of health care are individuals who poorly manage chronic illnesses which lead to unnecessary hospitalizations and use of the ER, large numbers of uninsured individuals, and expensive prescription medications. The evidence is vast: (1) CMS cites spending on prescription drugs as a primary contributor to the increase in overall health spending (National Health Care Expenditures Data, January 2012); (2) the U.S. had highest rates of potentially preventable asthma deaths and amputations due to diabetes, "suggesting a failure to effectively manage these chronic conditions that make up an increasing share of the disease burden." (Commonwealth Fund, May 2012); (3) many chronic diseases share the commonality that if well-managed every day, with a

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combination of drugs, lifestyle, and certain kinds of monitoring of physical conditions, it is possible to reduce the need for enormously costly episodes of hospitalization. (Ibid); and (4) the uninsured were found more likely: to have an ongoing chain of health crises, to generally not have regular health care, to have mostly sought medical care through ERs, to have sought care only when they had persistent symptoms that interfered with their daily lives, and to have identified lack of money as the biggest reason for not seeking care (The Western Journal of Medicine, 2001).

CHC proposes to address these challenges directly. Evidence indicates that the proposed ACM activities will have a measurable community impact. For example in Camden, NJ the site has identified and will target patients who disproportionately use hospital and ER services. To understand the importance of assisting these individuals make informed health care choices based on financial reasoning, consider the following: In Camden, NJ 27,199 adults visited one of the three city hospitals either as an ER patient, inpatient, or both. These visits resulted in \$704M in total hospital charges, but only \$82M in total hospital receipts. From 2002-2007, hospital claims data indicate the top diagnoses for residents visiting local ERs were head colds and ear infections. The use of ACMs to assist beneficiaries determine eligibility, enroll in health insurance and other services, select a physician, adopt a medical home, and divert such individuals away from expensive and unnecessary ER care and hospitalizations will result in real savings and prevent negative impacts to individuals' credit ratings.

ACMs serving through CHC have also successfully reduced costs incurred by patients that would have resulted from the purchase of expensive medications. In Idaho, ACMs helping families enroll in prescription assistance programs has led to savings of nearly \$980,000 in medications in 2011-12, a feat similarly documented across many CHC sites. Accompanying such assistance with financial literacy education by ACMs in FQHCs will help individuals better determine when less expensive generic brands reduce their economic burden so that they may continue to seek savings on their own. FQHCs were identified as "reducing health gaps for racial and ethnic minorities while lowering the cost of treating chronically ill patients, reducing hospitalizations, inpatient days, and ER use, generating significant returns on investment while improving community health" (Journal of Ambulatory Care Management, 2011).

Over the next three years, 67,500 economically disadvantaged individuals will increase their financial knowledge related to their health care options; 90,000 individuals enrolled in health services, health insurance and other health benefits programs will indicate an improved attitude toward use of preventive and primary care services; and 8,100 older adults and disabled individuals and 2,700

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veterans and military family members will increase their social ties and perceptions of social support. This overall change will catapult CHC's impact beyond increasing access to care to increasing self-sufficiency and connectedness for those gaining access. The performance measures were determined by reviewing previous successes and challenges; researching the targeted beneficiaries FQHCs serve; and through extensive discussions with current and prospective sites about data collection capabilities. NACHC will conduct pre and post surveys of beneficiaries and set reasonable expectations for responses based on smaller scale surveying experiences. Surveys will be used to measure the change in the areas of impact. The results of these surveys will be analyzed and findings reported annually.

As a current AC grantee, the impact of CHC's performance in 2011-12 is documented, with additional context for over-exceeding expectations on one measure and under-exceeding on another: (1) CHC enrolled 51,188 people in need in health services, and health insurance programs, reaching 102% of the goal (50,000); (2) CHC provided language translation services to 43,029 clients, achieving 239% of the goal (18,000) and over-exceeding all expectations. The National Health Law Program states Medicaid reimbursement rates for language translation services range from \$7-\$50/hour depending on state labor costs as well as training received or certifications held by the interpreter. Estimating that an ACM spends 15 minutes per translation, CHC may have leveraged services valued \$75,300 - \$537,850; (3) CHC assisted 103,809 people to use health care services that previously did not, who were uninsured and/or economically disadvantaged, achieving 115% of the goal (90,000); (4) CHC engaged 1,937 youth to reduce obesity, achieving over 160% of the goal (1,200); and (5) CHC improved fitness by at least 8% for 151 youth, achieving over 60% of its goal (250). While CHC under-exceeded expectations, only meeting over 60% of this measure, an additional 6% children saw a 3.5% to <8% increase in their aerobic fitness. CHC saw improvements in the efficiency of tracking heart rate (considered a high threshold for data collection that proved less effective in application than in theory). When NACHC learned of this challenge prior to the 2011-12 year, the sites were informed of the obstacles and NACHC provided training to try to reduce the data collection burden. As a result CHC made progress exceeding the output, strengthening data collection, and expects to meet the target in this current program year.

D) MEMBER RECRUITMENT: CHC sites have recruited and selected a balance of underrepresented populations, including 'opportunity youth', from the communities served by FQHCs, and nationally identified recruits via CHC's social media platforms and the My AmeriCorps Portal. Community members who become ACMs often understand the needs of the patients, 47% have been patients themselves. Some ACMs, especially those that are hired by FQHCs after their term of service ends,

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become dedicated alumni recruiters and go on to serve as mentors or site supervisors. At Cherry Street Health Services in MI, nearly 10% of the agency's overall workforce once served.

CHC and its sites will employ strategies identified in "Community Health Centers and Veteran Hiring -- Starting Points" (NACHC) such as establishing relationships with local veterans' offices and organizations, connecting with nearby military bases, and asking patients if they are veterans. Additionally, several CHC staff attended the National Service Inclusion Program Train-the-Trainer workshop and will provide training related to recruitment of disabled individuals and veterans. CHC has set a goal of selecting one veteran and/or military family member as an ACM at each site annually, resulting in nearly 40 veterans or military family members serving.

E) MEMBER TRAINING/DEVELOPMENT: Sites receive pre-service orientation (PSO) guidance to ensure that each ACM receives an introduction to AC and CHC, and the rules guiding their participation, including prohibited activities; an overview of the local community and site policies and procedures; and an introduction to the goals and performance measures.

The foundational training for all ACMs in CHC is the member curriculum, "The Prescriptions for Success". Topics include: disaster preparedness, cultural sensitivity, and patient relations at the PSO; health education, outreach, health disparities, and case management during the term; and life after AC as they close their service. NACHC will add training in financial literacy and self-care management, independent living and veterans resources, and childhood obesity reduction. Also, ACMs will gain a variety of skills in effective communication and customer service, motivational interviewing, leadership, partnership cultivation, and goal development.

F) MEMBER SUPERVISION: Program coordinators (PC) provide support to ACMs, lead the AmeriCorps resource at each site and set up service projects. PCs traditionally are workforce development, volunteer management or community engagement professionals who value national service as a solution to community problems, and may be an AC and/or CHC alumni.

Each ACM is assigned a day-to-day site supervisor who traditionally is a community health professional and values the opportunity to shape the development of future professionals; may be an AC and/or CHC alumni; provides direction for the ACM's service and ongoing training; and provides mid and end of term performance evaluation for the ACMs. All site supervisors are trained by NACHC (or from materials developed by NACHC) on prohibited activities, approving ACM timesheets, and supporting the ACM, and interviewed for adherence during site visits.

G) MEMBER EXPERIENCE: ACMs engage in powerful service experiences at both the national and local levels. The CHC Leadership Academy engages over 90 ACMs to create develop program specific

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national service day activities and service projects. These ACMs receive NACHC-led trainings in organizing community events and garnering media support. NACHC also coordinates a video testimonials project for ACMs to share their experiences. ACMs will continue to be surveyed annually to learn about their experience, satisfaction, and to solicit feedback.

At the local level, team meetings provide for reflection, service projects, and connections with the AC identity. ACMs participate in state commission events, trainings, and days of service, including MLK Day and National AmeriCorps Week. Several local highlights include: (1) For AmeriCorps Week 2012 the teams in San Francisco and Berkeley, CA partnered on a community garden build in Oakland; (2) ACMs in WA from Seattle and Yakima Valley participated in the State AC Launch and received disaster preparedness training; and (3) At Cherry Street Health Services' in MI, the CHC team was a finalist in the Governor's Service Awards for Outstanding National Service Program.

Working with sites in CA, CO, CT, MO, and TX, CHC demonstrated local impact during last year's AC Week and how it has helped individuals attain employment in FQHCs post-service. Sites gathered traditional and social media and engaged guests such as U.S. Rep. Jim Himes (CT-4), Bridgeport, CT Mayor Bill Finch, Bruce Cline (CNCS CO State Director), Toya Nelson (then Executive Director of Serve Colorado), and Matt Hess (Executive Director of World Hunger Relief, Inc.).

H) VOLUNTEER GENERATION: From Aug, 2010-Dec, 2012, CHC leveraged 17,163 volunteers, including baby boomers (2,453), college students (4,638) and disadvantaged children and youth (3,478). ACMs will mobilize and support volunteers to meet community needs such as arranging transportation to medical appointments for older adults to maintain their independence; conducting home readiness assessments for the disabled; and organizing health fairs.

ACMs will be trained on how to recruit, manage, and support community volunteers. Emphasis will be placed on recruiting veterans and military family members as volunteers to support ACMs service. ACMs will reach out to existing volunteers in all sites; develop position descriptions, and culturally competent and linguistically appropriate marketing materials as needed; and provide volunteer orientation, including coverage of prohibited activities and projects (e.g., political advocacy campaigns). Local site success stories on volunteer generation include: (1) In Waco, TX, CHC generated over 2,500 non-AC volunteer hours through expanded recruitment and strengthened relationships with local schools; (2) In Connecticut, ACMs collaborate with the Collegiate Health Service Corps (former Learn&Serve grantee) to gain access to additional college level volunteers; and (3) At Lutheran Family Health Centers in Brooklyn, NY 257 non-AC volunteers contributed 2,488 hours representing a diverse pool of volunteers, including baby boomers and retirees.

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I) ORGANIZATIONAL COMMITMENT TO AC IDENTIFICATION: CHC brands national service and displays the AC logo on all materials including the website (www.communityhealthcorps.org), social media pages, documents, calendars, uniforms and other ACM gear. Agreements with sites require that the AC logo be displayed at all service locations. All sites receive a banner at the beginning of the program year that displays the AC logo. NACHC staff monitor for AC branding during member interviews and while on site visits throughout the program year.

Organizational Capability

A) ORGANIZATIONAL BACKGROUND AND STAFFING: FQHCs serve 22 million people annually at more than 7,000 sites located throughout all 50 states and U.S. territories. FQHCs depend in large part on public financial assistance, need a unified voice, and common source for research, information, training and advocacy. To address these needs NACHC organized as a 501c3 non-profit in 1971. NACHC's mission is to enhance and expand access to quality, community-responsive health care for America's medically underserved and uninsured.

Founded in 1995 by NACHC, the Community HealthCorps has become the nation's largest health-focused AmeriCorps program. Its mission "promotes health care for America's underserved, while developing tomorrow's health care workforce". NACHC has previously been funded for Promise Fellows, Hurricane Katrina Recovery, VISTA (CA and NY), and Homeland Security programs through CNCS and four state-commission funded projects. In 2010 NACHC successfully combined its state commission & national direct grant into one fixed amount grant. State commissions continue to express support for CHC, some noting it may be the only health-focused AmeriCorps program.

CHC organizational structure supports the needs of ACMs and sites. Jason Patnosh, Associate Vice President, is the National Director and brings over 12 years' experience in health care and national service. Mr. Patnosh has provided numerous trainings at CNCS-sponsored meetings, has helped develop new staff at AC programs with consultation from CNCS, provides strategic direction for the program and is the chief advocate for its continued smart growth and effectiveness. Gerrard Jolly, National Deputy Director, has been with CHC for five years and ensures the implementation of CHC's goals and objectives. Mr. Jolly previously worked with the National Park Service and additionally staffs the Affinity Group for Healthy Futures programs across AmeriCorps. Pamela Ferguson, Director of Program Site Leadership provides oversight for program monitoring, training and technical assistance (T/TA), and has been part of the CHC for nearly 15 years - first as an ACM, then a PC, and finally joining the NACHC staff in 2003. The Program Site Leadership team is comprised of the Director, Senior Program Officer April Holloway, who chairs CHC's training workgroup (7 years with

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CHC); and three Program Officers: Rachelle Richards, (5 years with CHC) and AC Alum (CHC); Anastasia Romanova, (1.5 years with CHC) and AC alum (City Year); and Bethany Hamilton, JD, (1 year with CHC) and AC Alum (Equal Justice Works). This team serves as the primary points of contact for sites, and provides support, monitoring and T/TA that is designed to prevent the arising of potential issues. The online Help Desk, a mechanism for staff to respond to questions from sites and is repository of searchable self-help information, has also grown as a T/TA enhancement. CHC requires all PCs to attend a monthly mandatory national call, as well as a monthly call with their individual Program Officer. These calls are opportunities to provide regular policy updates, answer questions, and share best practices.

Additional staff support member development, data, communications, and grants management functions. Randy George has been with CHC for the past eight years and is currently the Director of Member Engagement managing ACM development. Mr. George previously worked at City Year and Experience Corps, in addition is an AC alum. Gina Smallwood, Manager of Grants Administration (3 years with CHC) is responsible for fiscal management of grant funds. Ms. Smallwood has decades of experience as an accountant and continues to provide financial orientation and T/TA to staff at the national and local levels. Lesley Rohrbaugh serves as CHC's Data/Communications Officer (3 years with CHC) with responsibility for capturing and converting data to achieve the maximum benefits of communications and social networking. Finally, James Merrick serves as Program Associate (1 year) providing overall departmental support and managing CHC's weekly e-newsletter, "The HealthCorps Connection," to all sites.

This proposal calls for one additional Program Officer to provide capacity for monitoring and T/TA for the 106 ACMs expansion and one Training Officer to take the lead in research, development and coordination of trainings, especially in the new priority focus areas. Additionally, CHC will utilize outside consultants, within the federally approved daily rates, to guide survey tools development, training in use of tools, analysis of data & evaluation.

NACHC worked with an external evaluator, Cedarloch Research LLC, for the preparation of the evaluation that has been submitted with this proposal. Staff provided oversight and direction for the evaluation and helped developed the questions to be considered by the evaluation, and managed the request for proposals process to secure the external evaluator. Additionally, current CHC staff have developed or been part of the development of three external evaluations (from research companies, independent contractors, and a university) over the past decade.

In addition to the federal funding from CNCS, NACHC receives funding from the federal Bureau

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for Primary Health Care (BPHC), other federal agencies (CDC, National Park Service), membership dues, foundations and corporations such as the Robert Wood Johnson Foundation, Covidien, Kaiser Permanente and Pfizer. NACHC has managed funding for the past 19 years (\$7 million in 2009-10 from BPHC) to provide information and T/TA to FQHCs and PCAs.

The roots of NACHC's leadership go deep in the FQHC movement and the CHC sits within the Office of the President. NACHC's Chief Executive Officer Tom VanCoverden has been with the association for over 35 years and is seen as a champion for the medically underserved. David Taylor, NACHC's Chief Operating Officer, oversees the day-to-day operations of the organization and the CHC is well integrated and supported within the Office of the President under his leadership. Finally, NACHC's financial staff, led by Senior Vice President of Operations/CFO, Mary Hawbecker - a CPA with over 20 years of federal grant financial management experience - provides fiscal and administrative oversight to all departments including CHC.

NACHC's Board of Directors oversees the association and is currently chaired by Mr. Kauila Clark, Chair of the Board of Directors of Waianae Coast Comprehensive Health Center (Kapolei, HI). For 10 years, Mr. Clark was President/CEO of West Oahu Employment Corporation and is seen as a national expert on native Hawaiian cultural health care traditions and has advised the National Institutes of Health. The incoming chair, Dr. Gary Wilcz, CEO of Teche Action Clinic in Louisiana has been a champion of clinical workforce development in FQHCs.

CHC's Steering Committee meets twice a year and oversees the operation, design, development and policies of the program. The Committee is representative of leadership from CHC sites across the country. The chair, Allison Dubois-Adach, COO of Hudson River HealthCare (Peekskill, NY), served as a VISTA and an ACM over 10 years ago at the same FQHC. The vice-chair, Allen Patterson, COO/CFO at Heart of Texas CHC in Waco champions the program locally with the public health department and Baylor University.

As a current AC grantee, NACHC is confident in its leadership over the CHC based on longevity as a grantee with a strong record of compliance and responsiveness. NACHC understands its responsibility to manage federal funds and takes very seriously the trust that has been placed to steward federal funds in a way that maximizes community impact and minimizes waste. CHC has been asked to demonstrate its compliance and training materials/principles with other programs at AC Grantee meetings regularly. When information is requested, such as citizenship verifications or position descriptions, CHC has submitted the materials in a timely and substantive manner.

B) SUSTAINABILITY: By enrolling patients in FQHC services, social services, and generating more

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non-AC volunteers, CHC builds capacity for community health improvement and sustainability for FQHCs. Developing impactful program activities for ACMs allow FQHCs to better distribute their resources to ensure there is not a duplication of activities among FQHCs staff by ACMs. Also, ACMs target new populations not previously served by the FQHC and assist previously uninsured patients to access health insurance. This helps to create more sustainable revenue streams (i.e., move uninsured patients to insured logs) for FQHCs and allows them to provide additional community services. As programs have matured over the years, roles that ACMs once did grew into paid staff roles at the FQHCs (case management and outreach) allowing CHC sites to take on new initiatives.

Sites have invested substantial resources, including but not limited to 40-50% matching funds, in-kind contributions, and leadership. Additionally, NACHC contributes in-kind support for conferences, meetings, and leadership supervision for the CHC.

Finally, CHC will continue nationwide replication through a variety of strategies: (1) Grow the CHC brand through an affiliate model that "leases" the brand to programs that adopt the model and share common performance measures. This currently exists with primary care association led projects in MI, NY, UT, and WI with programs funded through state commissions directly to the agency; (2) Relationships with state commissions also help to build an understanding of how FQHCs can contribute to their state service planning efforts to address the health care needs of their residents; and (3) NACHC remains committed to diversifying its funding at the national level and plans to pilot a corporate sponsorship model, ideally leading to the reduction of the federal share in grant awards, while maintaining a strong program.

c) COMPLIANCE AND ACCOUNTABILITY: NACHC uses an automated accounting system and federal cost principles. Receipt and disbursement of funds are tracked by grant and funding source. Time and activity records are maintained by funding source and project. There are established policies for salary scales, fringe benefits, travel reimbursement and personnel. Internal accounting controls comply with Generally Accepted Accounting Principles, including providing appropriate documentation for cash and in-kind matching funds. Prior to each program year, CHC sites submit their most recent A-133 Audit in compliance with the AC Provisions and as part of their contract with NACHC. If findings have been identified at site levels NACHC has moved quickly to ensure the site has taken all necessary corrective actions. Independent audits have found NACHCs financial systems and procedures to be in accordance with the principles set forth by the American Institute of Certified Public Accountants.

CHC will monitor activity to ensure sites comply with AC policies, including, but not limited to,

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prohibited activities. At trainings throughout the year, PCs review prohibited activities with site supervisors, ACMs, and mobilized volunteers. CHC carefully monitors ACM understanding and compliance through site visits, interviews, the CHC "Hotline" (a daily-monitored voicemail that provide confidential/anonymous information to NACHC staff), and frequent contact with sites, site supervisors and ACMs. Additionally, CHC staff update enrollments, exits and other monitoring-related measures almost daily by comparing the OnCorps (CHC's database) record to that of e-Grants. When issues are detected, staff meets regularly to discuss and refine appropriate corrective actions and develop further preventive measures. The CHC Director of Program Site Leadership monitors overall site progress related to these and other site monitoring activities. CHC uses its risk assessment form to assess site risk and includes questions on staff changes, multi-site placements, enrollment and retention, responsiveness, and financial reporting. The risk assessment is conducted by the Grants Administration Manager, who is not part of the daily monitoring, which creates a system of checks and balances on the program and CHC staff. As a current AC grantee, CHC demonstrated program compliance and delivered high levels of recruitment and retention of ACMs as follows:

DEMONSTRATED COMPLIANCE -- Through monitoring, CHC founder there to be insufficient timeliness in completing and approving member timesheets expediently. CHC issued guidance on the review and approval process, requiring all parties approve each timesheet by specific dates each month. NACHC reviews timesheets at the beginning of the year to lay the foundation for accurate and timely submissions, and check for adherence when completing quarterly reimbursements to the sites.

ENROLLMENT -- CHC's enrollment rate for program year 2011-12 was 102%. All 469 full time slots were filled and operating sites were able to refill 12 slots. CHC attributes this success to the hard work of staff and also the apparent increase in demand, nationally, to participate in CHC (application to slot ratio was 17:1).

RETENTION - The retention rate for the 2011-12 program year improved from the previous program year for a retention rate of 86% based on positions (93% based on hours served, an important distinction for fixed amount funded programs) -- a 4% increase over the previous year. Three sites had significantly lower retention rates which impacted the program's overall percentage. One site could not continue as a site in 2012-13 and another had a change in PC mid-year that appears to have affected their retention rate. The remaining site with retention challenges had several ACMs exit for financial hardship. Because CHC seeks a balance of local and national candidates and has a significant number of ACMs who come from economically disadvantaged communities, CHC acknowledge that some ACMs may have greater difficulty maintaining their commitment to serve if higher paying

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opportunities present themselves during the term. CHC supports all sites in their determination to retain ACMs by offering ongoing training support, projects to keep them engaged and opportunities for sharing best practices with other sites.

As a multi-state program, NACHC consults with each state where CHC proposes to host a program selected from a national competition for operating sites to be included.

STATE CONSULTATIONS - NACHC consulted with State Commissions (SC) in all states where it places ACMs by submitting and completing the form identified by the SC. After notification of award, NACHC will update each SC on sites that have been funded before the AC Grantee Meeting as has been our practice.

SITE SELECTION - Proposed sites submitted an application to CHC in response to a Request for Proposal (RFP) offered to all FQHCs nationwide. Application review panels, comprised of NACHC staff and outside non-profit professionals, assessed the merits of proposed program plans utilizing a standardized scoring system. Each applicant received an average score as compiled from those of individual panelists. Staff met to decide which sites to include in the application and partners were selected based on explicit criteria detailed below and organizational priorities ranging from recruitment of traditionally underrepresented populations to selection of NACHC-developed ACM activity summaries.

The following criteria ensure that the site selection process incorporated quality, innovation, sustainability, leadership, past performance, community involvement, and program activities that support distressed communities: (1) The source of matching funds had to be adequate and sustainable; and the A-133 audit had to be clear of any findings that may lead to concerns of internal controls or stability of a site; (2) The narrative had to be high quality, address the questions posed by NACHC, indicate innovative ways to meeting the program goals and performance measures, and demonstrate the organizational capability to achieve the expected impact of CHC on the community beyond what the FQHC currently provides filling gaps in service; (3) ACM activities had to be evidenced-based/informed approaches to meeting the identified need of the target communities. ACM roles also were not to be duplicative, supplanting or displacing of staff or volunteers and had to ensure that AC prohibited activities would be understood as unallowable from the moment of design and through implementation; (4) Community involvement, leadership and partnerships had to be clearly demonstrated and sustainable over the life of program; (5) Existing sites had to demonstrate low to moderate status in the previous year's risk assessment to receive any expansion of their program. Sites marked as higher risk had to have demonstrated significant progress towards achieving a low to

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moderate risk status since the assessment was conducted; and (6) Strong recruitment/retention over the last three program years.

The operating sites are as follows (by state): CA-LifeLong Medical Care (Berkeley), Community Clinic Association of LA County (Los Angeles), AltaMed Health Services (Los Angeles), Central Valley Health Network (Sacramento/Fresno), San Francisco Community Clinic Consortium (San Francisco), Redwood Community Health Coalition (Sonoma), Alliance for Rural Community Health (Ukiah), Family Health Center Network (Visalia) / CO-Metro Community Provider Network (Englewood), Salud Family Health Center (Ft. Lupton) / CT-Connecticut Association of Community Health Centers (statewide), Community Health Center, Inc (Meriden) / DC-DC Primary Care Association / HI-Hawaii Primary Care Association-United Healthcare (statewide) / ID-Institute for Rural Health, ISU (Pocatello) / LA-Louisiana Primary Health Care Association (statewide) / ME-Penobscot Community Health Center (Bangor) / MD-Community Health Integrated Partnership (statewide) / MA-MA League of Community Health Centers (statewide), East Boston Neighborhood Health Center, Boston Health Care for the Homeless / MI-Cherry Street Health Center (Grand Rapids) / MO-Grace Hill Neighborhood Health Center (St. Louis) / NJ -- Camden Coalition of Health Care Providers, Zufall Community Health Center (Dover) / NY-Lutheran Family Health Care (Brooklyn), Ryan-Chelsea Clinton Health Center (NYC), Institute for Family Health (NYC), Open Door Family Medical Center (Ossining), Hudson River Health Care (Peekskill), Syracuse Community Health Center / OH-OH Association of Community Health Centers (statewide) / PA-Hamilton Community Health Center (Harrisburg) / TX-Brownsville Community Health Center, Heart of TX Community Health Center (Waco) / WA-SeaMar Community Health Center (Seattle), Yakima Valley Farmworkers Clinic (Toppenish) / WI-16th Street Community Health Center (Milwaukee).

Across the identified operating sites there are nearly 265 proposed service sites, too many to list due to page restrictions but is available upon request. Additionally, if there are any changes to sites between the time of submission and start, NACHC implements the abovementioned processes prior to launching a new site.

SPECIAL CIRCUMSTANCES: All communities served by FQHCs and CHC sites are federally designated as medically underserved areas (MUAs) and health provider shortage areas (HPSAs), and in many cases also carry other federal designations indicating impoverished areas.

Budget/Cost Effectiveness

a) COST EFFECTIVENESS: NACHC's request is cost effective and reduces the federal cost per MSY from \$13,000 to \$12,750/MSY. Numerous studies conclude that FQHCs' proficient provision of

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preventive and primary care services reduces unnecessary, avoidable, and wasteful use of health resources. FQHCs are associated with reducing preventable hospitalizations and ER use, as well as reducing the need for more expensive specialty care services (The Effect of Community Health Centers on Healthcare Spending & Utilization. Streeter, S. et al, 2009). Greater FQHC capacity has been demonstrated to lower ER utilization among low-income and rural uninsured populations, and rural counties with higher FQHC capacity also have lower rates of ER visits for those conditions that could have been avoided through timely outpatient care (What Accounts for Differences in the Use of Hospital ERs Across U.S. Communities? Health Affairs, Cunningham, P., 2006 and Presence of a FQHC and Uninsured ER Visit Rates in Rural Counties. Journal of Rural Health, Rust, G. et al. 2009). Medicaid beneficiaries relying on health centers for usual care in four states are 19% less likely to use the ER for unnecessary visits and 11% less likely to be hospitalized compared to beneficiaries relying on other providers (Comparative Effectiveness of Health Centers as Regular Source of Care. Journal of Ambulatory Care Management, Falik, M. et al. 2006).

Health centers have a long history participating in a chronic care management program known as the Health Disparities Collaboratives, which have been shown to significantly reduce the expected lifetime incidence of diabetes complications, including blindness, kidney failure, and certain forms of heart disease, yielding a sizeable savings in health expenditures (\$33,386 per quality-adjusted life year) (The Cost-Effectiveness of Improving Diabetes Care in U.S. Federally Qualified Community Health Centers. Health Services Resources, Huang. E. et al. 2007).

The CHC builds upon the success of its sites to provide sustainability of the program with decreased reliance on federal support. Sites depend on revenues from health care services provided by the FQHC, foundation support, and others. The CHC maintains an increased level of support beginning at 40% of total program costs and in most cases, this amount exceeds 50%. The total program costs are estimated at \$14M (federal funds represent 50% of the program budget).

NACHC proposes deeper impact while requesting a decrease in Federal funds. Direct insight from the beneficiaries of ACMs service, and the ability to consider and act on these insights, are expected to help to strengthen program focus and impact and to increase support for AC in healthcare settings.

b) BUDGET ADEQUACY: The budget effectively meets the needs of the program while preparing for increased program efficiency, enhanced training of ACMs, and continued monitoring of program operations to ensure adherence to AC rules and regulations. The costs of National Service Criminal History Checks (inclusive of FBI checks) are fully accounted for and monitoring procedures are in place to ensure that vulnerable populations are protected from potential predators. NACHC's ability to

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develop new projects over the lifetime of the CHC is a sign of sustainability and innovation. As described, the addition of the potential new operating sites, along with increased commitment to the use of national service to solve community problems by existing sub-grantees will grow the number of ACMs serving through the program by over 20%, while lowering the federal request per member from past years. Launching new sites with a strong understanding of AmeriCorps guidelines, the mission and goals of the CHC and the forward thinking development of tomorrow's health care leaders continues to be a cornerstone of the program.

CHC teams are located in resource-poor communities, across rural and/or urban environments that struggle with disparate rates of poverty, unemployment, homelessness, and/or lack of access to health care services. The FQHCs and the communities need support from AC programs like CHC now more than ever before to identify the underserved, enroll individuals in health insurance, newly established health insurance marketplaces, and FQHC support programs, and provide comprehensive culturally competent health & financial education to increase knowledge and self-sufficiency, eliminate disparities in health and assist patients to make better informed health care choices.

Evaluation Summary or Plan

Evaluation - Attached

Amendment Justification

N/A

Clarification Summary

N/A

Continuation Changes

N/A