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Executive Summary

The National Health Corps (NHC) is a network of five operating sites (Chicago, North Florida, Philadelphia, Atlanta and Pittsburgh) with 94 current members whose mission is to increase access to and utilization of health care services for medically underserved communities; to improve the health and wellness of communities; and to foster member interest in health careers. NHC member activities are targeted towards economically disadvantaged and medically underserved individuals and communities. Members will serve in Community and School-Based Health Centers, Free Clinics, Public Health Departments and non-profit public health organizations where they will: enroll consumers in health insurance and free medication programs; recruit patients with chronic diseases for disease self-management programs; provide patient navigation services for vulnerable patients; and educate residents on health topics. This project falls under the Healthy Futures focus area. The CNCS investment of \$1.275 million will be matched with \$1.1 million in local contributions.

Rationale and Approach

Need: The National Health Corps (NHC) is a network of five operating sites whose mission is to increase access to and utilization of health care services for medically underserved communities and to improve the health and wellness of the communities we serve. NHC member activities are targeted towards economically disadvantaged and medically underserved individuals because the burden of death and illness associated with chronic disease falls disproportionately on low-income, racial and ethnic minority populations. Chronic diseases are the leading causes of death and disability in the US. Seven out of ten deaths among Americans each year are from chronic diseases and almost one out of every two adults has at least one chronic disease (CDC, 2012). Nationally, the prevalence of diabetes in blacks is approximately 70% higher than whites and the prevalence in Hispanics is nearly double that of whites. Blacks have a cancer death rate about 35% higher than that for whites (CDC, 2012) and are much more likely to die of heart disease and stroke than whites (CDC Health Disparities and Inequalities Report, 2011). Thirteen percent of black children have asthma, compared to 8% of white and 8% of Hispanic children (EPA, 2008).

NHC sites operate in cities/counties with large low-income and minority populations that are disproportionately impacted by disease. According to 2011 US Census Bureau data, poverty rates in these regions are above the national average of 14.3% (Chicago 21.4%, Philadelphia 25%, Atlanta 23%, Duval County 15%, Pittsburgh 22%). In Chicago, heart disease mortality for blacks is 24.3% higher than that for whites (Sinai Urban Health Institute, 2009). The rate of heart disease in Duval County,

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Florida's poorest zip codes is 64.7% higher than in the most affluent areas (Health: Place Matters, 2008). In Philadelphia, 43.7% of black residents have been diagnosed with hypertension compared to 32.4% of whites, and 17.2% of black residents have diabetes compared to 11.1% of whites (PHMC 2010). Black residents in Pittsburgh experience higher rates of hypertension (42%) than whites (33%) (Allegheny County Health Survey, 2009-2010).

There are many reasons that low-income and minority populations are at higher risk of developing and dying from chronic conditions. Among them are barriers that keep people from being aware of, enrolling in, accessing, appropriately utilizing, and successfully navigating healthcare programs. The uninsured are less likely to receive preventive care and are more likely to be hospitalized for conditions that could have been prevented. Nationwide, about two-thirds of the uninsured are poor or near poor and approximately one-third (33%) of Hispanics and 21% of African-Americans are uninsured, compared to 13% of whites (Kaiser, *The Uninsured: A Primer*, 2009).

As critical as health insurance is to health care access, there are currently 4.4 million adults and almost 3 million children who are eligible for Medicaid, but are not enrolled (US Interagency Counsel on the Homeless, 2012). A survey of families with eligible but un-enrolled children found that almost 50% of respondents did not think their child was eligible for CHIP, did not know how to enroll them, or thought the enrollment process was too difficult (Kenny G, 2009). Although additional options for insurance may become available for some people under the Affordable Care Act (via states that expand their eligibility for Medicaid and through Health Insurance Exchanges), the rules for eligibility, enrollment and essential benefits will be variable state to state and complex for many people to navigate, especially those who are newly eligible and inexperienced with the public benefits enrollment process. Cost is a barrier to health care for many low-income people, even those with insurance. Studies have shown that many low-income, chronically ill patients take less of their medication than prescribed owing to cost concerns (AJPH, 2004, Piette, Heisler). Pharmaceutical Manufacturer Assistance Programs (PMAPs) offer free prescription medications to many patients; however, the enrollment process for PMAPs is complex and cumbersome and often requires multiple reenrollments.

Access to health care services does not necessarily translate into appropriate and timely utilization of these services. Many people who are at risk for or who have chronic diseases do not seek out timely

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preventive or primary care and wait until they are sick. People who have a regular doctor are more likely to receive preventive care and are more likely to adhere to physicians' treatment regimens, allowing health problems to be identified early and treated before costly hospital admissions become necessary (AHRA, National Healthcare Disparities Report, 2009). Yet, according to a Commonwealth Fund survey, only 68% of respondents with incomes under the federal poverty level had a regular source of care compared with 86% of those with incomes at 400% of poverty or higher (The Commonwealth Fund, 2012).

All of these factors are compounded for people who have multiple, complex chronic disease that require medical and social services from a variety of providers. Competing priorities related to basic needs of survival (e.g., food, housing, and employment), inconsistent access to a telephone, lack of transportation, cultural barriers and issues of trust for racial and ethnic minorities, and language barriers can all contribute to difficulty accessing and utilizing health services (AHRQ, 2012).

AmeriCorps Members as Highly Effective means to Solve Community Problems: The NHC is requesting 100 full-time member slots. Members will be assigned to operating sites and, in turn to local host sites that include: Community and School-Based Health Centers, Free Clinics, Public Health Departments and non-profit community-based public health organizations. These host sites are selected by operating sites and have as their core missions and expertise the provision of health care and public health services to the NHC's target communities. These public and non-profit organizations are experiencing increasing challenges due to budgetary constraints coupled with new demands for expansion and transformation of delivery systems and new strategies to strengthen patient and consumer engagement. NHC members engage in activities that would not otherwise be possible due to lack of adequate funding, staffing and resources at their host sites, which must confront the ever-increasing community need. NHC members will help host sites expand their capacity to provide outreach, enrollment, navigation, care management and health education services to support access to and effective use of preventive and health management services by underserved populations.

NHC members serving at safety-net providers and community-based organizations will conduct outreach and provide direct support to community residents who are uninsured or underinsured but eligible for public benefits, including those who become newly eligible through the Affordable Care

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Act. Members will facilitate the complex process of eligibility determination, initial application, enrollment and/or recertification. NHC members will assist 500 people in understanding and navigating the steps to enrollment in appropriate insurance programs.

Members will engage and enroll 400 patients in disease self-management programs. Members will identify health center patients with specific diagnoses (e.g., diabetes, asthma), reach out to those patients through recruitment phone calls and letters and enroll them into these programs. Members will also make reminder calls for patients to attend group education sessions; conduct BMI, blood pressure and blood glucose screenings; teach health education classes following accepted curricula; and follow up with participating patients to help determine and encourage their progress with personal self-management goals.

To support patients in achieving chronic care management goals, members will assist indigent patients with enrollment in free medication programs. Members will inform patients of eligibility requirements, assist them in completing the required paperwork, and advocate with the pharmaceutical companies on their behalf. Members will enroll 3,000 new patients as well as assist existing patients with refills and recertification.

In order to strengthen care coordination and appropriate use of healthcare services by vulnerable patients, especially those who have difficulty navigating the healthcare system, such as the homeless and those who do not speak English, members will help patients make appointments for primary/specialty care and following up to ensure patients attend their appointments. Specific activities will include making phone call as reminders and to identify and resolve any barriers to adherence; e.g., arranging interpreter services for patients with limited English proficiency or helping to coordinate transportation.

In an effort to support access to prevention and early intervention, members will connect 500 youth and adults to preventive and primary care. Activities will include enrolling students in school-based health centers; conducting outreach to parents whose students do not have the immunizations and annual physicals required by schools; and coordinating the collection of consent forms and scheduling students for dental and vision screenings. Members will assist adults in accessing free cancer screenings to support early detection.

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Members will target youth for health education initiatives to help prevent and reduce their risk for developing chronic diseases such as diabetes and hypertension. Health education efforts will focus primarily on increasing children's knowledge of nutrition and strategies for healthy eating, engaging them in exercise and physical fitness, and educating youth on how to manage their asthma. These efforts will target both those at risk and those with chronic disease and use group health education, cooking demonstrations, and after school running and exercise clubs as ways of attracting and engaging youth in community and afterschool settings. NHC members will also provide health education to community residents on a variety of topics.

Finally, to further expand service capacity and community engagement, NHC members will engage Americans in service. Members will recruit and train 1,200 non-member volunteers to assist with access to care and health education services at their host sites and through local community organizations.

Evidence-Based/Evidence-Informed & Measurable Community Impact: Based on the NHC's theory of change, we expect to demonstrate the following overall impacts by the end of the 3-year grant cycle: increased ability of uninsured/underinsured patients to access health care; increased utilization of appropriate and timely preventive, primary and specialty health care by residents of participating communities; increased patient and consumer knowledge of healthy behaviors, self-efficacy and engagement in their own wellness; and, ultimately, contribution to the improvement of health outcomes for individuals and communities. The evidence supporting the NHC's proposed interventions is a combination of past implementation experience and successes as measured by NHC performance measure data; the results of the NHC 2010-2012 independent program evaluation; and scientific literature demonstrating that similar interventions have been shown to be both feasible and effective in achieving the proposed outcomes.

National healthcare reform trends, evidence-based practices that foster patient-centered health care services, and published evaluation findings provide support for the member activities and outcomes (e.g. Theory of Change) proposed by NHC. For example, a 2011 report from California Coverage and Health Initiatives compiled current research on best practices in outreach to support implementation of the Affordable Care Act. The report found that the most effective strategies to get people insured

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and connected to care were those utilizing person-to-person outreach and enrollment via partnerships with public health and health care organizations. These findings mirror NHC's approach of utilizing members, placed at safety-net providers and community-based public health organizations, to carry out individual outreach, education and enrollment support for Medicaid/CHIP. The NHC has also demonstrated the effectiveness of this intervention; in the last two program years NHC members have enrolled 1,292 people in health insurance; and, as a result, 732 of these patients then utilized health care services at host sites.

Studies have shown that patient-level interventions, including those directed at improved self-management (such as medication adherence, diet, exercise, self-monitoring, and appropriate use of health care services), are effective at improving the health outcomes of low-income patients with chronic diseases (Glazier R, *Diabetes Care*, 2006). NHC members serving health centers and public health organizations have succeeded in engaging vulnerable patients in self-management programs. In the last two years, NHC members recruited 800 patients into self-management programs including patients with diabetes, HIV and high risk pregnancies.

To help low-income patients manage their chronic diseases, pharmaceutical companies offer free prescription medication to some patients who cannot afford them. A 2005 study of patients found that after being enrolled in PMAPs, diabetic patients received more medications and their LDL cholesterol levels and blood sugar (A1C) values decreased significantly (Strum MW, Hopkins R, *Am J Health Syst Pharm*, 2005). Patient enrollment and maintenance in PMAPs is labor intensive and, as a result, these programs are often underutilized. A 2007 study showed that the cost of enrolling patients in PMAPs incurred by safety-net providers is significant, ranging from \$10.42 to \$46.30 per medication. Staff time accounted for half or more of the total cost per application (Clay P, *Mang Care Pharm*, 2007). Since 2008, NHC members have been assisting patients with enrollments, refills and annual re-certifications in PMAPs through their health center host sites. NHC members have helped 20,962 patients gain access to free medications thereby saving patients and safety-net providers \$19 million in direct medication costs. This in turn impacts chronic care management outcomes, cost savings and cost effectiveness. In 2012, the Philadelphia Health Corps was awarded a CNCS Community Impact Award for this innovative program.

The NHC has adopted evidence informed practices, as outlines above, that will have the following

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demonstrable impact each program year: NHC members will enroll 500 consumers in health insurance (Medicaid/CHIP/Health Exchange) and 3,000 in PMAPs. As a result, 2,100 of these consumers will report that their ability to access health care services and medications has increased. NHC members will enroll 300 patients in disease self-management programs and 180 will self-report an increase in their ability to manage their chronic condition. Members will help 1,200 patients make appointments for primary/specialty care and following up to ensure patients attend their appointments. To support access to prevention and early intervention, members will connect 500 youth and adults to preventive and primary care services including free dental and vision services. Members will also target youth for health education initiatives to help prevent and reduce their risk for developing chronic diseases such as diabetes and hypertension. 4,500 students will participate in nutrition education and physical activities in order to help reduce their risk for developing chronic diseases. Members will recruit and train 1,200 non-member volunteers to assist with access to care and health education services at their host sites and through local community organizations.

The NHC will measure the above impacts through a combination of member reported performance measure data, patient/consumer surveys, host site quarterly reports, and an independent program evaluation. Members will continue to track and report on the number of people benefiting from the program. The NHC currently has systems in place to track, collect, aggregate and report on performance measure data an ongoing basis. NHC performance measure targets are established through consultations with host site supervisors and program staff and informed by an ongoing analysis of performance measure data. In turn, each NHC member has a position description that includes individual target goals. Therefore, NHC performance measure targets are based on experience and realistic expectations of what our members and our programs can and will accomplish.

During the last two program years, the NHC has exceeded all of its performance measure goals. In those two years combined, NHC members provided 18,889 economically disadvantaged clients with information on health insurance, health care access and health benefits programs. 12,275 of those clients enrolled in these programs and 9,698 utilized preventative and primary health care services and programs as a result of being enrolled. Members taught health education classes to over 35,617 community residents, including disease management workshop to diabetics, hypertensive, and HIV positive patients. NHC members taught asthma management classes to 1,135 school-aged children,

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teaching children about the factors that trigger asthma, how to avoid those triggers and how to manage their asthma. To help combat childhood obesity, NHC members taught nutrition and fitness workshops to 11,196 children. Members screened and tested 17,216 community residents for diseases and connected youth to dental and vision screenings and immunizations.

Member Recruitment: NHC operating sites recruit members nationally and locally from the communities where members serve by utilizing the AmeriCorps recruitment database, NHC website, Idealist and Craigslist, NHC alumni and community outreach efforts with local universities and partner sites. The NHC's emphasis on promoting members' future careers in a health related field attracts a large pool of applicants, typically 800 applications a year.

The recruitment process includes a screening interview between the prospective member and operating site staff; an interview between the prospective member and host site supervisors; and a matching process that pairs candidates according to their background, interests and skills with the needs of the host sites. The active involvement of host site supervisors in the member interview and selection process helps ensure strong matches and ultimate retention of members. NHC programs have historically partnered with host sites to identify and refer candidates from the communities we serve. Programs also actively recruit new and first generation Americans as many of our host sites serve immigrant and refugee communities and look for members who have a linguistic and cultural connection to the populations being served. In the last grant cycle, the NHC expanded staff training to strengthen recruitment and work with members with disabilities; encouraged sites to participate in trainings through their State Commissions; revised recruitment materials; and developed new policies & procedures to ensure an inclusive Corps.

Member Training: NHC member orientation begins during the interview process when program staff provide prospective members with information on AmeriCorps and local service opportunities. Formal orientation takes place during a three-week Pre-Service Orientation (PSO) at the beginning of the term. Week one includes training on AmeriCorps 101 (e.g. contracts, member handbook, regulations, and AmeriCorps identity), prohibited activities, the NHC mission and citizenship. It also includes sessions on effective communication and cultural competency. Host site supervisors meet with members and review expectations and problem solving strategies. Members spend a week training at their host sites where supervisors introduce them to staff, discuss service activities, conduct

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a community tour, and initiate specific training necessary for member service activities. Week three includes sessions on local health care systems, effective health education techniques, curriculum development and classroom management; and community outreach, and patient confidentiality.

Members receive ongoing training from the program, host sites and outside partners throughout their term. Full day monthly member in-service trainings are based on a standardized set of NHC Core Competencies/Skills (Health Education, Patient/Client Relations, and Professional Development etc.). The program regularly assesses members' training needs through formal surveys and engages members in the development of training activities. Host sites are required to develop and deliver a site-specific training plan to their members. These plans are reviewed and updated during quarterly program site visits with members and supervisors to ensure member training needs are met. In addition to building specific competencies, members are given opportunities to meet and shadow health care providers to support members' interest in pursuing health related careers.

Members complete evaluations after every training and the NHC conducts member satisfaction surveys three-times a year as well as annual site visits to monitor, among other things, that members are receiving the training they need to support their service activities. Operating sites meet with host sites supervisors and members throughout the year to review and reinforce AmeriCorps regulations and prohibited activities and member timesheets and service activity logs are reviewed to ensure member activities are suitable. Any question about the allowability or appropriateness of a member's activities is carefully reviewed with the member and site supervisor and corrected, as needed.

Member Supervision: Supervising members is a shared responsibility between the Program Director and Host Site supervisors. NHC members have a designated supervisor at their host site. The supervisor is selected by the host organization and is typically a staff person with oversight of the specific program aligned with the members' service activities. Organizations complete a host site application and include details about the skills and qualifications of the designated supervisor and their plan for supervising and mentoring members. Program staff meet with new site supervisors to provide information on the program, AmeriCorps regulations and expectations of sites and site supervisors. Annual site supervisor training needs assessments are conducted in order to develop trainings for the mandatory quarterly site supervisor meetings. Program staff also provide one-on-one training and support to supervisors when needed.

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Site supervisors, with oversight from program staff, have an active and ongoing role in orienting, training, supporting, evaluating and mentoring members. Site supervisors are responsible for developing a member position description and reviewing, signing and monitoring their members' timesheet and service activity logs. They hold weekly meetings with members and are available on a daily basis to provide guidance and answer questions about member service activities. Supervisors conduct member evaluations and offer mentorship to members, particularly on future career/education plans.

In addition to the daily supervision provided by each host site supervisor, members receive supervision and support from operating site staff. Program directors review member timesheets, service activity logs and performance measure data bi-weekly to ensure that members are engaged in sufficient, meaningful and appropriate service activities. Time is allocated at all trainings and member meeting for members to reflect on successes and challenges at their sites. Program staff utilizes these check-in sessions as well as frequent ad hoc communications to assess members' satisfaction at their host sites. Formal site visits are conducted quarterly between the program director, member and host site supervisor. Site visits are used to identify and address member issues and ensure that members are receiving adequate supervision and support. The NHC surveys members throughout the year and conducts annual site visits to make sure they are receiving appropriate supervision, training and support.

Member Experience: The NHC provides members with several program components that lead to powerful service experiences and continued civic participation. Members serve the bulk of their 1700 hours of service at their host site where they provide comprehensive direct service linked to the NHC's proposed outcomes. In addition, members are encouraged to participate in outside service that is of special interest to them. Members plan and participate in a mid-year retreat that includes activities to promote reflection on their experiences and deepen ties to fellow Corps members. Facilitated reflection, built on the book *The Civically Engaged Reader*, is a regular part of monthly meetings and gives members the opportunity to connect their daily service to an ethic of service and civic engagement.

Operating sites foster a strong Esprit de Corps through various activities. Members serve on member

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committees (e.g. Professional Development, Communications, and Team Building/Peer Support), which helps to build leadership and cooperation. Members are encouraged to organize and participate in social events and group service projects, and to use social media tools such as Google Chat, Facebook and member blogs to connect with each other virtually. An End of Term Ceremony, planned collaboratively by members, supervisors and program staff, caps the service term and celebrates the program's as well as each member's accomplishment and successes.

NHC operating sites are engaged with other local AmeriCorps programs. NHC members serve alongside other AmeriCorps members on National Days of Service and connect at events sponsored by State Commissions. Members also participate in citywide National AmeriCorps Week events to highlighting the impact of AmeriCorps in the regions we serve.

The NHC ensures members proudly display their AmeriCorps identity. During PSO, program staff presents "AmeriCorps Identity," a presentation designed to help members understand the unique role of an AmeriCorps member, AmeriCorps "lingo," and identity requirements. Members participate in an exercise on developing a thirty-second speech to introduce themselves to host site staff and the general public as AmeriCorps and NHC members. Members receive AmeriCorps gear and are required to display the AmeriCorps logo while serving. Program staff monitors members' compliance with identity requirements at host site visits and at group events.

Volunteer Generation: Non-Member Volunteers (NMV) are an integral part of sustaining community-based programs and all NHC members are responsible for recruiting them. At some host sites, members recruit, orient and support volunteers as their primary service focus. NHC members receive training on volunteer recruitment and management strategies during PSO and conduct presentations and develop relationships with community organizations and local universities to recruit a broad range of NMVs. Members orient NMVs, explain prohibited activities, lead and/or help to organize volunteer activities, and track the number of volunteers recruited. NHC members recruit volunteers to provide street outreach to homeless individuals to provide child care services to parents who are participating in disease self-management workshops; and to coach children in after-school sports activities. Over the last two program years, NHC members recruited & supported 3,038 NMVs who volunteers a total of 25,102 hours.

Organizational Commitment to AmeriCorps Identification: The NHC will continue to proudly brand

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itself as an AmeriCorps program. The AmeriCorps logo is prominently displayed on our website, FaceBook pages and program blogs, forms, handbooks and all publicity and recruitment materials. Member uniforms all bear the AmeriCorps logo and host sites are required to display the AmeriCorps logo where members serve. Program staff will continue to include AmeriCorps on letterhead and email signatures and will train host site supervisors on AmeriCorps identification and language. NHC members are required to identify themselves as an AmeriCorps member in their host site emails and voicemails, as well as wear the appropriate AmeriCorps gear daily. The NHC regularly reviews operating site social media and outreach materials to ensure that the AmeriCorps logo is prominently displayed and conducts annual site visits to host sites to ensure that the AmeriCorps logo is displayed where members serve.

Organizational Capability

Organizational Background & Staffing: The mission of the NHC is to increase access to and utilization of health care services for medically underserved communities, to promote community health and wellness, and to develop new health professionals. Created in 1994, the NHC has operated for 18 years and has the experience and track record necessary to operate and oversee a multi-site AmeriCorps program. The Health Federation of Philadelphia (HFP) has 30 years of experience developing and overseeing large-scale initiatives involving multiple partners and networks of public and private organizations. Currently, HFP administers \$19 million in grants and contracts, including several federal grants such as Early Head Start, a Department of Justice Safe Start grant and a DHHS Health Information Technology grant. A Board of Directors comprised of member organization CEOs oversees HFP and has overall fiduciary responsibility. Several HFP board members have NHC members serving at their organizations and therefore have a direct investment in successful program implementation.

HFP Executive Director, Natalie Levkovich, will provide programmatic and fiscal oversight of the NHC. She has nearly 30 years of experience guiding the implementation of major projects. She will supervise NHC Network Coordinator, Corinne Lagermasini, MPH, who has managed the NHC for 8 years, providing program development, staff training and program monitoring. Tyrin Brown, Grants Manager, has 3 years of experience overseeing the financial aspects of the NHC and will carry out the day-to-day grant management functions. Staff from various HFP departments provide in-kind support to the program in the form of staff and member training, communications and strategic planning. Each operating site will have a Program Executive, responsible for the overall program and

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fiscal management, and a Program Director, responsible for all day-to-day activities including recruiting, training, managing and monitoring host sites and members. Sites with more than 18 members will also have a Program Coordinator to assist with daily activities.

The NHC will orient new program/fiscal staff by reviewing policies & procedures and AmeriCorps regulations; offering trainings on components of the NHC program design; and implementing a buddy program pairing new staff with more experienced staff. The NHC has a detailed policy and procedure manual that documents standards of performance and serves as a reference for new staff. Ongoing staff training and TA are determined through monitoring, annual site visits, program evaluations, monthly conference calls with staff, and formal staff needs assessment surveys.

The NHC Parent Organization uses a number of methods to assess, monitor and support its subgrantees. Monthly Program Directors conference calls promote information sharing and problem solving and an annual in person meeting fosters team building and support. Operating site directors lead many of the sessions and share best practices, tools and trainings that have worked well with their members and host sites. Member training and skills development are conducted by NHC operating sites with support and monitoring by NHC staff and in-kind support from the HFP training department. The NHC provides training to operating sites on assessing member training needs and developing and evaluating member trainings.

External evaluations are a required component of many grants administered by HFP, and the organization has relationships with evaluators at several Philadelphia universities. The NHC has conducted independent evaluations each of the last 3 grant cycles and evaluation and quality improvement processes are integrated into all facets of the NHC program. NHC staff have worked with evaluators on developing evaluation plans, creating data collection tools, and using evaluation findings to improve program design.

The NHC has put in place a number of tools and practices to ensure effective monitoring and quality improvement. These strategies have been effective in maintaining a high level of adherence to all policies and standards across the program sites and in early identification of any challenges so that timely technical assistance and performance improvement can be implemented. As a result, the NHC has a strong record of compliance and success in meeting performance objectives and maintaining

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high levels of satisfaction among members, host sites and program staff. CNCS conducted an onsite programmatic review of the NHC in 2011. The findings were overwhelmingly positive and only required minor changes to two policies. Grantee Progress Reports for the last two program years have all been satisfactory and the NHC has exceeded performance measure goals for the last 5 program years.

Sustainability: As a reflection of the value that local communities and host sites ascribe to their relationship with the NHC and its operating sites, local communities previously made (and have expressed a willingness to do so in the future) an investment in the program in the form of increasing cash and in-kind contributions. The NHC has exceeded the CNCS minimum match requirements the past two program years, allowing the NHC to operate with decreasing dependence on CNCS funds. Host sites now contribute an average cash match of \$10,000 per program year to host an NHC member and further sustain the program through in-kind donations of such things as staff supervisor time, meeting space and member training.

NHC operating sites have deep roots in the communities they serve and there are many vested stakeholders who help ensure the impact of the program is sustainable. In 2010, the Chicago Health Corps (CHC) operating site determined it could no longer implement the program after the death of the program executive. The CHC's 18 host sites, alarmed at the prospect of losing the program and the impact that would have on their communities, came together and recruited a new organization to implement the program, thereby sustaining the program.

The City of Philadelphia has invested over \$612,000 in the Philadelphia Health Corps (PHC) program during the last 4 years because of the direct cost savings to the City's public health budget that have resulted from member's efforts to enroll uninsured patients in free medication programs. For every dollar invested in the PHC, the city has saved \$31. Those savings have gone towards expanding medical services to the uninsured residents cared for by city supported health centers. The impact of the NHC is sustainable in several ways. Over the last two years, NHC members have recruited over 3,038 non-member volunteers to support community sites, many of whom remain engaged in community service in those communities. Members have improved the capacity of organizations to recruit, train and manage volunteers through the development of orientation materials, tracking systems and recognition strategies.

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Compliance and Accountability: The NHC uses a number of methods to assess, monitor and support its subgrantees and host sites. Member position descriptions are reviewed annually to ensure that proposed member activities comply with AmeriCorps regulations. NHC Parent staff utilize eGrants to monitor member recruitment and retention. Member files, including member eligibility and criminal history checks, are reviewed through on-site and remote monitoring. Members submit bi-weekly timesheets and service activity logs for approval by host site supervisors and program directors. Operating sites meet with members monthly as a group and check-in with members about their experiences at their host sites and they conduct a minimum of two site visits to all host sites during the year to ensure compliance with AmeriCorps regulations. Members are required to seek approval before engaging in fundraising activities to ensure they are allowable and they are strongly encouraged to ask questions any time there is uncertainty about the allowability of a member activity.

NHC staff assess and monitor sites through regular phone calls and emails. Member and host site surveys are used to identify areas of strength and any compliance issues. Performance measure data are reviewed and programmatic changes are made as necessary. Annual site visits are conducted at operating sites to review member files, interview members and visit host sites to ensure compliance and assess program performance. Operating sites submit monthly invoices for reimbursement of grant funded expenses and documentation of match dollars; these are reviewed for accuracy and appropriateness in accordance with CNCS and OMB regulations.

NHC fiscal and program staff attend annual CNCS grantee meetings, webinars and conference calls to ensure familiarity with current AmeriCorps regulations. The NHC Policies & Procedures manual is updated regularly and changes are reviewed with sites during monthly phone calls. Uniform and consistent member and host site monitoring tools are used across sites and staff at all levels are trained on how identify and respond to potential areas of noncompliance by operating sites, host sites and members.

Risk assessments of subgrantees are conducted annually and consider years of operation, staff turnover, and findings from monitoring activities. Operating sites identified as high risk receive additional training, technical assistance and monitoring throughout the year. If issues of noncompliance are identified, operating sites are required to submit and implement written correction

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action plans that identify the causes and concrete plans to fix and prevent future problems. The NHC subcontracts with each site annually and stipulates that ongoing noncompliance can result in termination of the sub-grant. Risk and noncompliance are also considered by the NHC during the competitive selection process held every three years; sites identified as high risk or that have a history of poor performance or noncompliance are not selected for future funding.

NHC host sites, new and existing, are required to submit competitive applications that are considered by operating site review panels that assess and score each application. Past performance and member satisfaction scores are among the factors considered when operating sites select their host sites. Host sites are required to sign Memorandum of Agreement that describe expectations, requirements and consequences of noncompliance. If a host site is found to be out of compliance, staff work with them to correct the situation. In rare cases of ongoing noncompliance, the member is removed and placed at a new site.

In June 2011, CNCS conducted a programmatic on-site review of NHC and there were no major compliance issues identified. In September 2011, CNCS conducted a fiscal on-site review and determined that some of the federal funds the NHC had reported as match did not have adequate documented approval from the federal agency that issued the funds. As corrective action, the NHC conducted training for all operating site executive and fiscal staff and implemented a more stringent review of reported match funds.

The NHC has had 100% enrollment the last two full years of program operation. The NHC's retention rate for the 2010-2011 program year was 91%; the retention rate for the 2011-2012 program year is currently 88%, however, there are still four members serving so we anticipate the final retention rate will be 93%. These are fairly high retention rates and reflect the loss typically of only one member per NHC operating site per program year.

Multi-site programs: The NHC is proposing to operate sites in Florida, Illinois, Pennsylvania and Georgia. Operating sites contacted their respective commissions in Nov/Dec 2012 and followed each commission's protocols for consultations. The following agencies will serve as NHC operating sites: the Allegheny County Health Department will continue its 18 year role running the Pittsburgh Health Corps; the North Florida Health Corps, started in 2004, will be hosted by the Duval County Health

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Department; the Chicago Health Corps will be directed by the Public Health Institute of Chicago, and the Atlanta Health Corps by Southside Medical Center, both operating sites since 2010; and the Philadelphia Health Corps will continue its 18 year history based at HFP.

The NHC has a formal operating site application and selection process. Proposals are reviewed and scored by a panel of staff and independent reviewers. Criteria that are considered include: the proposed site's experience operating AmeriCorps programs; organizational capacity to manage a federal grant; past performance and the experience and leadership of staff; and the ability to establish a sustainable program.

NHC host sites include Community and School-Based Health Centers, Free Clinics, Public Health Departments and non-profit community-based public health organizations. Host sites are selected by operating sites through a formal, competitive application, review and selection process using a standardized NHC application and member position description template. Sites are selected before the program year begins. Operating sites consider host site's alignment with the NHC mission, goals and proposed outcomes, their ability to offer members a meaningful, comprehensive and impactful service opportunity, their ability to supervise and support members and ensure they are not engaged in prohibited activities, and member feedback on existing sites.

Budget/Cost Effectiveness

Cost Effectiveness: For the last two program years, the NHC has leveraged a \$2.4 million investment by CNCS to secure an additional \$1.8 million in local cash and in-kind resources. These match levels have exceeded minimum CNCS requirements and are a reflection of the value that the program brings to local communities. Operating sites and host sites have committed to increasing their cash match in the upcoming grant cycle to \$11,000 per MSY. The NHC is applying under the Fixed Amount Grant category for the first time and we are requesting a cost per MSY of \$12,750, which is equal to the cost per MSY we requested and received for the 2010-2013 grant cycle. The NHC will continue, as previously demonstrated, to raise the additional resources needed to manage and operate the program beyond the fixed amount being requested. The NHC has budgeted \$1.275 million in fixed-amount funds from CNCS and \$1.1 million in local cash and in-kind contributions for an overall annual program budget of \$2.375 million. This amount was determined by reviewing detailed line item budgets submitted by operating sites as part of the NHC's competitive operating site selection process. These totals are consistent with previous years' budgets and include staff salaries, all direct

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member costs (including criminal history checks), training costs, program monitoring and evaluation costs.

The commitment of our program partners reflects the value that the NHC brings to local communities. The program design is an extremely cost-effective approach to addressing the health care access needs of economically disadvantaged individuals and the safety-net health care providers who care for them. For example, over the past four program years five healthcare organization host sites have invested approximately \$684,000 as cash contributions to the NHC to match \$912,000 in CNCS funds. In return for that investment, NHC members have saved these safety-net providers and their patients over \$19 million by securing free medications for 21,000 individuals.

During the last two program years, NHC members actively engaged and linked 9,698 un/underinsured patients to health insurance, health benefits and health access programs. By facilitating access to appropriate and timely preventative, primary and specialty health care services, NHC members helped patients to reduce avoidable utilization of higher acuity services (e.g., emergency room or in-patient care), which, in turn, reduces the cost of care. Similarly, members provided health education to over 35,000 people and screenings and immunizations to 17,216 people, services that are proven to help people identify and/or reduce risks for developing chronic diseases or delaying care for such conditions.

Budget Adequacy: The proposed NHC budget, including both CNCS grants funds and locally contributed resources, is adequate to support the proposed program design. Sufficient staff and resources (i.e., salaries and travel) have been allocated at the Parent Organization level to allow for a 1.0 FTE Network Coordinator and .40 FTE grants managers to provide ongoing program/fiscal monitoring of sub-grantees, both remote and on-site; technical assistance and training of sub-grantees through teleconferences, site visits and an annual network meeting; performance measure data collection and reporting; and program evaluation by an external evaluator. Operating sites; budgets support a program staff to member ratio of 1 FTE Program Director per 18 members (larger programs also budget for a part-time Program Coordinator) to ensure a high level of member supervision and support. Resources to meet members; training needs, including pre-service training, monthly in-service trainings and member meetings, a member retreat, and a end-of-term ceremony, have been allocated as well as funds for member criminal history checks, health insurance, member

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uniforms and local transportation. Resources have also been budgeted for staff training, local transportation and meeting expenses.

Evaluation Summary or Plan

The NHC's 2010-2013 evaluation summary has been submitted to CNCS via email. The NHC will work with an external evaluator from the Consultation Center at the Yale School of Medicine to conduct an impact evaluation during the 2013-2016 program years. The evaluation will answer the following questions: Did the NHC succeed in enrolling and linking the targeted population (uninsured and underinsured and medically underserved consumers/patients) to health insurance, health services and health benefits programs? Did these enrollment and linkage efforts result in increased utilization of appropriate health care services by these individuals? Did the target group experience a measurable increase in their ability to access preventative, primary and specialty care? Was there a measurable cost savings to these consumers and to safety-net providers as a result of this intervention?

Methodology: The evaluation will utilize a quasi-experimental design that will include a comparison of consumers/patients at safety-net providers and public health organizations where NHC members serve with consumers/patients at safety-net providers and public health organizations without members to determine if the expected changes did occur and if so, to determine causality. The evaluation will include a consumers/patient questionnaire, host site surveys and fiscal data. The evaluation will track impact from the 2013-2014 and 2014-2015 program years.

Amendment Justification

n/a

Clarification Summary

n/a

Continuation Changes

n/a