# Narratives

**Executive Summary**

The Association of Clinicians for the Underserved proposes to develop an AmeriCorps program serving in low-income medically underserved communities in the U.S. and its territories that will focus on the CNCS focus area of Healthy Futures. The CNCS investment of $74,266 will be matched with $32,099, $0 in public funding and $32,099 in private funding. No AmeriCorps members will be needed to execute this plan.

**Rationale and Approach/Program Design**

1. Need

The Association of Clinicians for the Underserved is a national organization dedicated to healthcare issues and solutions affecting the poor, the low-income, and the medically underserved communities in the United States and its territories. This application is focused on developing a program that will help vulnerable populations overcome modifiable barriers to care to achieve optimal health and well-being.

The U.S. health care system is a complex and fragmented system where poor and underserved communities face many barriers to care that affect their health status, access to appropriate care and therefore their future health outcomes. Many of these barriers are often related to patient, provider, and system modifiable factors. Patient barriers are related to the individual's financial barriers, educational attainment, communication skills, and transportation challenges, among many others. Provider barriers are often related to lack of available providers in an area, the lack of appropriate providers (i.e. - primary care), and the lack of cultural understanding or the health literacy level of the patient population. System barriers can range from insurance network challenges to difficulty navigating the entire health care system, from primary care to specialty care.

Patient Barriers

Access to health care and utilization of health care resources have been identified as important components that contribute to the health of patients as well as their communities. Even when families have health insurance coverage, they often face barriers that impede actual utilization of health care services. Published data show there exist huge disparities with access and use of available health care resources, particularly among the low-income and medically underserved populations. Published in the Annals of Family Medicine in 2007, a study designed to identify the barriers that low-income parents face when accessing health care for their children and how insurance status affects

their reporting of these barriers, families reported three major barriers: lack of insurance coverage, poor access to services and unaffordable costs. The study found that even families with health insurance had trouble affording the co-pays as well as needed medications and families with public health insurance had trouble getting access to a primary health care provider. When they did gain access, they reported feeling unwelcome and having to travel long distances to get to these providers. Those without any insurance struggled to obtain publicly-financed or any affordable health care options.

The Affordable Care Act provided health coverage for 20 million Americans yet it is estimated that more than 30 million persons remained uninsured in 2015. Still, while 100% access to healthcare is a Healthy People 2020 goal, the data for the start of this decade estimates that almost 1 in 4 Americans did not have access to a primary care provider and approximately 1 in 5 Americans did not have medical insurance. Considerable evidence exists showing that the lack of health insurance is a primary barrier to health care access and the development of more serious and costly health conditions. In short people who lack the ability to pay, especially the uninsured, do not seek care until symptoms are severe and disabling - often resulting in the overutilization of emergency rooms. Uninsured and low-income individuals are also the least likely to seek out all forms of preventive care, from routine screenings and immunizations to regular primary care checkups.

The inability to pay for care at any level goes beyond the 30 million uninsured. Census poverty data for 2015 estimates 43 million (13.5%) people in the U.S. live in poverty. An additional 97 million (31.7%) are low-income, defined as having incomes below twice the federal poverty level or $47,700 for a family of four. Taken together this means that approximately 45.2 % of the U.S. population is poor or low-income - nearly half the population.

Additional 2015 data indicates that low-income people are found among all races, but is most prevalent in minority populations where 24.1 % of African-Americans and 21.4% of Hispanics have household incomes below the official poverty line. The percentage of non-Hispanic whites below the poverty line was only 9.1% in comparison, with the national average of 11.3 % of U.S. families had incomes below the poverty level. Nearly 1 in 5 of all children in America (19.7%) are living under the federal poverty line.

Provider Barriers

For poor and low-income populations, the primary source of care is often local safety net providers such as public health departments, free clinics, community mental health centers, and Federally

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Qualified Health Centers (FQHCs) that are designed to provide affordable care services for the low-income and accept public funded health coverage such as Medicaid, Medicare and the Children's Health Insurance Program (CHIP). Because of this, many safety net providers disproportionally serve vulnerable populations: the poor, the low-income, the uninsured, and the medically underserved. Their patients often lack resources to access health care and lack awareness of the publicly funded health insurance programs and other available health care resources.

Safety net patients are characterized as the most vulnerable when it comes to health care and health outcomes. These patients are also likely to encounter many modifiable barriers to care across the patient's care continuum - from enrolling in the most appropriate and available health insurance options to medical diagnosis and successful treatment - with the potential to delay appropriate health care and result in poor health outcomes. Many are uninsured, have limited financial resources, competing priorities, delay essential preventive care screenings, and lack information on resources for effective care coordination and self-care.

System Barriers

Access to primary care and continuing care coordination is especially important for underserved populations to avoid more expensive health care options. Most often low-income patients lack information and access to services and the associated support systems to address potential health threats as well as get appropriate treatment. When patients lack access to primary health care and treatment they are more likely to develop chronic conditions. About two-thirds of all deaths in the U.S. are due to chronic disease, including heart disease, cancer, stroke, lung disease and diabetes.

Individuals with chronic conditions, especially those from low-income communities, encounter many provider and health system barriers that can impede treatment compliance. Often safety net providers lack the support system to implement recommended care. Similarly, patients in general, often find it difficult to navigate a complex health system and gain access to primary care providers and specialists. These are modifiable barriers can be overcome if patients are made aware of available resources to assist them with their health care.

Safety net providers often lack the resources to assist poor, low-income and medically underserved patients "navigate" our complex health system and provide support to address patient specific barriers to care.

2. Evidence-Based Intervention

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ACU proposes to partner with local safety net organizations to provide evidence-based patient navigation assistance interventions for underserved populations. AmeriCorps members will be trained as patient "navigators" to implement evidence-based patient centered interventions such as case management assistance with coverage enrollment, accessing primary care services, and awareness/effective utilization of health care resources across the respective individual's continuum of care. Patient navigation assistance also can help to identify maximum use of various clinical and non-clinical staff, contingent on their education and skill level, as patient navigators in a primary care setting.

Patient Navigation

Patient navigation was initially identified in 1990 by Harold Freeman as an intervention to address disparities in cancer care and health outcomes found between poor and non-poor Americans. Patient navigation has been identified as benefiting those most vulnerable to the myriad of access barriers across the spectrum of health care from diagnosis to treatment completion. With a focus on low-income patients, patient navigation consists of activities designed to improve patient utilization of health resources that contribute to better health outcomes. This patient centered approach utilizes patient navigators to improve treatment compliance, health outcomes, and treatment by assisting patients to overcome specific barriers faced across the care continuum. Since its inception the patient navigation model has been expanded to include the timely movement of an individual across the entire health care continuum from prevention, detection, diagnosis, treatment, and support, to end-of-life care.

The National Cancer Institute Patient Navigation Research Program defined the patient navigator role as follows: "A patient navigator is a person with or without a health care related background that engages with patients on an individual basis to determine barriers to care or following recommended guidelines and provider information relevant to their specific circumstances to increase access to components of the health care system and to enhance their disease care. Navigators do not provide clinical advice but rather focus on helping patients to access, understand, or better utilize available health care resources. The navigator role must be formalized as opposed to casual, untrained peer, family or friend support."

A patient navigator is a member of the healthcare team who helps patients "navigate" the healthcare system and get timely care. Navigators help coordinate patient care, connect patients with resources, and help patients understand the healthcare system. Patient navigators work in many areas of health

care and, contingent on any formalized clinical education and training, may assist in a clinical and non-clinical lay role. Specific lay (non-clinical) tasks associated with patient navigation include: health insurance enrollment and eligibility assistance, community education, community liaisons and other enabling services such as transportation, interpretation assistance. Patient navigation interventions such as cancer screenings, specific disease education and self-management education are more appropriate for clinical staff as opposed to non-clinical staff.
Patient navigation is consistent with a patient centered focus to assist patients with their care including access to health care services, assistance with care management and self-care support, awareness and utilization of community resources, health and disease education, and development of support systems to improve patient and population health outcomes.

Intervention #1: Patient Case Management - Assistance Navigating Health Insurance Enrollment
In 2014 the Journal of Health Care for the Poor and Underserved published a study by the University of Utah and the Association for Utah Community Health that documented an evidence-based intervention using AmeriCorps members to assist with health insurance enrollment case management and increased utilization of preventive care services (JHCPU, Volume 25 Number 2 May 2014). The study entitled "AmeriCorps Members Increase Enrollment in Medicaid/CHIP and Preventive Care Utilization at a Community Health Center," was a randomized controlled trial that examined health insurance enrollment and preventive health care utilization rates at an urban FQHC utilizing AmeriCorps members to provide enrollment case management (CM) to Latino parents. The center had not provided case management assistance prior, but only information about the availability of health insurance and health care services. The study sought to: 1) determine whether case management by AmeriCorps members increased enrollment of children in Medicaid/CHIP at an FQHC, 2) identify factors associated with non-enrollment, and 3) compare health care utilization by enrolled and non-enrolled children. In the study, Latino parents at one site were provided enrollment case management assistance compared to another site where just application instructions were provided. Results showed that of the 107 children where case management was provided 74% were enrolled compared with 26% of the 96 children from the non-case management clinic. Non-enrolled children also completed fewer preventive care visits than enrolled children despite sliding-scale fees that made the cost of care affordable at both FQHC sites. The researchers concluded the intervention by the AmeriCorps members was an effective approach to increasing health care access and utilization for Latino children.

## Narratives

Participating AmeriCorps members received training in clinic flow and privacy by the clinic manager and in data entry and data integrity by the project director. They were instructed how to assist families to apply for Medicaid and CHIP. Members were high school graduates who were fluent in English and Spanish. Clinic receptionists offered patients who were checking in with uninsured children an appointment with the AmeriCorps members. Upon obtaining informed consent, AmeriCorps members could act as their proxy for interactions with the Utah State Medicaid Agency. Case management continued through enrollment or denial with a range of zero to 171 days from date of first contact until case closure. The AmeriCorps members assisted families to gather the supporting documentation necessary to expedite their application. These included birth certificates, Social Security cards, school report cards, vaccination records, and paycheck stubs. In some cases, additional documents were required. Examples included AmeriCorps members assisting families to obtain letters from employers certifying salaries. Obtaining letters from ex-spouses verifying lack of child support, and applying for out of state birth certificates. Finally, AmeriCorps members assisted with completion and submission of the application, arranged interviews with Medicaid eligibility workers, and acted as liaisons between the workers and the families.

The researchers point out several reasons for the success of the evidence based interventions. Too often caseloads are too large to allow eligibility workers to provide ongoing support to obtain documentation throughout the application process. Combined with a complex application process requiring high levels of documentation, the outcome is very low enrollment for the most vulnerable patients. AmeriCorps members ensured initiation of the application, assisted families to obtain documentation, and functioned as liaisons for the families throughout the process. The study determined this was associated with substantial increases in enrollment compared with those unassisted through the application process.

With respect to the utilization of care, the study also showed the benefits of enrolling children in Medicaid/CHIP. For Latino children, who are disproportionately affected by certain chronic disease, such as obesity and asthma, less preventive care reduces their opportunity to receive anticipatory guidance to prevent or mitigate those diseases. The study determined that a greater proportion of children that had been enrolled in insurance completed the recommended number of preventive visits in the six months following enrollment. This was true across age groups, with the highest disparity in children younger than 12 months. Over 90% of enrolled children had received the appropriate care, while only 36% of non-enrolled children received such care.

The authors conclude by suggesting that to increase enrollment of eligible children, states should work

with community organizations and cite that the mission of the project was to "reduce economic, geographic, cultural, and linguistic barriers to health care and to expand primary care services for the medically underserved populations. Utilizing AmeriCorps members for case management is consistent with this mission." Finally, the authors close by observing that "Underserved populations need support to navigate the enrollment process, and AmeriCorps members are an affordable resource to provide this service."

Intervention #2: Patient Case Management - Assistance Navigating Local Health Resources

Patient navigation studies have also included the applicability to assisting patients with clinical disease management. Patient navigation often involves assisting patients with navigating community partnerships and identification of resources that can assist with appropriate and timely screenings. Published in the June 2015 Journal of Community Health, A Community-Based Partnership to Successfully Maintain a Breast Health Navigation Program describes the successful implementation of an evidence-based patient navigation program that promotes sustainability, increased knowledge, and sharing of best practices among more than 30 navigators in the region that facilitated coordination efforts when assisting women to navigate the system from screening to treatment and follow-up. Patient navigators in the study were responsible for developing collaborative relationships with cancer service and treatment providers, providing face-to-face, telephone and mail-based support to connect women to appropriate screening, diagnostic and treatment services, assisting women through the initial and follow-up visit process, and providing assistance to patients as needed to encourage appointment attendance. As a result of the navigators, nearly 95 percent of the low-income women targeted for the intervention received a mammogram within the study period. This two-year increase in the screening rate more than doubled the overall rate of mammography for the FQHC's study site. In addition to the clinical outcome improvements recognized in the study, the authors point out that the "program was a successful implementation of an evidence-based patient navigation program that continues to provide significant impact in a high-need area." The breast cancer navigation program was continued by the FQHC despite the end of the temporary funding mechanism used to start the program. The program "filled a clear gap" in access to care and these roles were therefore sustained beyond the federally-provided funding.

Program Training

AmeriCorps members will be trained as patient navigators to assist patients navigate their health

care needs. Training will include understanding the U.S. healthcare system, health insurance coverage and financial assistance, patient navigation models and interventions, and motivational interviewing. In addition, members will be trained on the AmeriCorps programs and compliance requirements. AmeriCorps members will be trained to assist with patient, provider, and system barriers and provide evidence based patient specific assistance/interventions for uninsured, poor, and low-income patients to assist them with "navigating" the health system. Trainings will help improve the AmeriCorps members' knowledge of the health system, patient health status, and effective use of health resources. Contingent on their education and skill sets, members will be trained as part of the healthcare team to assist with identifying barriers to care, implement appropriate evidence based patient navigation interventions, and resolution of patient clinical and non-clinical barriers from diagnosis through treatment compliance.

3. Planning Process / Timeline

The AmeriCorps planning process will be led by ACU's Executive Director Craig Kennedy, MPH, with support from several key ACU staff, including Director of Training and Technical Assistance Allison Abayasekara, MA, and Staff Assistant Mariah Blake. The program will also be developed with the assistance of a recognized community health services management consultant (John Ruiz) and a veteran national service management and program design consultant (Cal George).

Planning Process

As a key element of developing this evidence-based planning grant application, ACU began forming a preliminary AmeriCorps Planning Committee comprised of five ACU organizational members with experience operating AmeriCorps programs. Each of these organizations have worked with other AmeriCorps National Direct grantees and State Commissions to assist medically underserved populations improve access to care. The Planning Committee will be formalized upon award and, in keeping with the case management interventions described, help develop a preliminary AmeriCorps program designed to address these needs in underserved communities. The core development components of the planning process include:

A.) Formalization of the AmeriCorps Planning Committee;

B.) Development of a Request for Proposal (RFP) for recruiting and selecting operating sites;

C.) Development of an ACU staffing and management structure (including job descriptions) for contracting with and monitoring operating sites, data collection and analysis, development of pre- and

in-service member training modules and delivery (as appropriate);
D.) Development of program-specific financial reporting and reimbursement systems;
E.) Recruitment of a Third-party Evaluator with demonstrated success in health care delivery and development of a multi-year Evaluation Plan and Logic Model drawn from prior evidence based intervention research and the Theory of Change;
F.) Development of an organizational Sustainability Plan, including identification and solicitation of potential foundation and corporate sponsors for key program elements;
G.) Refinement of specific patient-centered case management interventions, related Theory of Change and Logic Model, based on and closely adhering to the respective evidence-based intervention research described in the application, and
H.) Development and submission of an application to CNCS for a 2018-2020 AmeriCorps National Direct Grant with operating sites in at least five states with concurrences / letters of support from State Commissions in each state.

Program Development
With a projected July 1, 2017 start date, the ACU AmeriCorps Planning Committee will be convened for a one-day working meeting in conjunction with ACU¿s Annual Conference in Washington, DC, in late July 2017. Key documents that will be prepared for this initial Planning Committee meeting include: 1.) a 1-2 page Overview Summary of the ACU AmeriCorps Planning Grant, including needs analysis (MUAs/populations to be served), AmeriCorps program model and healthy futures priority area, a description of the Utah evidence-based case management interventions, and the planning process timeline; and 2.) a draft RFP from interested operating sites, including a detailed description of full-time AmeriCorps member allowances, benefits, displacement restrictions, prohibited activities, model position description and supervision plan based on the respective evidence-based interventions identified and populations to be served, member pre- and in-service training plans (including AmeriCorps identity activities), minimum matching funds requirements and so forth. Specifically, the RFP will place emphasis on respondents demonstrating a thorough understanding of the respective evidence-based case management intervention research and making a commitment to faithfully replicate the intervention in their health care setting.
Based on input from the ACU Planning Committee, the Overview and the draft RFP will be revised in August 2017, and sent in early September (with a mid-October response deadline) to the ACU full membership, along with all State Primary Care Associations (PCAs) and Primary Care Offices (PCOs)

with a request that they share the RFP with health care providers in their respective states. The RFP will be structured like the 2017 CNCS NOFO (in abbreviated form) and will specify criteria by which responses will be reviewed and ranked. RFP responses will be reviewed and ranked in late October by an independent panel of health care and national service professionals, with support from ACU¿s staff and management consultants. Based on the quality of the RFP responses and such other criteria as overall manageability, geographical (urban, suburban, rural) and population diversity, ACU will select organizations that proposed to host full-time members that meet the performance goals in the most cost-effective manner. Selections will be made by December 1, 2017 for inclusion in ACU's 2018-20 National Direct Application.

Concurrent with the above steps, ACU's planning grant management consultants will work with ACU senior staff and Board of Directors to develop a Staffing and Management Structure for the proposed ACU AmeriCorps program, as discussed above. The size and scope, as well as expected economies of scale, resulting from the RFP selection process will inform and guide the nature and systems required for the Staffing and Management Structure, which will be drafted for review by the ACU AmeriCorps Planning Committee in November 2017, and incorporated into the 2018 application expected to be submitted in January 2018.

Evaluation

Key elements of the Staffing and Management Structure are the monitoring/technical assistance and data gathering/analysis system, which, in conjunction with an in-depth understanding of the evidence based case management interventions, will guide and inform the Evaluation Plan development, including the Logic Model and Theory of Change, and the recruitment of a third-party evaluator. The recruitment and selection of the third-party evaluator will begin in October 2017, concurrent with the RFP Selection Process, and consultant fees will be built into the budget for the selected third-party evaluator to guide the development of the Evaluation Plan, Logic Model and Theory of Change consistent with the outcomes for the program for incorporation into the 2018-20 Application due in January 2018. Further, the Evaluation Plan will delineate additional methods for assessing each operating site¿s success in replication of the evidence-based interventions and documenting any variations from the original interventions, including reasons for the variation and/or positive effects of such variation.

Similarly, the Sustainability Plan and related Marketing Materials (with an emphasis on the respective evidence-based interventions being utilized) will be developed in early November 2017 and will be

used for corporate and foundation prospecting and relationship-building activities. This will be led by ACU's Executive Director and key ACU Board members, and is expected to continue through June 2018.

Outcome

The result of the above action steps will be the submission of a 2018-20 application for an ACU National Direct Grant

**Organizational Capability**

Organizational Background

ACU is a 501(c)(3) nonprofit organization of clinicians, advocates and health care organizations that provide care for underserved communities. Our programs include professional education, clinical tools, advocacy, patient education, training and technical assistance. ACU was established in 1996 by participants and alumni of the National Health Service Corps (NHSC). Today the NHSC has nearly 10,000 participants serving in more than 2,500 sites across the country. Our membership includes individuals representing 18 professional disciplines as well as community clinics, health care organizations and professional societies.

ACU focuses on issues such as: health care reform, health care access, elimination of health disparities, a transdisciplinary approach to health care, workforce development and diversity, cultural competency in the health care setting, health care quality improvement, access to medicines and pharmacy services, and integration of behavioral health and complementary care into primary care practice. In pursuing its mission, ACU is committed to six objectives:

- Enhancing support for health care teams to deliver comprehensive primary care and preventative services,
- Providing access to information relevant to clinical practice,
- Providing opportunities for clinicians to interact with other professionals,
- Promoting research to increase understanding of underserved practice,
- Increasing opportunities for training relevant to providing health care to underserved populations, and
- Enhancing the health care team's use of health information technology and clinical informatics to improve health outcomes.

ACU has an official research journal, The Journal of Health Care for the Poor and Underserved (JHCPU). The JHCPU is a peer-reviewed research journal focusing on contemporary health care

issues of medically underserved communities. Regular features include research papers and reports (including the Utah study referenced above), literature reviews, policy analyses, and evaluations of noteworthy health care programs, as well as a regular column written by members of ACU.

ACU has a track record of successfully implementing appropriate operational and oversight controls to successfully perform major federal grant projects. ACU has been both a direct recipient and a sub-recipient of several federal grants and cooperative agreements; many directly assisting providers in FQHCs. Recent direct awards from the Department of Health and Human Services (HHS) and the Environmental Protection Agency (EPA) have demonstrated the capacity of ACU to be the primary manager of federal grant funds. ACU is the current recipient of HHS' National Cooperative Agreement to help FQHCs with their clinical workforce recruitment and retention activities. Through this project ACU has established both programmatic, financial and evaluation components in alignment with federal goals. ACU was also a direct awardee of the EPA Indoor Air Quality division¿s work to reduce the prevalence of childhood asthma. ACU aligned its work with the Coordinated Federal Asthma Action Plan to Reduce Racial and Ethnic Disparities, a joint effort of 14 federal organizations. This multi-year EPA project concluded in 2015 with all work, including grant deliverables, financial management and reporting officially accepted by the EPA.

Staffing

ACU Executive Director Craig Kennedy has been in association management for more than 17 years. In this role, he has developed budgets, tracked deliverables, oversaw annual reports and recruited appropriate staff for specific projects. He has expertise in contracting, grants management, and organizational staffing and leadership. He earned his Masters in Public Health (MPH) from the George Washington University.

ACU Director of Training and Technical Assistance Allison Abayasekara joined ACU in 2014 after having worked with community health centers for over seven years, first building a statewide workforce program at the Pennsylvania Association of Community Health Centers and then serving as the program manager for the Primary Care Association and Health Center Controlled Network department at the National Association of Community Health Centers. She currently manages the HRSA National Cooperative Agreement (NCA) for ACU. She received her Master of Arts from the University of Maryland, College Park, and has a Bachelor of Arts from Lebanon Valley College.

ACU Staff Assistant Mariah Blake is an AmeriCorps alumna and supports ACU's work on the NCA project. She has experience with project tracking and partner engagement at the local, state and national levels. She drafts content and prepares materials for ACU's NCA project, and works directly

with FQHCs across the country. Mariah is also the lead ACU staff for our information technology platforms and database management. Mariah joined ACU in 2015 after working in nonprofit and association support and serving with KEYS Service Corps in Pittsburgh, Pennsylvania. She received her Bachelor of Arts from the University of Pittsburgh in Pittsburgh, Pennsylvania.

ACU primary consultants on the project are John Ruiz and Cal George. They will assist with the planning process, and preparation and submission of the final AmeriCorps application.

Cal George is the principal of Cal George Consulting (CGC). He is the former National Director/Founder of the Community HealthCorps program from 1995 through 2008. CGC clients include YouthBuild USA in Somerville, MA, HealthCorps in New York City, NY, and the Council for Opportunity in Education in Washington, DC. Mr. George was also the co-founder of the Eleanor Roosevelt Institute's Youth Project (now Youth Services America).

John Ruiz is the founder and principal of FQHC Associates. He has over 25 years working with the Community Health Center Program, including as Chief Financial Officer at an FQHC in San Juan, Puerto Rico. Mr. Ruiz held various leadership positions at the National Association of Community Health Centers (NACHC) including the management of NACHC's $6.5M training and technical assistance cooperative agreement from HRSA. FQHC Associates is a national healthcare consulting firm specializing in the needs of established, new, and potential FQHCs whose clients include FQHCs, Primary Care Networks, Health Centered Controlled Networks, hospitals, and health plans.

ACU will hire additional staff to manage the project contingent on funding from AmeriCorps and the planning process identified above.

**Cost Effectiveness and Budget Adequacy**

The budget will cover staff and consultants' costs necessary for the refinement and development of the patient navigation interventions, partnerships, identification of additional sustainable resources, AmeriCorps Planning Committee activities, and the preparation of a final application for submission in January 2018 (see timeline above to additional detail on activities).

Total budget proposed is $106,365. This amount includes funds from CNCS consisting of $74,266 and ACU matching funds of $32,099. Staff personnel and fringe benefits costs for planning grant deliverables are $42,067. Staff costs are calculated at current salary rates. Fringe benefits are calculated at 19.34%, and include FICA, health insurance, dental insurance, disability insurance, vacation, sick and holiday leave. Consultant costs of $35,000 for planning grant activities are estimated for 350 hours at $100 /hour. Staff and consultant travel costs are estimated at $4,950, including airfare, hotel costs, ground transportation and pier diem, to attend three planning

committee meetings.

Total indirect costs are 28.9 percent of all direct costs, as per ACU's federally-negotiated rate. Total indirect costs are $23,848 consisting, with $4,126 (5% of direct costs) funded by CNCS. The remaining costs ($19,722) will be funded by ACU from our general reserves.

**Evaluation Summary or Plan**

Building on the positive results of the case management interventions referenced above, ACU plans to develop a national patient navigator program focused on case management to achieve similar outcomes at FQHCs across the country.

Theory of Change

The general theory of change proposed for AmeriCorps funding, and to be developed, is to address barriers to care faced by low-income, medically underserved populations. ACU proposes to train AmeriCorps members as patient navigators to assist safety net patients with enrollment in health insurance programs and accessing local health resources with the goal to increase use of preventive care services and improved self-care. As shown in the evidence-based interventions identified previously, assisting patients with enrollment and accessing preventive care resources for low-income populations resulted in increased enrollment and use of preventive care resources.

Outcome of Interest/Logic Model

Utilizing AmeriCorps members as patient navigators, based on the interventions identified, outcomes for a preliminary logic model could include: 1) increased patient knowledge and enrollment in health insurance plans as short-term outcomes, 2) increased utilization of preventive care and knowledge of local health care resources as medium term outcomes, and 3) improved patient clinical outcomes and self-care management skills as long term outcomes.

Research Questions to be Addressed

- Identify replicable evidence-based interventions utilizing AmeriCorps members as patient navigators to provide patient enrollment assistance at safety net provider sites.
- Identify replicable evidence-based intervention utilizing AmeriCorps members as patient navigators on the practice health team to assist with care and treatment barriers for patients with acute and chronic conditions.
- Identify specific evidence-based patient navigation interventions in the care continuum for low-

income, medically underserved populations that can be implemented in the primary care setting.

The Study Components

The development of the research design, sampling methods, measurement tools, data collection procedures and analysis plan are all built into the planning process described previously. ACU will work with the Evaluation Consultant to ensure a RCT can be performed ethically.

Qualifications Needed for the Evaluator

As discussed above in section B. 3. Planning Process / Timeline, the outcomes in the case studies will guide the development of a multi-year Evaluation Plan and Performance Measures. Central to this will be the recruitment and selection of a third-party evaluator with prior RCT experience in community based health care delivery, particularly in the areas of case management and patient navigation for low income, underserved populations. Consultant funds are built into the Planning Grant budget for the third party-evaluator to assure a high quality and feasible research design, along with the necessary data collection instruments and systems for analysis.

Estimated Budget

The estimated evaluation budget is difficult to determine at this early stage and will depend on the scope of the proposed project. As mentioned in the organizational capacity section of this application, ACU's official journal is The Journal of Health Care for the Poor and Underserved (JHCPU). Each edition includes many peer-reviewed research articles focusing on contemporary health care issues of medically underserved communities. ACU has a regular column in the JHCPU and can therefore publish the evaluation of the patient navigator program therein.

**Amendment Justification**

NA

**Clarification Summary**

NA

**Continuation Changes**

NA

**Grant Characteristics**