PART I - FACE SHEET

APPLICATION FOR FEDERAL ASSISTANCE

Modified Standard Form 424 (Rev.02/07 to confirm to the Corporation's eGrants System)

1. TYPE OF SUBMISSION:
Application [X] Non-Construction

2a. DATE SUBMITTED TO CORPORATION FOR NATIONAL AND COMMUNITY SERVICE (CNCS):	3. DATE RECEIVED BY STATE:	STATE APPLICATION IDENTIFIER:
01/25/11		N/A
2b. APPLICATION ID:	4. DATE RECEIVED BY FEDERAL AGENCY:	FEDERAL IDENTIFIER:
11ED125151	01/25/11	10EDHMD002

5. APPLICATION INFORMATION

LEGAL NAME: National Association of Community Health Centers, Inc.

DUNS NUMBER: 074846601

ADDRESS (give street address, city, state, zip code and county):
Community HealthCorps
7200 Wisconsin Avenue, Ste. 210
Bethesda MD 20814 - 4838
County: Montgomery

NAME AND CONTACT INFORMATION FOR PROJECT DIRECTOR OR OTHER PERSON TO BE CONTACTED ON MATTERS INVOLVING THIS APPLICATION (give area codes):

NAME: Jason Patnosh

TELEPHONE NUMBER: (301) 347-0400 2068

FAX NUMBER:

INTERNET E-MAIL ADDRESS: jpatnosh@nachc.com

6. EMPLOYER IDENTIFICATION NUMBER (EIN):
520939952

7. TYPE OF APPLICANT:
7a. Non-Profit
7b. Community-Based Organization
National Non-Profit (Multi-State)

8. TYPE OF APPLICATION (Check appropriate box).

[ ] NEW [ ] NEW/PREVIOUS GRANTE
[X] CONTINUATION [ ] AMENDMENT

If Amendment, enter appropriate letter(s) in box(es): [ ] [ ]

A. AUGMENTATION B. BUDGET REVISION
C. NO COST EXTENSION D. OTHER *(specify below):*

9. NAME OF FEDERAL AGENCY:
Corporation for National and Community Service

10a. CATALOG OF FEDERAL DOMESTIC ASSISTANCE NUMBER: 94.006

10b. TITLE: AmeriCorps Fixed Amount Grant

11.a. DESCRIPTIVE TITLE OF APPLICANT'S PROJECT:
National Assoc of Community Health Ctrs

11.b. CNCS PROGRAM INITIATIVE (IF ANY):

12. AREAS AFFECTED BY PROJECT (List Cities, Counties, States, etc):
Arizona, California, Colorado, Connecticut, District of Columbia, Idaho, Illinois, Kentucky, Louisiana, Massachusetts, Maine, Maryland, Michigan, Missouri, New York, Ohio, Pennsylvania, Puerto Rico, Tennessee, Texas, Washington, and Wiscc

13. PROPOSED PROJECT: START DATE: 08/01/11 END DATE: 12/31/12

14. CONGRESSIONAL DISTRICT OF: a.Applicant MD 008 b.Program MD 008

15. ESTIMATED FUNDING: Year #: 2

a. FEDERAL	$ 6,097,000.00
b. APPLICANT	$ 0.00
c. STATE	$ 0.00
d. LOCAL	$ 0.00
e. OTHER	$ 0.00
f. PROGRAM INCOME	$ 0.00
g. TOTAL	$ 6,097,000.00

16. IS APPLICATION SUBJECT TO REVIEW BY STATE EXECUTIVE ORDER 12372 PROCESS?

[ ] YES. THIS PREAPPLICATION/APPLICATION WAS MADE AVAILABLE TO THE STATE EXECUTIVE ORDER 12372 PROCESS FOR REVIEW ON:

DATE:

[X] NO. PROGRAM IS NOT COVERED BY E.O. 12372

17. IS THE APPLICANT DELINQUENT ON ANY FEDERAL DEBT?

[ ] YES if "Yes," attach an explanation. [X] NO

18. TO THE BEST OF MY KNOWLEDGE AND BELIEF, ALL DATA IN THIS APPLICATION/PREAPPLICATION ARE TRUE AND CORRECT, THE DOCUMENT HAS BEEN DULY AUTHORIZED BY THE GOVERNING BODY OF THE APPLICANT AND THE APPLICANT WILL COMPLY WITH THE ATTACHED ASSURANCES IF THE ASSISTANCE IS AWARDED.

a. TYPED NAME OF AUTHORIZED REPRESENTATIVE:	b. TITLE:	c. TELEPHONE NUMBER:
Savolia Spottswood	Director of Program Development & Eval	(301) 347-0400 2077

d. SIGNATURE OF AUTHORIZED REPRESENTATIVE:

e. DATE SIGNED:
05/06/11

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Executive Summary

Through the National Association of Community Health Centers, the Community HealthCorps (CHC) improves health care access and enhances workforce development through community health center based national service programs. CHC will place 500 full time AmeriCorps members in rural, suburban and urban communities across 19 states, Washington, DC and Puerto Rico to identify the underserved, assist with health insurance outreach and support programs, and provide culturally competent health education.

Rationale and Approach

a) COMPELLING COMMUNITY NEED: Medically underserved people began receiving health care from federally qualified health centers more than 40 years ago. Federally qualified health centers (FQHCs) are community owned, neighborhood-based and federally funded nonprofit organizations that serve millions of patients annually.

Founded in 1995 by the National Association of Community Health Centers (NACHC), the Community HealthCorps (CHC) is the largest health-focused, national AmeriCorps (AC) program that promotes health care for America's underserved, while developing tomorrow's health care workforce. The mission is to improve health care access and enhance workforce development through community health center based national service programs. CHC proposes to place 469 full time AmeriCorps members (ACMs) in 19 states, Washington, DC and Puerto Rico.

With increases in demand, decreasing health indicators in underserved communities, and demands to develop a new health care workforce for the future, FQHCs and communities they serve need support from AC programs like Community HealthCorps now more than ever before to identify the underserved, enroll individuals in health insurance and FQHC support programs, and provide comprehensive culturally competent health education to increase knowledge and eliminate disparities in health. These

communities were selected based on a competitive review process discussed later in this proposal.

Below is a snapshot of each community where CHC will place ACMs (due to space limitations, data citations and further demographic details about sites are available upon request):

ARIZONA (AZ): Marana Health Center (MHC) is an FQHC located in the rural, farming community of Marana, AZ and this is their first proposed year with CHC. MHC operates through Pima County (south central part of AZ) serving 35,000 patients of which 48% have no health insurance or are enrolled in Medicaid, serve a majority Latino, have uninsured rates up to 17% and include rural, unincorporated areas where patients have few employment opportunities and little public transportation. Marana also hosts a National Guard facility and MHC is increasingly providing support for military, veterans and families including flu shots and medical services.

CALIFORNIA (CA): (a) SOUTHERN/LOS ANGELES: Nearly 70% of individuals in AltaMed Health Services' area live below 200% of the federal poverty line (FPL). An overwhelming majority of AltaMed's patients are minorities: 76.8% Latino, 11.1% White, 3.7% Asian/Pacific Islander, and 1.6% African American. Also, AltaMed 57.6% patients have limited English proficiency (LEP) and are best served in a language other than English.

(b) CENTRAL VALLEY: Family HealthCare Network (FHCN) serves Tulare and Kings counties within the Central Valley, where the vast majority of residents live in small, unincorporated towns or remote rural areas. Over 47,000 patients per year are farm workers. Central Valley Health Network (CVHN) is a consortium of FQHCs that provide services through the Central Valley and Inland Empire. CA's unemployment rate has risen to a record of 12%, while rates in the Central Valley have remained above 15% since January 2009.

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(c) NORTHERN/BAY AREA: In the Alliance for Rural Community Health's rural and geographically-isolated communities, three hours north of San Francisco, patients served by FQHCs are low-income, speak English as a second language, and are unable to navigate paperwork necessary to receive benefits for which they and their children may be eligible. In San Francisco, over 80% of clients served by participating host sites are low-income (in some areas 94% of the patients live at or below 200% of the FPL). Moreover, there are thousands of veterans living in the San Francisco area and San Francisco Community Clinic Consortium is available to assist them via their homeless outreach programs. Finally, LifeLong Medical Care operates FQHCs in northern Alameda County and provides a disproportionate amount of care to the elderly, 35% of patients are 55 or older. According to the most recent homeless census, there are approximately 6,215 homeless individuals live in Alameda County, 28% of who are children, and over 69% are in LifeLong's service area.

COLORADO (CO): (a) Metro Community Provider Network (MCPN) provides health care to over 40,000 patients in Englewood and areas just east of Denver. During the recent economic downturn, demand for MCPN's services has increased by 65%. MCPN operates in Adams, Arapahoe, Jefferson and Park counties. Currently, there are over 219,000 uninsured residents living in MCPN's service area, 24% of which live at or below 200% of the FPL.

(b) Salud Family Health Center provides health care services to 65,225 low-income patients annually along the Rocky Mountains' eastern valley. While the views may be majestic to some, many that live and work in the areas are victims of poverty and an economy that has slowed down--55% of patients live 100% below the FPL and another 25% live 100-200% below the FPL.

CONNECTICUT (CT): (a) Community Health Center Association of Connecticut (CHCACT) proposes to

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place ACMs in Fairfield, Hartford and New Haven counties, of which serve CT's largest and poorest cities. In CT Latino children have a 20% uninsured rate compared to the state average rate of uninsured of 5.2% for all children, and in total 7,552 uninsured children under the age of 19 were served by these proposed FQHCs. This is CHCACT's first proposed year with CHC.

(b) Community Health Center, Inc proposes to place ACMs at FQHCs in Meriden, New Britain and several other cities. Situated in the city's poorest census tracks, the FQHC in Meriden serves over 8,000 patients, most of who are poor and suffer LEP, walk to the site for care, and depend upon the center for all of their health care, while the site in New Britain cares for 10,000 patients in this old industrial city of 75,000 people and is the medical home for thousands of low income residents from predominantly Latino and Polish neighborhoods.

DISTRICT OF COLUMBIA (DC): According to CHC's partner, the DC Primary Care Association (DCPCA), over half of DC's 591,833 residents live in federally designated medically underserved areas (MUAs). DC's uninsured population is estimated between 8-15% of all residents, and 30-50% of residents suffer from chronic diseases such as diabetes and HIV/AIDS. DC leads the nation per capita of people living with HIV/AIDS. DCPCA will target placements to the most underserved areas in Columbia Heights, Anacostia, and non-contiguous land areas east of the Anacostia River.

FLORIDA (FL): Premier Community Healthcare Group, Inc. (PCHG) has been in Pasco County since 1979. Pasco County has seen a 30.6% population growth in the county from 2000 to 2006 and is located in west central Florida, just north of Tampa Bay. In 2008, 17.8% of patients farm workers. Recently, PCHG piloted a program initiated with Pasco High School to place two disabled students into an On the Job Training-initiative and will target local partnerships like this to ensure recruitment of ACMs and/or volunteers with disabilities.

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IDAHO (ID): Due to the economic downturn more families find themselves without health insurance and premiums for working families have increased by 122%. During 2004, 30% of seniors in ID did not participate in physical activity and were more likely to report "fair" or "poor" health than those who did participate in physical activity, 61.5% of seniors in ID were considered overweight, and 20% of seniors were considered obese. CHC will continue to partner through the Institute of Rural Health at ID State University who places ACMs at FQHCs and non-profit health care agencies around southeastern Idaho.

ILLINOIS (IL): In 2008, Lawndale Christian Health Center (LCHC) served 39,982 patients considered among the most medically underserved in Cook County and proposes to place a CHC program for the first time. LCHC's patient base includes 98% minorities -- primarily African American and Mexican American; 67% of which are living below 200% of the FPL; 55% who have not received a high school diploma; and a 24% unemployment rate, two times then the rest of Chicago. Finally, in response to the growing obesity epidemic LCHC opened a fitness center that provides 60,000 visits/year. The facility provides aerobic and weight training equipment and space dedicated to medically based specialty and general exercise classes.

LOUISIANA (LA): CHC's efforts in LA grew out of the recovery phase following Hurricanes Katrina and Rita. Today, due to continued significant challenges LA is ranked 47th in the nation's health rankings. While glimmers of hope have begun to emerge in New Orleans with improved health outcomes for patients seen through FQHCs all parishes in Louisiana have been identified as MUAs. The Louisiana Primary Care Association (LPCA) supports the integration of capacity building programs consistent with the needs of each FQHC and will continue to serve as the CHC program placing ACMs across LA.

MAINE (ME): Maine is home to 205,000 patients served by FQHCs that comprise 16% of the state's

population. These working class families, homeless and farm worker populations encompass nearly 50% of FQHC patients below the FPL and 77% below 200% of the FPL. The ME Primary Care Association will place one to two ACMs at FQHCs throughout ME allowing these smaller community organizations to provide enhanced outreach and health education for their patients.

MASSACHUSETTS (MA): (a) Massachusetts is home to the largest expansion of access to health care to its population in the U.S. and increased the demands for outreach and helping new patients understand the services available through a FQHC. MA League of Community Health Centers (MLCHC) plans to deploy ACMs across the state. During 2008, FQHCs saw 762,119 patients and provided 3,622,098 medical, dental and mental health visits.

(b) At the East Boston Neighborhood Health Center (EBNHC) people living in poverty face untold public health risks and experience marked health disparities. Among the poor, proper nutrition and exercise are difficult to achieve and obesity is common. EBNHC addresses this prevalent problem through expert-recommended action, targeting unhealthy weight gain in children to reduce adult obesity and improve the health of a community.

(c) The Boston Health Care for the Homeless (BHCH) assist homeless who struggle to access health care and social services because of societal problems as well as their personal struggles with poverty, social isolation, and being disenfranchised. Additionally estimates suggest that only about 20% of homeless veterans have accessed VA health services -- a result of limited supply, eligibility restrictions, and preference. BHCH's clinic, where an AC member currently serves, is attempting to close this gap.

MICHIGAN (MI): Cherry Street Health Services (CSHS) provides health care to MUAs in Grand Rapids and Greenville MI, along the southeastern corner of the state. These populations demonstrate

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disparities in health conditions such as high blood pressure, diabetes, asthma, depression and infant mortality. Of 41,373 patients: 27% are uninsured; 91.6% have public health insurance; and 17% have LEP. Four local partners will also place ACMs allowing the participation of smaller community based organizations: two mental health agencies that provide short and long-term services; a non-profit that recruits physicians to donate specialty care to patients; and the county's program for uninsured people.

MISSOURI (MO): Grace Hill Neighborhood Health Center (GHNHC) has been a long standing beacon of light for the medically underserved around St. Louis. GHNHC provides services to over 41,000 individual patients, of whom 31% were children, 24% were homeless, and 18% were public housing residents in 2008 and has been a CHC site since 2000. Within their patient base: 55% were uninsured, 36% on Medicaid, 90% were under 100% of the FPL; 78% were African American, 13% Caucasian, 8 % Latino and 9% of patients had LEP. GHNHC serves over one-third of the areas marked by the St. Louis Department of Health with the greatest health needs.

NEW YORK (NY): (a) MANHATTAN and the BRONX - First, Ryan/Chelsea-Clinton Community Health Center encompasses a number of racial and ethnic minority communities that lack high quality and culturally competent primary and preventive health care. In 2008, 77% of the patients were of a racial minority and 85% lived at 200% or below the federal poverty level. In recent years, a large influx of immigrants from Haiti, Southeast Asia, Africa, and Central and South America have established themselves in Ryan's service areas. Second, the Institute for Family Health (IFH) provides health services to over 75,000 patients each year in Manhattan and the Bronx; the majority of patients served are racial and ethnic minorities, face significant health problems, including high rates of HIV/AIDS, obesity, and depression, as well as low literacy and education levels, and high unemployment.

(b) BROOKLYN - The Sunset Park community of Brooklyn is home to 139,269 people. More than a third

of the population was foreign born, 46.1% have LEP, and is home to 42% Latinos. Many ACMs at Lutheran Family Health Centers (LFHC) provide translation services, including Spanish and Chinese, which help area residents apply for services and better navigate health and social services systems. LFHC is also located in close proximity to the U.S. Army Garrison at Fort Hamilton. ACMs provide services to the many military families and veterans who benefit from the LFHC's health and wellness programs.

(c) HUDSON RIVER VALLEY/CENTRAL - First, Open Door Family Medical Centers operates in communities where substantial portions of the population struggle with poverty, lack of insurance, low educational attainment, and linguistic/cultural isolation. Nearly all patients have incomes at or below 200% of the FPL, over 54% have no health insurance, and more than half are best served in a language other than English. Second, Hudson River Health Care (HRHC) serves one of the largest farm worker populations in the country. HRHC's migrant and seasonal farm worker populations face psychological, domestic violence and substance abuse related to the stresses surrounding migration, and oppressive working and living conditions that have serious health consequences that often go untreated. Finally, the Syracuse Community Health Center serves a large African-American and growing refugee population from Bhutan, Burma, Iran, and Myanmar. ACMs have integrated into the community and continue to assist area groups that facilitate the refugee populations' needs.

OHIO (OH): Ohio is home to four of the top ten areas impacted by the downsizing of auto and manufacturing plants--more than any other state. The OH Association of Community Health Centers will serve as placement locations for CHC and this is their first proposed year with the program. ACMs will serve in cities like Cleveland, Cincinnati, and Columbus and more suburban and rural locations like Chillicothe, Ironton, Lancaster, Milford, Mansfield, and Zanesville. Together these areas reported 162,000 patients, of which approximately 35% were uninsured, over 40% were Medicaid patients, and

almost 35% were under the age of 19.

PENNSYLVANIA (PA): (a) Southeast Lancaster Health Services propose a second year as a CHC program. Slightly more than 58,000 of Southeast Lancaster residents lack basic health care and 42,229 residents were living in poverty, with greater than 18,000 of those residents under the age of 18. The local United Way found that 69.5% of uninsured children belong to families living at or below the FPL.

(b) Primary Health Network (PHN) recently identified 25,414 patients in need of assistance with utilization of health care services across three counties on the OH/PA border: In OH, Ashtabula County; and in PA, Mercer and Trumball Counties. These FQHCs represent small rural locations along the state border between OH and PA with the smallest in Ashtabula County, OH representing 3,000 patients and the largest in Mercer County, PA representing 12,000.

PUERTO RICO (PR): The communities served by Corporacion De Servicios De Salud Y Medicina Avanzada (COSSMA) are mostly rural located in the central/eastern part of PR and serves the municipalities of Cidra, Humacao, Las Piedras, San Lorenzo and Yabucoa that have total population of 220,747 and show an unemployment rate higher than PR in general. Over 25,800 patients were served by COSSMA of which 27% were uninsured and up to 59% of persons were under 200% of the FPL.

TENNESSEE (TN): (a) United Neighborhood Health Services (UNHS) works to increase access to health care for underserved people in Nashville and Davidson County. UNHS has 16 sites that serve over 20,000 underserved residents in Nashville. About 60% of patients are uninsured and underserved. Poverty rates and ethnicity indicate the need: 96% are under 200% of the FPL and 76% are minorities, primarily African-American, with growing numbers of Latinos and refugees.

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(b) The TN Primary Care Association (TPCA) is a 34 year-old nonprofit whose mission is to strengthen community-based primary health care systems in Tennessee and this is their first proposed year with the CHC. In FQHCs 34% of patients are covered by Medicaid and 40% are uninsured; 54% have incomes that fall below 100% of the FPL and 66% fall below 200% of the FPL. TPCA will concentrate their placement efforts outside of the Nashville area to ensure opportunity for agencies in rural areas to utilize ACMs for outreach and health education.

TEXAS (TX): (a) Heart of TX Community Health Center (HOTCHC) in Waco, the biggest city in McLennan County, and home to 113,000 of the county's residents, has a poverty rate of 27.6%, twice the national average of 13%; and provided services to 47,189 patients. HOTCHC addresses about 45% of primary medical, 14% of primary dental and 1.5% of mental health needs-leaving a large unmet need. Also, every year thousands of veterans and their families who come to and/or live in McLennan County (Ft. Hood Army Base nearby) seek care from the VA, many of whom, for whatever reasons, instead choose to get their services at HOTCHC.

(b) The Valley Primary Care Network (VPCN) provides opportunities for CHC placements in Cameron, Hidalgo, Starr, and Willacy Counties, along the U.S.-Mexico border. This large geographic area covering nearly 5,000 square miles is characterized with extremely low levels of access to health care, low health care utilization rates, low income levels, limited transportation availability, and limited formal educational attainment.

(c) Brownsville Community Health Center (BCHC) is located at the southernmost tip of the state of TX, less than one mile from the U.S.-Mexico border. Its proximity to the border has implications for the center in terms of its patient population that face significant environmental and economic problems. The health status of BCHC's patient population is one of the poorest in the nation. Of 23,101 adult visits,

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29% were for diabetes and 37% were for high blood pressure. Furthermore, only 62% of all adults are uninsured as well as only 76% of children.

WASHINGTON (WA): (a) Thirty-three percent of Sea Mar Community Health Center's service area and 92% of patients served had an income below 200% of the FPL. Also in 2008, 89% of Sea Mar's clients had public insurance or were uninsured, 18% were best served in a language other than English, 5% identified themselves as farm workers, and 6% of Sea Mar's clients were homeless.

(b) Yakima Valley Farm Workers Clinic (YVFWC) covers the central through southeastern parts of WA, just beyond Mount Rainier where there lies desert areas which battle extreme weather throughout the year. In 2007-08 YVFWC's primary service area had 26.3% of adults were uninsured; 25.0% increase in residents with HIV/AIDS; and 17.3% of residents had LEP.

WISCONSIN (WI): The Sixteenth Street Community Health Center (SSCHC) service area has the highest rate of uninsured individuals (36%) in Milwaukee and has been identified as having some of highest health status disparities in WI. The most pressing gaps in services have a direct connection to language, cultural and literacy issues related to the large Latino target population trying to access services, and receive comprehensive medical and case management services. SSCHC is the only FQHC on the south side of Milwaukee and the only one providing culturally and linguistically competent services to the growing Latino population.

b) DESCRIPTION OF ACTIVITIES AND MEMBER ROLES: CHC has helped countless individuals and families obtain health insurance and effectively use health and social services. Strategies employed by CHC include community outreach; enrollment in health insurance and FQHC programs; health service utilization assistance; and health education delivery (specific examples described in Community Outputs

and Outcomes).

CHC and its program sites ensure ACMs are not duplicating, displacing and/or supplanting existing staff roles through reviews of ACM workplans, interviews with AMCs and staff, and maintaining an open communication between ACMs and CHC staff if questions arise during their service year.

The roles of ACMs are diverse; compliment the communities they serve; and all lift barriers that medically underserved people experience in accessing health care. Below highlights the roles ACMs serve and outline the infrastructure of the type of activities that will feed into the Corporation for National and Community Service's (CNCS) focus area, Healthy Futures:

(a) COMMUNITY OUTREACH: In CHC, outreach conducted by ACMs can be street-based to homeless populations, can target youth at schools, can occur at residential facilities or in public housing units, or it can be the implementation of strategies that emphasize the needs of farm workers. ACMs expand beyond the role staff and/or other volunteers play by identifying new populations that have not been served adequately by the FQHC and/or new initiatives that may offer benefit to the medically underserved populations.

(b) HEALTH EDUCATION: Whether ACMs focused on the importance healthy oral health habits or educated teens recovering from substance abuse on the importance of fitness and nutrition, CHC made an impact increasing knowledge and helping to change unhealthy lifestyles. ACMs are often assisting staff who are certified health educators to deliver set curricula (or design new curricula) to populations that are not currently served in this capacity by existing resources.

(c) HEALTH INSURANCE AND HEALTH PROGRAMS ENROLLMENT: ACMs assist patients with

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understanding and completing enrollment documentation for health insurance and FQHC programs. Every CHC program addresses the needs of their population differently in this activity. In many cases, the outreach ACMs provide may lead to assisting the patient directly with this enrollment and/or referring them to a staff member who has a designated role to enroll patients. In the latter cases, ACMs are only part of the referral process and not the enrollment

(d) OTHER PATIENT ASSISTANCE: ACMs schedule appointments, provide translations, and link patients to transportation assistance for services. ACMs help patients to participate in depression, dental, diabetes, asthma and cancer screenings. Many times, ACMs are supporting a particular department (e.g., pediatrics) or a specific initiative and target the patients who are non-compliant with past directions from clinicians.

The sustainability and stability of the above activities will continue. As more people have become uninsured and healthy lifestyles have become harder for underserved populations to reach, CHC will play integral roles in all placement sites to address the specific needs of their communities.

CHC will place 469 full-time ACMs in 19 states, Washington, DC and Puerto Rico. All ACMs will be trained on activities they are prohibited from performing, aspects and 'big picture' items of AmeriCorps and the national service and FQHCs movements (discussed in more detail in Member Development)

c) MEASURABLE OUTPUTS AND OUTCOMES: CHC identifies Healthy Futures as the Focus Area it will participate in for the national performance measures pilot.

Delivery of Health Services (primary service category) is as follows:

- OUTPUT: 75,000 patients/year enrolled in health insurance and FQHC programs

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- INTERMEDIATE OUTCOME: 30,000 individuals/year that are uninsured, economically disadvantaged, medically underserved, or living in rural areas will utilize preventive and primary health care services.

- END OUTCOME: Over the long term, economically disadvantaged individuals will improve their health status and overall quality of life.

Health Education (secondary service category) will be measured as such: 92,000 individuals/year will participate in health education programs.

CHC will also target 1,200 children or youth/year engaged in in-school or afterschool physical education activities with the purpose of reducing childhood obesity.

CHC will implement program management, monitoring and data collection through OnCorps, an online program management system that collects, manages, monitors and aggregates data. NACHC staff and program coordinators will have access to aggregate data reports, such as total number of volunteers mobilized, location of member hours served, demographic data, and clients/patients served by CHC.

d) PLAN FOR SELF-ASSESSMENT AND IMPROVEMENT: Self-assessment, evaluation, and continuous quality improvement are critical to CHC.

ACMs submit monthly reports to program coordinators that aggregates the data and reports progress. NACHC then reviews and provides feedback on the site progress reports. Feedback loops such as meetings, surveys, questionnaires, and on-site interviews between program staff, partners, ACMs, and

service recipients support improvement. NACHC will work with ACMs, partners and evaluators to standardize and adopt pre-existing effective data collection tools.

NACHC's T/TA provides the most important subject matter (e.g., recruitment strategies, conflict resolution, etc) to all programs through conference calls, web trainings and email communications; and specific T/TA to individual programs based on weaknesses presented in their risk assessments. Moving forward, a variety of trainings will be provided through NACHC's Live Learning Center (web-based training system) offered to program coordinators, site supervisors, financial staff, and ACMs.

Finally, NACHC conducts annual risk assessments on all CHC programs that include assessing recruitment/retention levels, timeliness of reporting, communications between the service site and NACHC, and overall staffing/support for the local program. Along with site visits, file reviews, and member surveys, these scores help to design future T/TA needs, identify strengths and weaknesses and provide feedback to service sites on their performance.

e) COMMUNITY INVOLVEMENT: NACHC continues to engage CHC sites and their community partners by: working with leadership and community boards to identify needs; collaborating with site staff, ACMs, and community stakeholders to improve program design, implementation and evaluation and member roles; and collaborating with center development staff on long-term sustainability.

In 2009 CHC expanded its "community" by increasing its presence in social media, finding innovative ways to keep in touch with ACMs, AC alumni, FQHCs, and residents in the communities we serve. CHC launched a website, created a Facebook page and a Twitter feed, and has provided T/TA to CHC sites on how to effectively utilize social media. Also, NACHC is partnering with AmeriCorps Alums in 2009-2010 on a video campaign, through which CHC sites have received video 'flip-cams' and ACMs will film videos

at their site that highlights patients and FQHC impacted by the program, reasons for serving in AmeriCorps, and other related stories.

FQHCs are led by majority consumer/patient boards to ensure community involvement in the design and implementation of FQHCs and CHC. Their roles to represent the community served and initiate program development for CHC in their communities is essential. With the help of management and staff, these boards ensure programs like CHC are responsive to the needs of the community and are making an impact over the life of the program.

f) RELATIONSHIP TO OTHER NATIONAL AND COMMUNITY SERVICE PROGRAMS: CHC has operated a national direct program and four initiatives funded by state commissions (SC) in CA, FL, NY, and TX. NACHC proposes to bring the SC-funded initiatives into one proposal to simplify grant reporting and activity tracking, align with changes in the Kennedy Serve America Act, and position for growth under the Healthy Futures focus area of the CNCS. Prior to this submission all SCs verified receipt of CHC's letter of intent.

CHC also operates a 25-member AmeriCorps VISTA program in NY that places VISTAs with FQHCs to work on capacity building and program development. NACHC also will apply for a 110-member Professional Corps project during this funding cycle. In the past, NACHC has operated a VISTA program in CA, a Promise Fellows program and was part of the emergency/disaster response initiatives post September 11 and Hurricane Katrina.

CHC has partnered with several PCAs to develop their own AC programs in the model of CHC. Prior to the start of CHC, the PCA in UT launched an AC program in its first year. Since then model CHC have been launched and operated by the PCAs in KS, MI and NY. During this current competition CHC also

worked with the WI PCA to help develop an AC program after a successful linkage from the SC.

Finally and notably, NACHC signed a memorandum of understanding with the Peace Corps in December 2009--the first ever partnership between Peace Corps and an AC program. This initiative will contribute to more effective volunteer service domestically and abroad; improve the quality of life for residents in communities throughout the US and Peace Corps host countries; and promote the long-term professional development of participants to serve in community health settings. Innovative bi-national health promotion programs for MUAs worldwide will be designed, while tomorrow's health care workforce will be developed.

g) POTENTIAL FOR REPLICATION: CHC will continue nationwide replication through a variety of strategies: involve partner sites in development of program enhancements such as launching Professional Corps positions; and improve value of the program through communications, systematic evaluations and the development of "live" data reporting vehicles. Additionally, relationships with SC also help to build an understanding on how FQHCs can be part of their statewide strategic planning in addressing the health care needs of their residents.

This year's funding competition for sites to join CHC led to outreach meetings at NACHC conferences and interest calls with over 110 different agencies across the country. The competition yielded 45 interested sites requesting over 600 ACMs. NACHC has put forth a 20% growth in the program with 39 proposed CHC sites and 469 full time ACMs, while developing a cadre of interested partners to develop in years to come.

Organizational Capability

1. SOUND ORGANIZATIONAL STRUCTURE

a) ABILITY TO PROVIDE SOUND PROGRAMMATIC AND FISCAL OVERSIGHT: FQHCs serve 20

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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 help and 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, Community HealthCorps is the largest health-focused, national AmeriCorps program that promotes health care for America's underserved, while developing tomorrow's health care workforce.

NACHC uses an automated accounting system and federal cost principles. Receipt and disbursement of funds are tracked by grant and funding source. Records of time and activity 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. In addition to the federal funding from CNCS, NACHC receives funding from the federal Bureau for Primary Health Care (BPHC), other federal agencies, membership dues, foundations and corporations such as the Robert Wood Johnson Foundation, Covidien, Direct Relief International, Kaiser Permanente and Pfizer. NACHC has managed funding for the past 19 years ($6 million in 2006-07 from BPHC) to provide information and T/TA to FQHCs and PCAs. NACHC receives funding from the Centers for Disease Control and Prevention to assist FQHCs with training on HIV/AIDS testing services.

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. 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.

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NACHC is now celebrating 15 years of operating AC addressing health care access for underserved communities. Funding for 2009-10 sites includes: 270 MSYs-national direct; 92.5 MSYs in CA; 30 MSYs-NY VISTA; 40 MSYs in NY; and 35.5 MSYs in TX. Previously, NACHC was funded for Promise Fellows, Hurricane Katrina Recovery and Homeland Security programs through CNCS. With changes in AC legislation and to simplify grant reporting for CHC and its non-profit partners, NACHC will combine the four SC funded sites (all up for recomplete this year) in with its national direct grant. SCs have expressed support for CHC, noting that in many states, CHC is the only health-focused AmeriCorps program.

SITE SELECTION: Current and newly proposed FQHCs and PCAs submitted a program application to CHC in response to a Request for Proposal (RFP) process offered to all FQHCs and PCAs. Application review panels comprised of program, other NACHC staff, and outside non-profit professionals assessed the merits of proposed program plans utilizing a standardized scoring system. Each applicant program 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:

- 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 of stability of a site;

- The narrative had to be high quality, address the questions posed by NACHC in the RFP, indicate innovative ways to deliver outreach and health education information, and demonstrate the expected impact of CHC on the community in need beyond what the FQHC currently provides and should fill gaps in service;

- Member roles and activities had to be substantive, necessary and described in depth. Member roles

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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;

- Community involvement, leadership and partnerships had to be clearly demonstrated and sustainable over the life of program;

- Existing sites must had to demonstrate low to moderate status in the previous year's risk assessment to receive any expansion of their program. Sites marked as high risk had to have demonstrated significant progress towards achieving a low to moderate risk status since the assessment was conducted; and

- A high recruitment rate as of October 1st for established sites, November 1st for new sites; and strong recruitment/retention over the course of the last three program years.

SUPPORT AND MONITORING: CHC staff interfaces on an ongoing basis with staff and ACMs at partner sites. CHC staff provides monitoring and T/TA, working closely with sites to resolve challenges, establishes strong fiscal and programmatic reporting systems, and monitor member files. CHC will continue to ensure member compliance with AC policies, including "prohibited activities." During trainings throughout the year, PCs thoroughly discuss and review prohibited activities with site supervisors, ACMs and volunteers. CHC carefully monitors AC member understanding and compliance through the assessment of member work plans at the beginning of a service year, during site visits and interviews. Additionally, NACHC launched an anonymous 'hotline' in 2008 for individuals to call if they have questions or concerns about the program. When this hotline has been called it has been to address concerns that were resolved with interaction between CHC and the PC.

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Additionally, CHC is implementing the OnCorps Reporting System to improve monitoring, strengthen notifications and to reduce calculation errors that make tracking and verification of hours significantly more difficult. This system, already used by many state commissions, will be piloted from March-August 2010 with at least seven existing sites and will launch with the next program year as proposed for September 2010.

Finally, CHC sites benefit from networking with each other. PCs meet by conference call monthly to review current activities, program-wide plans, and facilitate peer-to-peer T/TA on issues such as recruitment and selection of members. CHC meets with fiscal and program staff, as appropriate, during site visits. CHC also provides training at the Program Development Institute (PDI), the annual sub-grantee meeting and training. Attendees participate in skill-building sessions that focus on performance measurement, reporting, member recruitment and retention, partnerships and finance issues.

b) BOARD OF DIRECTORS, ADMINISTRATORS, AND STAFF: NACHC's Board of Directors oversees the association and is currently chaired by Ms. Anita Monoian, CEO of Yakima Neighborhood Health Center (Yakima, WA). Ms. Monoian is a tireless champion for the growth of FQHCs and the development of the next generation of health care leaders across the workforce spectrum.

CHC's Steering Committee meets twice a year in person 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, David Quackenbush, CEO of Central Valley Health Network (Sacramento, CA), is an expert on FQHCs and workforce development in CA's Central Valley and has participated on several NACHC committees since joining his agency a few years ago. The vice-chair, Allison Dubois-Adach, VP of Community Development at Hudson River Health Care (Peekskill, NY), served as a VISTA and an AC member about 10 years ago before becoming a PC, working for NACHC and the PCA in New

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York, and four years ago returning to the center where she started.

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 30 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 oversees the staff that manages the CHC. Finally, NACHC's financial staff, led by Senior Vice President of Internal Administration, Mary Hawbecker a CPA with over 20 years of federal grant financial management experience, manages large grants and provides fiscal and administrative oversight to all departments including CHC.

CHC redesigned its organizational plan two years ago and developed high quality departments supportive to the needs of the ACMs and program sites. Jason Patnosh serves as the National Director, bringing over 10 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 serves as Deputy Director and ensures the implementation of program goals and objectives. Pamela Ferguson has served as the Director, T/TA for the past two years and has been part of the CHC for the past 12 years first as a member, then a site coordinator, and finally joining the NACHC staff in 2003. Savolia Spottswood, Director of Program Development and Evaluation, has steered the program's evaluation efforts for the past three years including the design of national common performance measurements for the program. Ms. Spottswood has also worked with CNCS staff on developing common national performance measures for health care based programs in response to the Kennedy Serve America Act. Gina Smallwood became Manager, Grants Administration in December 2009 and is responsible for fiscal management of grant funds. Ms.

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Smallwood has decades of experience as an accountant and proprietor of her own accounting firm. Randy George has been Manager, Member Development and Support for the program over the last two years and previously worked at City Year and Experience Corps, in addition to serving as an AmeriCorps member.

Additional staff includes Howard Liebers-Sr Program Officer, Policy and Innovation with increased responsibility for achieving the maximum benefits of communications and social networking; Megan Headley-Sr Program Officer, Grants Administration with responsibility for program wide monitoring and compliance; April Holloway-Program Officer assisting with T/TA; Vanessa Respicio-Program Officer, Grants Administration; and Rachelle Richards continues to serve as Program Assistant. This proposal calls to add one additional Program Officer, ideally to focus website development and implementing the OnCorps reporting system.

PCs based at CHC sites are experienced and knowledgeable about national service, health care and project management. Often CHC or other AmeriCorps alumni themselves, coordinators have the following functions: recruit, place and coordinate activities of ACMs; develop placement sites; train site supervisors and ACMs; provide technical assistance; monitor and evaluate local CHC sites; fulfill reporting requirements; and organize service projects.

c) PLAN FOR SELF-ASSESSMENT OR IMPROVEMENT: CHC is consistently assessing its systems, procedures and tools to identify strengths, best practices, and weaknesses and to increase administrative efficiency and sound management policies, practices, and procedures. Over the last program year several instances of this include:

- Regularly implemented tools (i.e. questionnaires, surveys) and request feedback from staff, board

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members, ACMs, service recipients, and community stakeholders;

- Currently awaiting the results of its recently completed programmatic and organizational evaluation, conducted by renowned researchers in the area of community health workers;

- Reestablished the Deputy Director position to strengthen day to day direction for staff and to support increased partnership development and cultivation by the National Director;

- Established the Senior Program Officer for Policy and Innovation to identify creative opportunities to maintain CHC's lead role among health-focused AmeriCorps programs.

Also, when opportunities have presented themselves for CNCS program officers to observe CHC in fulfilling their monitoring duties CHC is pleased to take advantage of such opportunities and implement recommendations that can help to strengthen program effectiveness. CHC's program officer from CNCS recently commended CHC staff for the thoroughness with which its site visit monitoring activities are conducted she witnessed 2009.

Finally, in conjunction with CNCS policies CHC is submitting its external full program evaluation as completed by the University of Texas at El Paso. This evaluation demonstrates the positive impact the program has made in the lives of ACMs and the communities they serve. A summary of this report is included below in Evaluation Summary.

d) PLAN FOR EFFECTIVE T/TA: CHC serves as the day-to-day contact for program monitoring, T/TA, and program reporting. CHC provides sites and local staff with T/TA, opportunities for sharing of best reporting and program practices, telephone/e-mail assistance, and linking to SC sponsored trainings.

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Annually, CHC staff complete a minimum of one member file review and risk assessment for each program to determine the level of T/TA needed at the site and the scope of site visits. CHC staff also conducts financial monitoring year-round.

PCs attend monthly conference calls; participate in work groups that focus on program management, training, and resource development; and participate in the three-day PDI, which brings together program coordinators for workshops, sharing best practices, and roundtable conversations annually. This year's PDI, planned for early August 2010, will provide policy updates on starting the first full program year for ACMs to serve under the Serve America Act and will offer an additional one-day pre and post PDI session for new CHC sites/staff.

2. SOUND RECORD OF ACCOMPLISHMENT AS AN ORGANIZATION

a) VOLUNTEER GENERATION AND SUPPORT: CHC and the FQHCs are critically dependent on volunteers. NACHC's committee structure relies on volunteers from FQHC boards and other FQHC leaders to identify priorities for FQHC development; provide T/TA to enhance performance; and assist with program implementation. Many CHC alumni continue to support communities by becoming health or social service providers; volunteering locally; and providing inspiration and leadership to current ACMs, staff, and volunteers. CHC has partnered with other national service groups and one international service agency to engage volunteers, in addition to developing volunteer opportunities as part of its own operation:

- Participated in the United We Serve campaign by posting a video at www.serve.gov calling on all FQHCs to mobilize volunteers and CHC was featured as a community health "cause" through the Entertainment Industry's iParticipate initiative;

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- Partnered with HandsOn Network and AmeriCorps Alums in the "Give a Day, Get a Disney Day" initiative;

- Placed opportunities on Idealist as a part of Mozilla's "Volunteer for Mozilla Service Week" in September 2009. Separate from this, CHC recruited a 'virtual' college volunteer from University Michigan to help develop its presence on Facebook, Twitter and You Tube;

- NACHC will continue to look to outside experts to assist with growth as it has in the past (Bridgespan in 2003). Recently 12 volunteer University of Maryland MBA recently supported CHC and its program sites in the areas of strategic planning, partnership development and other related activities;

- Finally, the new partnership with Peace Corps will allow for more effective volunteer service as applicants and alumni will be referred across programs for service opportunities.

b) ORGANIZATIONAL AND COMMUNITY LEADERSHIP: NACHC has been a national leader of the community health center movement since 1971. The association was the catalyst for expanding: Medicaid and SCHIP eligibility and benefits; the Federal Tort Claims Act-medical liability insurance for CHC health care professionals; 340b drug pricing/pharmacies programs-affordable medications for low-income communities; and enabling the creation of new CHCs in areas of the US that lack adequate health care. NACHC collaborated with Pfizer's Sharing the Care Program, providing over $400 million of medications over the last decade. NACHC has provided research, health center startup support and technical assistance to new health centers, part of a new federal five-year initiative to increase the reach of CHCs. More specifically to the CHC: (a) Jason Patnosh lends his voice and experience as an organizing committee member of Voices for National Service; (b) Savolia Spottswood serves on the Board of Directors of an FQHC in Maryland and was recently selected as only one of seven participants

in the first cohort of the Robert Woods Johnson Foundation Retooling Professionals Evaluation Fellows program; (c) Gerrard Jolly and Pamela Ferguson were selected to serve as mentors to new AC programs and staff in 2009; and Mr. Jolly also facilitates the health related AC program Affinity Group meetings for AC State & National grantees; and (d) Howard Liebers is actively involved with AmeriCorps Alums, serving on working groups of their Leadership Council and assisted with the redesign of their new website.

c) SUCCESS IN SECURING MATCH RESOURCES: CHC sites have always matched at least 20-30% of member costs, instead of the 15% minimum first year AC programs are required. Building on a diversified funding base, all CHC sites have matched 40-50% since 2006-07. FQHCs are financed by federal grants, Medicaid and other health insurance revenues, foundation grants and fees-for-service (federal funds are not used to match on the CHC program). NACHC has secured match resources from health care foundations and corporations such as Hearst, the California Endowment, APS Healthcare and Covidien in the past. CHC and its program sites have a strong track record and commitment to increasing resources for the sustainability of the CHC and the community-based services provided by the ACMs.

3. SUCCESS IN SECURING COMMUNITY SUPPORT

a) COLLABORATION: By design, patients and other community stakeholders help prioritize pervasive and emerging issues; and influence the shape of health services and programs. The CHC site in Seattle, WA collaborates with the local Medical Reserve Corps chapter, the Washington Commission, and the American Red Cross. Sites in Boston, MA work in close partnership with area colleges and universities for recruitment and training of ACMs. CHC sites frequently attend trainings, meetings and service events of SCs. Nationally CHC has worked with several groups that have local affiliates that partner with CHC sites:

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- The National Area Health Education Center Organization to enhance the CHC member training curriculum, utilize local trainings for member development, and recruit ACMs from local programs;

- CHC has also partnered with other non-profits on a national level to strengthen member roles, such as American Legacy Foundation for tobacco cessation efforts and The Cancer Project for nutrition education efforts; and

- CHC's "Global Health Community Innovations" initiative with Peace Corps increases the quality and reach of services our health centers provide by carving a path for more innovative health education programming, and by enhancing the training and experience our future health care workforce will be receiving.

b) LOCAL FINANCIAL AND IN-KIND CONTRIBUTIONS: Partner CHCs have significantly increased financial investment into the CHC over time. In addition to the 40% funding match previously noted, CHC partners will contribute in-kind support as well (i.e. supervision and mentoring by health professionals, computers and internet access, training resources, rent and office space, meetings/trainings space, supplies and incentives for ACMs). Community and corporate partners have provided cash and in-kind support such as office space, staff time, educational materials, incentives and refreshments for member events. CHC partners clearly demonstrate commitment to the program and the value of the ACMs to their overall service delivery.

c) WIDE RANGE OF COMMUNITY STAKEHOLDERS: Community stakeholders continue to support the CHC. In response to increasing pressure on resources, sites have increased the number of ACMs and non-AmeriCorps community volunteers involved in service delivery. As mentioned and unique the

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FQHC model, patients continuously play significant roles as stakeholders and board members. CHC partners work with faith-based organizations to implement health education and outreach efforts by brokering the knowledge and expertise of parish nurses and lay health ministers. Other stakeholders engaged in program strategies include: government agencies; public schools; colleges and universities; local business; first responders such as fire and rescue; and other national service programs.

d) SPECIAL CIRCUMSTANCES: All communities served by FQHCs and CHC sites are federally designated as medically underserved areas and health provider shortage areas. In many cases, these areas also may carry other federal designations indicating impoverished areas. CHC places ACMs in rural and urban settings that may be resource poor and/or forgotten by private funders, but the dedication from the provider and top FQHC management to the volunteers and ACMs cannot be measured.

Budget/Cost Effectiveness

1) COST EFFECTIVENESS

a) CORPORATION COST PER MSY: $13,000/MSY.

b) DIVERSE NON-FEDERAL SUPPORT: CHC builds upon the success of its program sites to cultivate outside funding sources allows sustainability of the CHC and decreased reliance on federal support. NACHC has also increased the non-federal match for living allowance/benefits over time. The federal cost per MSY for the 2010-11 grant cycle is proposed at $13,000/MSY. In the past three years this reliance on federal support has only increased 3% while the matching support for the program and increased up to 10-15% in many program sites. Program sites depend on revenues from health care services provided by the FQHC, local and state foundation support, and other revenues. CHC calls for an increased level of support beginning at 40% of total program costs and in many cases this amount exceeds 50%. Beyond the level of cash support towards the stipends and operational needs, sites provide immeasurable learning opportunities for ACMs to prepare for careers at FQHCs.

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CHC is requesting to move to a fixed-cost grant in 2010 in order to reduce fiscal grant reporting burdens. CHC previously maintained a fixed-cost grant under AmeriCorps' Promise Fellows program. Moving to the fixed cost grant will allow sites to dedicate more staff time to program development, recruitment and retention of ACMs, and developing sustainable partnerships rather than burdensome fiscal grant reporting. With this move, sites are expected to likely take more fiscal responsibility for the program. Sites will still be responsible to pay the full living allowance and any benefits for ACMs (some sites pay above the minimum living allowance), maintain adequate staffing and training levels for the program, and ensure timely reporting on the grant. Sites also inherit a risk, that they have all indicated they are prepared, with fixed cost grants that link their federal award directly with the recruitment and retention in the program. NACHC will work closely during this first year of fixed cost grants and will participate in all evaluative efforts on the program design.

2) BUDGET ADEQUACY: The budget effectively meets the needs of the program while preparing for increased program efficiency, enhanced training of ACMs, and improved monitoring over program operations. CHC's ability to develop new projects over the lifetime of the program is a sign of sustainability and innovation. As described throughout the proposal the addition of seven potential new sites will grow the program by 20% in both members and sites. Systems are in place and have been described to launch new sites with a strong understanding of AmeriCorps guidelines, the mission and goals of the CHC and the forward thinking develop the next health care leaders of tomorrow is a cornerstone of the program.

Investment in the online OnCorps member management system will create an on-line community for ACMs, site level supervisors, PCs and CHC staff to record and analyze member and program data. Development of new staff positions focused on website and data development will complement the OnCorps system while increasing communications directly with ACMs on the ground throughout and

beyond their service years. In future years CHC hopes to increase funding from outside resources to launch regional training institutes bringing teams of ACMs together to prepare them for life after AmeriCorps.

AFFECTING THE MOST NEEDED COMMUNITIES: As the application has discussed the Community HealthCorps is a national program that addresses the specific needs of a local population and community. Whether it is in the impoverished rural areas of northeastern CO where the harsh working conditions of meat-packing plants or farms are some of the only available places to find work, the Rio Grande Valley where new immigrant families struggle to provide for families on both sides of the U.S.-Mexico border, or the Yakima Valley in WA where the traditional pictures the state as being flush with greenery is replaced by desert that brings temperature extremes for the large migrant-farm worker population; poor working families gentrifying to the growing urban areas on the outskirts of the city centers in Los Angeles, CA, Denver, CO, or St. Louis, MO; or the communities still rebuilding and/or having to redesign their economic base after Hurricane Katrina in LA and the exit of auto manufacturing plants in OH and eastern PA, Community HealthCorps sites are located in resource-poor communities, across rural and/or urban environments that struggle with disparate rates of poverty, unemployment, lesser education level completion, and/or access to health care services. These areas, often missed by corporate or philanthropic resources and/or have lost local businesses that may have supported them financially in the past, reflect the cross-section of America that have dealt with new homelessness and unemployment highs, have seen newly uninsured residents in their communities, and have seen overall cuts in health and social services. The FQHC serves as the 'medical home' for these individuals and the services provided by the Community HealthCorps becomes the opportunity for the community residents to become more stable in their own health care.

Evaluation Summary or Plan

NACHC contracted with the University of Texas, El Paso (UTEP) to conduct an external program

evaluation. The Evaluation Team, under the direction of Principal Investigator E. Lee Rosenthal, PhD, MPH, worked from August 2008 thru January 2010 to assess the impact of the Community HealthCorps (CHC) on multiple levels. This evaluation of CHC looks at the program's activities and impact on four distinct levels: individuals (patients), CHC Members, host federally qualified health centers (FQHCs) and agencies, and the community served.

The evaluation as planned relied on multiple methods combining existing and new quantitative and qualitative data. Existing data sources include the Uniform Data System maintained by the Healthcare Resources and Services Administration (HRSA); CHC host agency-developed Member Work Plans, qualitative and quantitative data taken from NACHC's records in the CNCS AmeriCorps's Web Based Reporting System (WBRS) and CNCS National Service Trust (education award) data. New data for the evaluation comes from two on-line surveys targeting CHC Alumni and host- agency program administrators and coordinators and follow-up interviews with selected survey respondents.

EVALUATION RESULTS

MEMBER IMPACT ON OTHERS: A framework of evaluation levels identified during the planning phase served to guide the evaluation team during the evalaution. However, the findings are presented here in different order than what was originally presented in the planning stage. The report of findings looks first at the HealthCorps' impact on 1) others (individuals and families; FQHCs/host agencies; community) and then the discussion turns to the impact of service 2) on Members themselves.

According to 94% of the respondent administrators, HealthCorps Members have a "Very Significant" or "Significant" positive impact on the "individuals and families served by your health center/agency" respectively. Additionally, routinely documented Performance Measures show that:

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- 72,000 individuals per year received assistance in increasing access to care. CHC improved access to care by referring individuals to FQHC programs and low-cost or free health insurance plans, especially in the case of immigrant patients.

- Over 120,000 individuals per year received assistance in Improving Utilization of Care. CHC Members assisted FQHC staff to identify patients who needed follow-up care assistance such as reminder calls, making appointments, translations, and transportation.

- An average of over 110,000 individuals per year benefitted from Health Education provided by CHC Members. Members assisted FQHC staff by facilitating workshops, hosting health fairs, and conducting one-on-one and group health education sessions with community residents.

- 93% of the respondent administrators perceive the positive impact of CHC Members on the FQHCs/agencies as 'Very Significant' or 'Significant,' specifically mentioning their impact on hours of service, patient flow, and continuity of care, and reported that a number of programs such as patient outreach, follow up and surveillance, doula services, and formalized educational classes would not be possible without CHC.

- CHC Members impacted nearly 50,000 others in the community per year over the reporting period and the volunteers/ CHC Member interaction increased each year. Volunteers assisted in heath awareness campaigns, outreach, service events, and other FQHC support activities.

Members note the importance of collaborating with others especially when playing roles in disaster preparedness and response. In collaborating with other agencies responding to disasters, Members were

involved in food and clothing drives, environment cleanup, and volunteering in disaster relief shelters.

Members report that they contribute to community improvements. Members' Great Stories report on activities they participate in such as cleaning streets, helping to secure ordinances to encourage the use of walking trails, planting trees, and improving garden conditions.

According to administrators and Alumni CHC Members, Members impact the community significantly. Most (83%) of the respondent Administrators/Program Coordinators perceive CHC Member service to have significant positive impact on the community they served, mainly through assisting with health education and disease management.

IMPACT ON MEMBERS THEMSELVES: Members report building important career confidence and skills during their service. From the Great Stories many Members indicated that they felt that they had developed important skills while serving. They also described an increase in self-confidence and self-efficacy.

Members developed cultural and linguistic competence as well as compassion for others. Members reported in their Great Stories about the positive experiences they had while serving patients and their families. Those experiences include activities that went beyond the realm of health care such as assisting patients with little or no English proficiency and addressing other social barriers.

Great Stories entries were also able to capture feelings about opportunities that helped them grow as individuals. Members credited these positive experiences with encouraging them to continue their education, most often in the field of health care. Members reported that learning not only came from formal trainings but also from interactions with the community. Members that reported assisting

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someone with limited English proficiency (these Members also reported having some experience with other cultures) mentioned a feeling of particular usefulness because they realized the extent to which the non-English speaking patients experienced isolation.

Alumni report that CHC provided them with valuable skill development. Members indicated that in their service had 'A Lot' of impact on their knowledge about health disparities, patient relations, professional development, cultural competency, health outreach, and health education.

Administrators perceive that CHC's training and service builds Members' skills on the job and for the future. Fifty Four percent of Administrators perceive HealthCorps service to have a 'Very Significant' positive impact on the Members' professional and/or personal development. Administrators rated CHC as having 'A Lot' of positive impact on Members' knowledge of all the ten HealthCorps-identified basic competencies except for case management and disaster preparedness.

Members join CHCs in order to get involved in health issues. About one third of the Alumni survey responses indicated that they already had an interest in pursuing an education in the health sciences field before serving in CHC. A third of the respondent Alumni reported that they had joined CHC to enhance their application for admission to a health sciences program. One third of respondents had worked at a FQHC or some other type of healthcare organization prior to serving in CHC.

CHC members' interest in a health career increased as result of their service. About two thirds (62%) of Alumni reported having interest, including 'A Great Deal' and 'A Lot' of interest, in a health career before serving, but 81% indicated that they had these levels of interest after their service experience. About two-thirds of Alumni reported that their service had 'Significant' or 'Very Significant' influence on their education choices and/or their career choices.

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CHC members consider education awards a valuable incentive to serve. Sixty-five percent of Alumni reported that the AmeriCorps education award was "Very Important" or "Important" in their decision to enroll. Black and Latino Members are disproportionately more likely to leave their service with "no award" or only a "partial award" granted. Members may be denied an education award for failure to complete their hours of service commitment although a "partial award" may be given if a Member needs to terminate their service early due to "compelling personal circumstances." Specifically, higher percentages of Black and Latino Members than White Members completed their service with "no award" or "partial award" (52% and 33% vs. 22% respectively). Black and Latino Members in this same database were also much less likely than other racial/ethnic groups to have a four-year college degree prior to enrollment (18% and 25% vs. 62% respectively).

Most Education Award payments were made to four year colleges and universities. About half (49.9%) of education award payments were made to colleges/universities, followed by lending institutions (33%) for repayment of student loans. Sixty three percent of respondents to the HealthCorps Alumni Survey reported using education awards for direct tuition payments, 46% for student loan repayment, and 33% for other educational expenses.

CLOSING REMARKS

Based on this evaluation, it is evident that the CHC Program is making a positive impact on its intended audiences. Specifically, for the individual and families served, Members are providing valuable direct "caring" to patients and families. Further, FQHC host sites' capacity to reach out to others is enhanced, enabling more community-specific programming. And Members appear to inspire the community to engage more fully in activities to promote community wellness.

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For Members, their skills, compassion for others, and both their academic and career goals, appear to be advanced while in CHC. The Program creates pathways to success that allows individuals to find their way into the hallways of academia, into health professions, and into an array of jobs in various settings including local clinics and other social service agencies.

The full Evaluation Report (in draft) has been sent to CNCS. Final recommendations for program improvement will be provided to NACHC in March, 2010.

Amendment Justification

07/22/10 - The program in Chicago discussed in the narrative was unable to participate or the 2010-2011 program year. The positions were redistributed to other programs. Additionally the programs through the Valley Primary Care Network (Harlingen, TX) and the Maine Primary Care Association will not continue with the program, but other agencies in their geographic territory will still exist (no change to demographic information in the narrative)

Clarification Summary

In response to the April 26, 2011 communication to clarify NACHC's Community HealthCorps application, the following additional information has been provided in order of the questions posed (questions have not been restated in order to save character space).

1) Social Determinants:

Social determinants of health content was included in the application narrative, to give emphasis to social determinants since they have been a pre-existing, long-standing part of our philosophy and program strategies. In other words, social determinants of health have been integrated into locally deployed strategies for many years, and the application reflects NACHC's commitment for strengthening integration into the future. Therefore, related member activity will continue regardless of MSY award levels.

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Of the circumstances that affect people, the World Health Organization confirms that social determinants of health are the "Most Responsible for Health Inequities" such as access to services, access to resources (e.g., grocery stores), lapses in health insurance coverage, housing challenges, and socioeconomic status (e.g., income). Poverty is the biggest factor contributing to poor health outcomes, which worsen as poverty becomes more severe. [WHO Citation] Groups with disproportionately high levels of disease have similar living conditions. "Studies have shown that HIV-infected persons with low literacy levels had less general knowledge of their disease and disease management and were more likely to be non-adherent to treatment than those with higher literacy." [CDC Citation, page 7] Although many people with education and incomes above the national average die prematurely from preventable health problems, those with less incomes and education have far worse health status, and activity limitation due to chronic disease. [RWJF Citation] Social determinates are a complex, integrated set of societal factors [i.e., social structures, economic systems and health services] that can either create paths or barriers to good health.

Citations: Centers for Disease Control and Prevention. Establishing a Holistic Framework to Reduce Inequities in HIV, Viral Hepatitis, STDs, and Tuberculosis in the United States. Atlanta (GA): U.S. Department of Health and Human Services, Centers for Disease Control and Prevention; October 2010. Available at: http://www.cdc.gov/socialdeterminants/docs/SDH-White-Paper-2010.pdf

World Health Organization. Closing the gap in a generation: Health equity through action on the social determinants of health. Report from the Commission on Social Determinants of Health. 2008. Available at: http://www.who.int/social_determinants/thecommission/finalreport/en/index.html.

Egerter S, Braveman P, Cubbin C, et al. Reaching America's Health Potential: A State-by-State Look at

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Adult Health. Washington, DC: Robert Wood Johnson Foundation Commission to Build a Healthier America, 2009. Available at www.commissiononhealth.org.

2) California Volunteers - NACHC has connected with California Volunteers to clarify any additional questions they may have. The program officers for NACHC and CV have been cc'd on these messages. We believe there was a mistake in their automated system that did not pick up the needed information, and NACHC is prepared to answer any additional questions.

3) Performance Measures - changed as requested, including targets to reflect proposed funding level of 469 MSYs. The health education measure was removed, because that activity is a (formal) preventive health service. The intermediate outcome for the Delivery of Health Services measure already captures provision of such preventive health services. Also, health education was not a separate measure in the Recompete Application PY2010-2012.

4) The budget has been adjusted to reflect 469 MSYs.

Continuation Changes

[YEAR 2]

The allowable scope of member activities formally includes social determinants of health such as but not limited to housing assistance and unemployment referral and counseling. As supported by published literature, such an expansion of scope will increase positive impact for people with unmet needs that are served by agencies where members are placed. Indirect services, such as collaboration and health services development will continue to be part of member assignments.

CHC proposes to place 500 full time AmeriCorps members (ACMs) in 19 states, Washington, DC and Puerto Rico. Activities of expansion members will be the same as those of members at current program

sites. Proposed program sites in Florida and Illinois sites were not implemented PY2010 due to funding considerations at the local level. Additionally, a program through the Tennessee Primary Care Association was not implemented for similar reasons, though the Community HealthCorps remained in the state with a partnership in Nashville. Member slots from these programs were successfully redistributed to other HealthCorps program sites.

Maryland is a new state - chosen because of its demonstration of high need (i.e. health disparities), very large minority population, high access to health centers and other community-based assets. The 6.5% expansion is modest given the health status and unmet needs of populations nationally. Also, NACHC is confident in the choice of expansion as 'smart growth' due to the strong program model and track record of successful enrollment of full-time slots at or near 100%. The following locations are new additions to further address unmet need:

MAINE (ME): Penobscot Community Health Care (PBHC) is the largest of the state's federally qualified health centers (FQHCs), serving 50,000 patients, and the only FQHC in the largely rural area that includes an underserved population of 114,000 residents. PBHC is surrounded by nine rural counties from which its patient population is drawn. Roughly 65% of PCHC's patient population is at or below 200% of federal poverty level (FPL). PCHC will provide enhanced health education to assist patients in managing chronic diseases, accessing community resources that support overall health, and introducing area youth and displaced workers to health career occupations.

MARYLAND (MD): The Community Health Integrated Partnership is a non-profit health center controlled network in Maryland that provides services for quality improvement, operational and clinical management, revenue enhancement, and health information technology (HIT) to its members. The network is comprised of nine community health center organizations that are dispersed across

numerous service locations throughout Maryland. Of the 261,875 patients served by MD FQHC's in 2009, 4,190 were veterans. Also, 86% of the patient population is at or below 200% of FPL. The following three key indicators of health status are worse in Maryland compared to the U.S.: Infant Mortality Rate (7.9 MD vs. 6.8 U.S. per 100,000 population); Teen Death Rate (67 MD vs. 62 U.S. per 100,000 population); and AIDS Diagnosis Rate (27.6 MD vs. 12.3 U.S. per 100,000 population). [Source: www.statehealthfacts.org]

The 2008 Census estimated Maryland population is 41.6% minority, with eight of Maryland's 24 jurisdictions have minority populations over 30%. For the period 2004-2006, Black or African American death rates exceed White death rates in 20 of the 23 Maryland jurisdictions. "Nine of the top 14 causes of death show a mortality disparity between Blacks or African Americans and Whites. Black or African American age-adjusted heart disease mortality exceeds that for Whites by 52.1 deaths per 100,000 people. Blacks or African Americans are 16 times more likely to die from HIV/AIDS than Whites." [MDHHS, Office of Minority Health and Disparities, 2009 Annual Report]

ENROLLMENT - Explanation and Plan for Improvement (if less than 100%)
NACHC filled 85.1% of all awarded slots in 2009-10, but 100% of full-time positions were enrolled. Half-time and quarter-time slots were the leading root condition for less than the 100% enrollment, whether related to the economy is unknown. The enrollment rate for current program year further illustrates our success in filling FT slots. PY 2010 nearly 99.79% of slots (468 filled of 469 awarded) as of the submission of this application.

Enrollment efforts have been strengthened by more training for program coordinators. NACHC has newly implemented a national member recruitment campaign that launched on MLK Day, 2011 and will continue annually thereafter. To ensure better slot utilization across sites, CHC reviews enrollment rates

Narratives

by site within the first two months of the program year, and moves available slots to sites that are able to fill them if a particular program site is having a difficult time.

RETENTION - Explanation and Plan for Improvement (if less than 100%)
The program exited 84.7% of ACMs with an education award in 2009-10. Economic conditions for members seem to be the most significant factor impacting retention at less than the 90% requirement. CHC sites typically recruits 40-50% of ACMs from the communities served. Exit surveys suggest that many who left the program early did so for economic reasons.

CHC has provided the "Guide to Recruitment, Retention, and Recognition" that helps sites think of member retention as an ongoing activity, and crucial part of the member service experience. These tools include more member involvement in the sharing of program impacts, as well as ongoing recognition tips to help enhance the member experience, including service reflection activities. As economic reasons have been identified as one of the primary barriers to many ACMs being able to complete the program, CHC also created an updated and enhanced training guide to living effectively on the AC living allowance. Although this guide was introduced during the 2009-10 program year, its impacts are expected to be more discernable at the end of the 2010-11 program year when program sites have been able to utilize it for a full recruitment and retention cycle.

CHC has improved existing, and enacted new standard operating procedures and policies as an overall effort to strengthen the program. CHC works with local program coordinators to implement more effective recruitment, screening, and retention strategies.

OPERATIONS UPDATE: Despite the challenges, NACHC is committed to the development of more effective strategies for monitoring program sites, including site visit procedures, risk assessments and

Narratives

improving member enrollments and exits. Several systematic approaches have already begun to be implemented during 2010 that enables the national program to efficiently query information for data-driven decision making, and access intellectual capital as well as evidence-based practices. Additionally, as the number of NACHC program sites that were high risk continued to decrease, NACHC was able to adjust its site visit schedule from one every 18 months to one every 24 months for the lowest risk sites. Moderate risk sites extended to one every 18 months and high risk sites remained one every 12 months (or as needed). Monitoring of these programs though increased with the advent of the OnCorps reporting system (see below).

* Responsive Staffing Model: The department was reorganized to better align current staffing with adjusted program needs for the next three years. Two new positions were added, a Data and Communications Assistant and Program Assistant.

* Knowledge Management: NACHC adopted OnCorps Reporting (OCR) through the vendor, Settani and Company. This online database allows program data entry, viewing and reporting such as member timesheets, and service reporting. The system timekeeping allows members to submit hours, categorize hours year to date, view hours needed to complete, and view average hours per week needed to qualify for education award. Compliance accountability will include automated processes such as system notifications for supervisors, program coordinators and NACHC staff. NACHC will no longer need to wait and program coordinators will not need to shoulder the administratively burdensome responsibility of aggregating and reporting member data, because NACHC has instant access to member-level timekeeping and service activity. OCR was pilot tested from March to July of 2010 and implemented among all programs August 2010 in preparation for PY2010. NACHC is currently testing the remaining customizations. OCR is now the hub for program wide data collection and information management as of January 2011.

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* Relationship to other AmeriCorps: CHC serves as the coordinating program for the affinity group of health focused AmeriCorps programs. Through monthly conference calls and meetings at the National Conference on Volunteering and Service, AmeriCorps Grantee Meetings and AmeriCorps Best Practices Conferences, NACHC provides leadership and coordination on discussions regarding the Healthy Futures Focus Area and the National Performance Measure Pilot among other topics of discussion.

FOR MULTI-STATE CONTINUATIONS: Consultation with State Commissions (manner & extent)

NACHC sent completed consultation forms to State Commissions for every state in which the program operates. In early January, 2011 State Commissions received the Executive Summary of the National Program Evaluation of Community HealthCorps. As follow-up, NACHC is preparing electronic booklets customized by state that will feature more current state-specific data. Distribution of those publications is expected by late February.

CHANGE AS OF 07/08/11

Marana Community Health Center (Marana, AZ) and Southeast Lancaster Health Services (Lancaster, PA) will not be program sites in the upcoming year due to budget cuts. The slots will be re-allocated to other programs.

Performance Measures

SAA Characteristics

- [ ] AmeriCorps Member Population - None (
- [x] Geographic Focus - Rural
- [x] Geographic Focus - Urban
- [ ] Encore Program

Priority Areas

- [ ] Education
  Selected for National Measure [ ]
- [x] Healthy Futures
  Selected for National Measure [x]
- [ ] Environmental Stewardship
  Selected for National Measure [ ]
- [ ] Veterans and Military Familie
  Selected for National Measure [ ]
- [ ] Economic Opportunity
  Selected for National Measure [ ]
- [ ] Other
  Selected for National Measure [ ]

Grand Total of all MSYs entered for all Priority Areas 469

Service Categories

Hospital and Clinical Support Services including Rehabilitation

Other Health/Nutrition

National Performance Measures

Priority Area: **Healthy Futures**

Strategy to Achieve Results

Briefly describe how you will achieve this result (Max 4,000 chars.)

The roles of Community HealthCorps members are diverse, but all are targeted to lifting the barriers that low-income, uninsured, and medically underserved people experience in accessing health care, their ability to self-care, and achieving better health. Outreach can be street-based to homeless populations or can target youth adolescents at schools; it can target residential facilities, public housing, or community centers; it can occur at community events and health fairs; and/or can be the development and implementation of strategies that emphasize the needs of seasonal farm and other migrant workers. CHC conducts outreach on FQHC services and programs, health issues, and to identify medically underserved community members. CHC assist patients with understanding and completing enrollment documentation for health insurance and health center programs. In many CHC sites members commonly serve as interpreters for non-English speaking patients. The majority of the translations are being provided English to Spanish. Members translate health education and other materials from English to Spanish, and create new material in Spanish. Additionally, some members who perform this function provide other direct services such as outreach, navigation, application assistance and health education for patients and others in communities in languages other than English. The highest priority will be for enrollments that better enable people to adequately use preventive and primary care services such as health education.

Whether focused on the importance healthy oral health habits or educated teens recovering from substance abuse on the importance of fitness and nutrition, members will assist health centers in increasing knowledge and helping to change unhealthy lifestyles of service recipients. Members will most often assist certified health educator staff to deliver set curricula (or design new curricula) to populations that are not currently served in this capacity by existing resources.

Strategy to Achieve Results

Briefly describe how you will achieve this result (Max 4,000 chars.)

Result: Intermediate Outcome

Result.

Anticipate that the same uninsured, economically disadvantaged, medically underserved people that were enrolled, assisted through translation, and received health education will better use preventive and primary health care services and programs.

National Performance Measures

Result.

Indicator: Use of preventive and primary health care services and programs by people that

Target : individuals who are uninsured, economically disadvantaged, medically underserved - note: target number not increased to reflect 5% increase in requested slots due to already being highly ambitious for unduplicated counts of people.

Target Value: 90000

Instruments: Use (e.g., kept appointments) of the health education preventive service is the primary source data for reporting this outcome. The Direct Service Report form in OnCorps is also used by AC members to record daily activities with and/or on behalf of specific patients/clients that use health education services. Local source documentation with specific data about each patient/client are attendance logs, and in some instances notations about such service utilization are entered into the electronic database of patient records. For more detail about reporting in OnCorps, see the Output Instrument Statement above.

PM Statement: 90,000 individuals who are uninsured, economically disadvantaged, medically underserved, or living in rural areas utilizing preventive and primary health care services and programs.

National Performance Measures

Result.

previously did not who were uninsured, economically disadvantaged, medically

National Performance Measures

Result.

underserved, or living in rural areas. Use of services is primarly defined as 'kept

Result.

appointments' for the purposes of our program model.

Result: Output

Result.

People with Limited English-Proficiency or documented limitations in writing/speaking skills are provided

language translation services at locations such as clinics and emergency departments.

Indicator: H7: Clients receiving language translation services.

Target : individuals who are uninsured, economically disadvantaged, medically underserved

Target Value: 18000

Instruments: The Direct Service Report form in OnCorps, the online data collection system, is used by AC members to record daily activities with and/or on behalf of specific patients/clients. Within this online service report, members only record # of NEW PEOPLE SERVED each day. People SERVED can only include those assisted directly, and not the extraneous persons who benefited aside from the individual. Once all activities are recorded for a particular day (up to three), members are directed to identify the # of New People Served in Multiple Activities. This number represents those clients who may have been served in more than 1 activity during that day. This number is calculated every day by members as extra assurance that the report only represents the total unduplicated people served.

PM Statement: 18,000 clients receiving language translation services at clinics and in emergency rooms.

Result: Output

Result.

People in need will be enrolled in health services, health insurance and other health benefit programs.

Indicator: H3: Clients enrolled in health benefits programs.

Target : individuals who are uninsured, economically disadvantaged, medically underserved

Target Value: 50000

Instruments: The Direct Service Report form in OnCorps, the online data collection system, is used by AC members to record daily activities with and/or on behalf of specific patients/clients. Within this online service report, members only record # of NEW PEOPLE SERVED each day. People SERVED can only include those assisted directly, and not the extraneous persons who benefited aside from the individual. Once all activities are recorded for a particular day (up to three), members are directed to identify the # of New People Served in Multiple Activities. This number represents those clients who may have been served in more than 1 activity during that day. This number is calculated every day by members as extra assurance that the report only represents the total unduplicated people served.

PM Statement: 50,000 clients enrolled in health insurance, health services, and health benefits programs.

Priority Area: Healthy Futures

Strategy to Achieve Results

Briefly describe how you will achieve this result (Max 4,000 chars.)

Community HealthCorps members will engage children and youth in a variety of physical activity as part of a

comprehensive set of health service activities that, in concert are designed to address childhood obesity. For

example, physical activity will be combined with the provision of healthier choice snacks and drinks, and nutrition

National Performance Measures

Briefly describe how you will achieve this result (Max 4,000 chars.)
education that includes caregivers of participating children and youth. The kids will experience varying levels of intensity during physical education sessions, from low to moderate to vigorous intensity. The extent of exercise intensity and types of physical activity across programs is unkown as this time, but planned data collection will reveal more detail about the physical activity methods our programs use kids engage.

Result: Output

Result.
Children and youth wil engage in physical education activities of varying intensity, and other healthy behaviors to decrease prevalence of overweight.

Indicator: H5: Youth engaged in activities to reduce childhood obesity.

Target : number of children and youth activily participating in in-school or afterschool physical activities -

Note: small proportion of slots engaged compared to the other measures

Target Value: 3000

Instruments: attendance logs

PM Statement: 3,000 children and youth engaged in in-school or afterschool physical education activities with the purpose of reducing childhood obesity.

Result: Intermediate Outcome

Result.
Participating children and youth will experience improved aerobic fitness by at least 8% due to the in-school or afterschool physical education.

Indicator: Fitness improves by at least 8% for the children and youth that are engaged in

Target : number of children and youth participants who's aerobic fitness increases by at least 8%

Target Value: 600

Instruments: A better indicator of physical activity impact than measuring weight or Body Mass Index, aerobic fitness estimation will be measured by using a formula that includes age and heart rate. Data collection instrument will be Excel spreadsheet that contains the following fields: alphanumeric child ID (no personal identifiers such as SS# or Medicaid #); date of physical activity; activity type (e.g. bicycling, soccer); activity duration (# of minutes); age; and heart rate (# of heart beats in 10 seconds to minimize count error for kids). The measure and methods were selected based on the resources; the Centers for Disease Control and Prevention Physical Activity Guidelines for 6 to 17 Years of Age; and http://www.mayoclinic.com/health/fitness/SM00086.

PM Statement: 600 children and youth that participate in vigorous-intensity physical activity will experience improved aerobic fitness by at least 8%.

National Performance Measures

Result.

vigorous-intensity physical activity during in-school or afterschool physical education.

Required Documents

Document Name	Status
Evaluation	Already on File at CNCS
Labor Union Concurrence	Not Applicable