National Health Corps

2022-24 Final Evaluation Report

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Executive summary

In National Health Corps' (NHC) 2022-23 and 2023-24 service years, 149 NHC members were placed at 78 host sites and served approximately 59,351 underserved youth and adults in California, Florida, Illinois, and Pennsylvania. NHC contracted with Wilder Research to evaluate member, host site, and client outcomes for the 2022-23 and 2023-24 service years.

Wilder administered surveys at the beginning and end of the NHC service year to members, a comparison group, and host site supervisors. Members completed client evaluation forms on an ongoing basis throughout their service year. Additionally, NHC alumni were sent a follow-up survey 12 months after the end of their service year.

Key findings from this study include:

- NHC members experienced statistically significant increases in their knowledge of the public health field and social determinants of health, public health practice knowledge and skills, and leadership skills. These gains in knowledge and skills surpassed changes observed in the comparison group across the same time period—which suggests members' growth was due to their participation in the NHC program.
- Twelve months after the end of their service year:
  - Most NHC alumni are enrolled in a postgraduate education program.
  - Among alumni who sought public health-related employment, most were able to secure a role—and they credit NHC for helping them do so.
  - Most are still spending time engaged in service and volunteer activities.
- Members valued the numerous and varied public health training and professional development NHC provides, alongside opportunities for building relationships with other NHC members, professionals, and community members. Many NHC members reported that the program helped prepare them for their educational and professional careers in health and public health.
- At the end of members' service year, host site supervisors reported an increase in knowledge of oppressive structures that create and perpetuate health disparities. Most host sites reported making changes within their organization to address biased or discriminatory institutional practices or policies.
- Host sites reported that members increased their organizational capacity and improved the quality of client care, and that they have experienced few challenges or downsides to hosting an NHC member.
- Most clients increased their knowledge following services received from NHC members.
- There are opportunities to continue to improve the NHC program by further developing and refining trainings, revising member recruitment materials and position descriptions, helping host site staff understand member roles and responsibilities, providing adequate oversight of host site placements, and reviewing and improving member working conditions.

On the whole, these findings suggest that NHC is making great strides towards their mission of building healthy communities while also developing future health and public health leaders.

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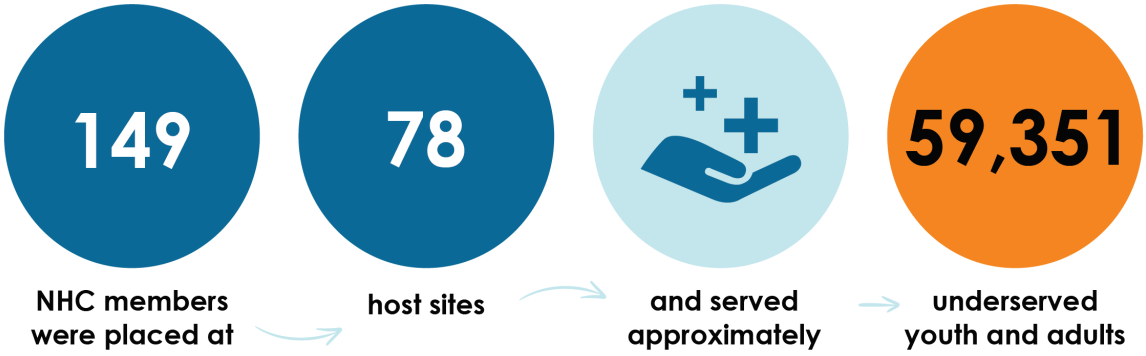
Introduction

National Health Corps

The National Health Corps' (NHC) mission is to build healthy communities by delivering and connecting those who need it most with health and wellness education, benefits, and services, while developing future health and public health leaders. To achieve this mission, each year NHC partners with six operating sites in California, Florida, Illinois, and Pennsylvania to recruit, train, and place NHC members in host site organizations working to improve health outcomes in underserved communities.

In National Health Corps' (NHC) 2022-23 and 2023-24 service years,



Theory of change

The National Health Corps program aims to create positive change among NHC members, their host sites, and the clients they serve.

Members. If National Health Corps (NHC) staff and host sites train and mentor NHC members, members will develop their knowledge, skills, and confidence in trauma-informed public health practice, addressing social determinants of health including structural oppression, leadership skills, and social cohesion and capital. Members will apply their new knowledge and skills to their NHC service positions. Following NHC service, members will be more likely to participate in volunteer or community service, enroll in public health-related education, and pursue public health-related employment that provides a living wage in their own community.

Host sites. Through capacity-building activities, NHC members will increase visibility, accessibility, availability, and reach of public health and social services addressing social determinants of health; the coordination of public health and social services; and host site staff knowledge of social determinants of health and their relationship to structural

oppression. Over time, these activities will lead to increased availability of services and changes to practice and policy at host sites that address structural barriers to health and wellness. In the long-term, NHC will address social determinants of health through improved organizational efficiencies, improved programming, and increased community engagement.

Clients. NHC members will provide public health education, health screenings, service navigation, and care coordination to address social determinants of health and health and social service benefit enrollment.

Through these activities, clients will increase their knowledge about:

- Available public health or social services and benefits
- How to access those services or benefits
- How services or benefits can assist with improving their health
- Steps to lead a healthier lifestyle
- Disease prevention and management strategies

Clients who receive repeated services from NHC members will increase their use of public health or social services and benefits, services that promote steps to lead a healthier lifestyle, or services that promote disease prevention and management strategies. Through increased use of these services, clients will experience decreased barriers to improving their health.

Evaluation purpose and research questions

Evaluation purpose

The purpose of this evaluation is to assess the extent to which NHC has created positive impact on 1) member knowledge, skills, and development as public health professionals; 2) host site supervisor knowledge, skills, and organizational capacity; and 3) client knowledge, as they relate to the theory of change outlined above.

Research questions

This evaluation aims to answer the following research questions.

Members

1. To what extent do members increase their knowledge and skills related to trauma-informed public health practice, the social determinants of health and their relationship to structural oppression, leadership skills, and social capital and cohesion?

2. To what extent do members apply their gained knowledge and skills to their position during their NHC service year?
3. To what extent do members pursue public health-related volunteer or community service, education, and/or employment 12 months after the end of their service year?
4. What is the impact of participation in NHC on member public health knowledge and skills, leadership skills, social capital, and social cohesion, compared to individuals who were accepted to the program, but not placed at a host site?

Host sites

1. To what extent do individual host sites improve their program development, service delivery, and community engagement following placement of NHC members compared to the beginning of NHC members' service year?
2. To what extent did host sites make changes to practice and policy to address underlying manifestations of structural oppression?
3. What could NHC host sites do to improve the experience for NHC members and their effects on program development, service delivery, and community engagement?

Clients

1. To what extent do clients increase their knowledge related to health and social services and benefits, health-promoting behaviors, and disease prevention and management?
2. How often do clients return for repeated NHC services during members' service year?

Population under study

This research focused on three populations during the 2022-23 and 2023-24 cohort years: 1) the individuals who served as National Health Corps members; 2) supervisors from NHC host site organizations at six operating sites in California, Florida, Illinois, and Pennsylvania; and 3) clients who received services from NHC members.

Previous evaluation

Wilder Research has evaluated the National Health Corps program since 2014. Each evaluation of the program has provided evidence that NHC has a positive impact in members' public health knowledge, public health practice skills, and commitment to the field; host site capacity; and client knowledge of health topics and health services available to them.

Past evaluations provide evidence that the NHC program provides a number of benefits to members in their development as public health professionals. Specifically, previous evaluations suggest that members have experienced increased public health knowledge, including their knowledge of health disparities, social determinants of health, and public health services available in the community. Members have also gained important skills necessary to practice public health, including their skills in communication, conflict management, working cooperatively in a team, and cultural competency and responsibility. Finally, participating in NHC appears to have strengthened members' motivation and commitment to pursuing education, work, or volunteer service in the public health field—including serving underserved communities and working to address health disparities.

Past evaluations have also assessed the impact of NHC member service on host site capacity. Previous evaluations have found evidence that NHC supports host sites to offer a broader range of services, improve client access to services, improve the quality of services provided, and adopt new approaches to their programming.

Finally, prior evaluations suggest that as a result of NHC member services, clients have experienced increased knowledge of health services, how to access them, and specific health topics.

Included in this report

This report includes findings from the quantitative and qualitative data collected from members, host site supervisors, and clients from the 2022-23 and 2023-24 NHC service years. Findings from the member, host site, and client surveys are reported, including the results of the member-comparison group ANOVA tests, pre-post matched analyses, and key themes from the open-ended qualitative responses alongside select illustrative quotes.

Evaluation design and methodology

The National Health Corps evaluation takes a multifaceted approach to measuring program impact among members, host sites, and the clients they serve, as well as understanding program strengths and areas for improvement.

Evaluation design

Members

Evaluation approach and design. To understand the impact of the NHC program on members' self-reported knowledge and skills, Wilder utilized an impact evaluation approach. This approach allows us to assess possible changes in members' knowledge and skills that are attributable to their participation in NHC, beyond learning and development that may have taken place in the absence of the program. Additionally, our evaluation incorporated some elements of a process evaluation approach, to support NHC's ongoing learning about program strengths and areas for improvement.

NHC used a quasi-experimental evaluation design to assess changes in members' self-reported knowledge and skills by administering pre- and post-service surveys to both members and a comparison group at the beginning and end of members' service years.[1] This design allows NHC to assess whether participation in the program increases member public health knowledge and skills, leadership skills, social capital, and social cohesion, beyond changes they may have experienced if they had not participated in the NHC program. The pre- and post-surveys also incorporate process evaluation measures related to NHC and host site strengths and challenges, to support ongoing program improvement. Additionally, long-term member outcomes were assessed using a 12-month follow-up survey administered to members from the 2022-23 cohort year.

Data sources and data collection. Members were asked to complete a web-based survey at the beginning and end of their service year. The survey assessed members' knowledge and skills related to their position, social and professional resources, leadership skills, satisfaction with the program, and perceptions of how well the program operated. Additionally, members from the 2022-23 cohort were sent a follow-up survey 12 months after they completed their service year, to assess long-term outcomes related to volunteerism, educational enrollment,

[1] We originally planned to statistically match the member and comparison group using demographic variables, but were unable to do so due to insufficient sample size. However, as described on pp. 12 and 13, the members and comparison group participants were largely comparable across most demographic variables, except for age and geography of their childhood community.

employment status, and income. Members received a $10, $20, and $30 gift card if they completed the pre-, post-, and 12-month follow-up survey, respectively.

In 2022-23 and 2023-24, 131 NHC members completed the pre-service survey (out of 168 members) and 83 members completed the post-service survey (out of 114 members) at the time of analysis, for a response rate of 78% and 73%, respectively. A smaller number of members (77) completed both the pre- and post-service survey. Members representing all of the operating sites completed the pre- and post-service survey (Figure 1). Twelve months after the end of their service year, all 77 NHC alumni from the 2022-23 cohort were invited to complete a follow-up survey assessing their long-term outcomes. Forty-five alumni participated, for a response rate of 58%.

1. Number of respondents per operating site at pre- and post-service time points, 2022-23 and 2023-24

	Pre (N=131)		Post (N=83)	
Operating site	Number of completes	% of pre-test respondents	Number of completes	% of post-test respondents
Central California	18	14%	5	6%
Chicago	20	15%	12	15%
Florida	20	15%	13	16%
Philadelphia	29	22%	21	25%
Pittsburgh	20	15%	13	16%
San Francisco	24	18%	19	23%

Note. Percentages do not total 100% due to rounding.

Finally, NHC identified a relevant comparison group comprised of individuals who had applied to the NHC program and been recommended for placement at a host site, but who were not matched. Applicants who participated in an alternative public health leadership program other than NHC were excluded from the comparison group (N=4). Wilder Research administered two web-based surveys at pre- and post-service time points. These surveys included repeated measures of knowledge and skill consistent with those in the member pre- and post-survey. Comparison group members received a $30 and $50 gift card if they completed the pre- and post-survey, respectively.

In 2022-23 and 2023-24, 45 comparison group participants completed the pre-service survey (out of 104) and 35 completed the post-service survey (out of 50), for a response rate of 43% and 70%, respectively.[2] A total of 33 comparison group participants completed both the pre- and post-survey in full.

[2] Only comparison group participants who completed at least part of the pre-service survey were invited to complete the post-service survey.

During evaluation planning, an a priori power analysis using G*Power3[3] was conducted to determine the power needed to detect a significant within-between interaction of the repeated measure analysis of variance, with a small to medium effect size (f = .175) and an alpha of .05. Results showed that a total sample of 68 with two equal sized groups of 34 is required to achieve a power of .80. The number of comparison group participants (n=33) approached this requirement but fell slightly short. Because of this, our analyses may be slightly less sensitive to small effect sizes than if we had a higher response rate from the comparison group.

Data analysis. Wilder compared NHC members and comparison group participants across two time periods using a two-way repeated-measures of analysis of variance (ANOVA) with the following effects:

- Main Effect (1): Group (Members / Comparison)
- Main Effect (2): Time (Pre / Post)
- Interaction: Treatment by time

Additionally, we tested for statistically significant differences in the proportion of members reporting the highest level of knowledge and skills or the strongest level of agreement between pre- and post-service time points using McNemar's tests. Member outcomes related to application of their gained knowledge and skills during their service year, and participation in public health-related volunteer or community service, education, and employment at 12-months follow-up were analyzed using descriptive statistics. Qualitative open-ended responses from member surveys related to program strengths and improvements were analyzed to identify key themes, which are reported alongside illustrative quotes.

Host sites

Evaluation approach and design. Changes in host site organizational capacity and staff knowledge were assessed using a non-experimental outcome evaluation design. This approach allows NHC to assess the impacts of members on host site organizational capacity, and is most feasible, given the unavailability of a relevant comparison group for the host sites. The post-survey also included open-ended questions that assess possible changes to practice and policy at the host site during the member's service year. To support ongoing program improvement, the pre- and post-surveys also incorporated process evaluation measures related to the benefits and challenges of hosting a member.

[3] Faul, F., Erdfelder, E., Lang, A.-G., & Buchner, A. (2007). G*Power 3: A flexible statistical power analysis program for the social, behavioral, and biomedical sciences. *Behavior Research Methods, 39*(2), 175–191. https://doi.org/10.3758/BF03193146

Data sources and data collection. Host site supervisors were asked to complete a web-based survey at the beginning and end of their member supervisee's service year. The survey explored supervisor knowledge, organizational capacity, changes they experienced, and perceptions of benefits and challenges related to hosting an NHC member.

In 2022-23 and 2023-24, 129 NHC host site supervisors were invited to complete a pre-service survey at the beginning of their member's service year. Across both cohort years, 52 supervisors completed the pre-service survey, for a response rate of 40%. Ninety-two supervisors were invited to complete the post-service survey at the end of their member's service year (at the time of analysis). Thirty-nine supervisors completed the post-service survey, for a response rate of 42%. Fewer supervisors (N=23) completed both the pre- and post-service survey. Supervisors representing all of the operating sites completed the pre- and post-service survey (Figure A16 in the Appendix).

Data analysis. Possible changes in host sites' organizational capacity were assessed using matched pre-post analyses and descriptive statistics. Differences in the proportion of host site supervisors reporting "high" organizational capacity for each area between pre- and post-service time points were tested for statistical significance using McNemar's tests. Qualitative open-ended responses from host site surveys related to perceived benefits and challenges of hosting a member were coded and are reported as frequencies with illustrative quotes.

Some host site supervisors took pre- and/or post-surveys in multiple cohort years. If supervisors with duplicated surveys had matched pre- and post-surveys in a single cohort year, and unmatched pre- or post-surveys in the other cohort year, the matched survey data were included in analysis. If supervisors had multiple years of matched pre- and post-survey data, the most recent year of matched data was included in analysis.

Clients

Evaluation approach and design. Changes in client knowledge are assessed using a non-experimental outcome evaluation design, using a brief post-survey during each eligible client interaction. Members also track client participation in NHC services, including both total number of clients served and the total number of visits for repeated or long-term client interactions.

Data sources and data collection. NHC implemented post-intervention surveys at all sites where members provided in-person services to clients over age 18. Members used motivational interviewing techniques to ask clients what they had learned from the service interaction, assess the degree to which clients increased their knowledge of the health issue, and identify whether they needed any further information or access to resources.

Data analysis. Services provided to clients and client changes in knowledge or access to resources across all host sites were assessed using descriptive statistics. Members' open-ended responses summarizing clients' self-reported learnings were coded and reported as frequencies.

Strengths

Quasi-experimental design. This evaluation employed a rigorous quasi-experimental design to assess the impact of NHC program participation on members' knowledge and skills over the service year. Changes in member knowledge and skills were compared to those of a relevant comparison group over the same time period. This design gives us confidence that the growth observed in the member group, above and beyond those observed in the comparison group, was attributable to program participation rather than coincidental gains in knowledge that naturally occur over time.

Long-term outcomes. For the first time, this evaluation collected data on NHC alumni's long-term education, employment, and volunteerism outcomes through a 12-month follow-up survey. These data, alongside members' personal reflections and feedback, allow us to better understand NHC members' growth and development as public health professionals.

Minimal administrative burden on clients. The data collection approach for client outcomes is designed to minimize administrative burden among clients. Members are also trained to ask questions using motivational interviewing techniques. These conversations create opportunities to ensure that clients have understood what information the members provided, that they have the information they need, and ultimately reinforces principles of quality client care.

Limitations

Self-report and social desirability biases. This evaluation design relies on members and host site supervisors' self-report of their own knowledge and skills. It is possible that individuals' perceptions of their own knowledge may not be accurate or reflective of their objective abilities. In addition to general misperceptions of self-reported knowledge and skills described above, some measures of knowledge may be particularly susceptible to social desirability bias. In particular, our evaluation design relies upon members to assess client responses and determine whether or not the clients they serve increased their knowledge as a result of services received. Members may perceive the results of client surveys as a reflection on their professional performance, and may be more likely to report that their client gained knowledge so the findings will reflect positively on their performance. While members are asked to document clients' responses to the question about

what they learned from the service interaction, and these responses are reviewed by the evaluation team, it is possible that client data overestimate the knowledge gained by clients as a result of NHC member services.

Member and comparison group differences. Our impact evaluation was designed to identify and survey as close a comparison group to NHC members as possible. The comparison group consisted of applicants who were accepted into the NHC program, and were "recommended" or "highly recommended" following an initial interview, but not placed at a host site. All individuals in the member and comparison group met the same foundational professional competencies. This comparison group was determined to be similar enough to NHC members to provide a relevant and meaningful comparison group, and were also accessible for the purposes of the evaluation because NHC had access to their contact information. However, there may be some unmeasured differences between the groups by virtue of members having been placed at host sites, and comparison group participants having not been. It is possible that these unmeasured differences could affect the comparability between the two groups.

Ongoing host site participation in the NHC program. A notable challenge in assessing changes in host site organizational capacity is how most organizations have hosted NHC members for many years in a row. In the 2022-23 and 2023-24 cohort years, a large majority of host site supervisors (85%) reported having hosted a member before, with two-thirds of supervisors having hosted a member for at least 3 years. While community organizations' continued participation in NHC program may demonstrate the value NHC members impart to their host organization, it poses challenges to our pre- and post-service survey design. The pre-service survey time point, for organizations who host NHC members routinely, may not be an accurate assessment of their organization's baseline capacity. Their organization's capacity may have been increased by NHC members in previous years, and so the capacity measured at the pre-service survey time point may be skewed upward and observed changes during the members' service year may be reduced. It may be possible to better understand changes in capacity using a pre- and post-survey among host site organizations who have never hosted a member before, but the number of qualified organizations in the sample is too small to assess this change with the data available. Future evaluations should consider alternative approaches to assessing host site capacity that take into account the continuity of NHC participation among some host sites.

Response rate. Less than half of host site supervisors completed the pre- or post-surveys (40% and 42% of the sample). The responses of participating supervisors may not be representative of the experiences of all host sites. Additionally, even fewer host site supervisors completed both the pre- and post-survey, which was necessary to be included in the matched analysis. This small group size makes it more difficult to assess potential changes in host site supervisor knowledge and organizational capacity.

Research findings

Member survey results

Demographics

At pre-service, both members and comparison group participants were asked several demographic questions about their identity, lived experience, family, and the community they were raised in. There were some small differences in the demographic profiles of NHC members and comparison group participants (e.g., age, geography of the community they grew up in) but, overall, the two groups look similar in most demographic dimensions, including race and ethnicity, LGBTQIA+ community membership, and parent or guardian education background.[4]

- On average, NHC members were slightly younger (23 years old; N=122) than comparison group participants (26 years old; N=31).
- Among both NHC members and comparison group participants, most identified as Asian or Asian American or White (Figure 2).

2. Race and ethnicity of NHC members and comparison group participants

	Members (N=131)		Comparison group (N=32)	
	Number	%	Number	%
Asian or Asian American	57	44%	11	34%
White	50	38%	14	44%
Black, African, or African American	19	15%	7	22%
Hispanic, Latinx, or Latino	11	8%	1	3%
Middle Eastern or North African	4	3%	0	0%
American Indian, Native American, or Alaska Native	1	1%	0	0%
Another self-identification	3	2%	0	0%

Note. Numbers add up to more than 131 or 32 and percentages add up to more than 100% because some members selected more than one response option.

[4] Member and comparison group surveys also included a question about whether they have ever been diagnosed with a disability or impairment. The 2022-23 member and comparison group surveys, and 2023-24 comparison group survey did not include a "none of the above" option for this question. This makes it difficult to report on and interpret these data accurately, and so they are excluded from this report. Data from the 2023-24 member survey (which did include a "none of the above" option) are included in the Appendix (Figure A2).

- In terms of religious identification, both NHC members and comparison group participants most often identified as Agnostic or Protestant (Appendix Figures A1; A10).
- Approximately one-third of both NHC members (29%; N=130) and comparison group participants (36%; N=33) identified as a member of the LGBTQIA+ community.
- A similar proportion of NHC members' (83%; N=131) and comparison group participants' (82%; N=33) parents or caregivers have completed a 4-year college degree or more (Appendix Figures A3; A11).
- One-quarter of NHC members (23%; N=130) and one-third of comparison group participants (32%; N=31) reported that they or someone in their immediate family had received welfare payments or public assistance at some point.
- A higher proportion of comparison group participants reported growing up in an urban setting (42%; N=33) than NHC members (27%; N=131). NHC members reported growing up in a suburban setting slightly more often (70% vs. 61%). In both groups, a similar proportion grew up in a rural area and on a military base (15% and 2% of members; 9% and 3% of comparison group participants).[5]

Comparison group participants were asked "what work, education, or volunteer positions did you end up participating in this year, instead of doing NHC" (N=33). Most often, comparison group participants reported working in direct service positions in the health or public health field (n=13). These positions included health care paraprofessional roles (e.g., caregiver, scribe; n=5), clinical service providers (e.g., nurse aid, medical assistant, EMT; n=4), health educators (n=2), and program coordinators (n=2). Some comparison group participants reported working in research (n=6) or participating in another AmeriCorps program (not public health leadership-related; n=6). A couple of comparison group participants reported starting graduate school programs (n=3).

Impacts of NHC on member knowledge and skills

NHC members' self-reported knowledge and skills (including of the public health field, public health practice skills, social and professional resources, and leadership skills) were assessed at pre- and post-service time points. Possible changes in their self-reported knowledge and skills over time were compared to changes among comparison group participants over the same time period.

A two-way repeated-measures ANOVA was conducted to examine the effect of NHC program participation and time on self-reported knowledge and skills. This analysis assessed whether participating in NHC was associated with a statistically significant increase in knowledge and skills across the service year, above and beyond the changes observed in the comparison group who had not participated in a public health leadership program.

[5] Percentages add up to more than 100% because members could select more than one type of community.

Findings from the ANOVAs are presented below. Supplementary analyses, including frequencies of NHC members' and comparison group participants' self-reported knowledge and skills and the results of McNemar's tests, can be found in the Appendix.

Members' knowledge of the public health field and social determinants of health increased.

NHC members and comparison group participants were asked about their knowledge of the public health field and social determinants of health at pre- and post-service. Results of the ANOVAs indicate that there is a statistically significant (at p=.05 or lower) interaction between participation in the NHC program and time on several areas of public health knowledge and skills (Figure 3).

That is, NHC members experienced a statistically significant increase in knowledge during their service year, above and beyond what was experienced by comparison group participants. Statistically significant differences were observed in 3 out of 5 areas of public health knowledge assessed, including: efforts in public health practice to address health disparities and remaining gaps in service delivery ($p < .001$); programs and services provided by public health organizations to improve the health of a community ($p < .001$), and how public health systems and organizations influence local, national, and global population health (p=.004).

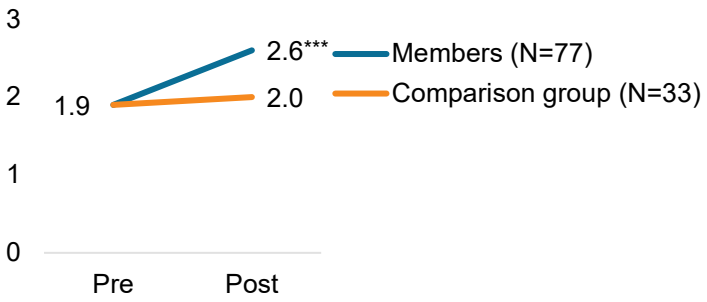
3. Variation in average public health knowledge among NHC members and comparison group participants, pre- and post-service year

		Average knowledge		
		Members (N=77)	Comparison group (N=33)	p-value
How public health systems and organizations influence local, national, and global population health**	Pre	2.1	2.1	.004
	Post	2.5	2.2	
Programs and services provided by public health organizations to improve the health of a community***	Pre	2.0	2.0	< .001
	Post	2.6	2.0	
Social determinants of health, and other factors that impact the health of a community	Pre	2.5	2.4	.236
	Post	2.8	2.6	
Identities that are impacted by structural oppression and resulting health disparities	Pre	2.4	2.5	.073
	Post	2.8	2.6	
Efforts in public health practice to address health disparities and remaining gaps in service delivery***	Pre	1.9	1.9	< .001
	Post	2.6	2.0	

Note. Average knowledge can range from 0 to 3 with 0="none," 1="low," 2="medium," and 3="high." Significance tests were conducted using a two-way repeated measures analysis of variance (ANOVA). Differences are significant at **p < .01 and ***p < .001.

To further illustrate these changes, the results from one two-way ANOVA, on individuals' knowledge of public health practices to address health disparities and gaps in service delivery, are shown in Figure 4 below. NHC members and comparison group participants self-reported their knowledge on a scale ranging from 0 (none) to 3 (high). At pre-service, the average knowledge score for both groups was 1.9, just below "medium" knowledge. At post-service, comparison group participants' average score was similar to their average score at pre-service (2.0), while NHC members' average score had increased to 2.6, between "medium" and "high," a statistically significant increase in knowledge.

4. Average knowledge of efforts in public health practice to address health disparities and remaining gaps in service delivery, NHC members and comparison group participants, pre- to post-service



Note. Average knowledge can range from 0 to 3 with 0="none," 1="low," 2="medium," and 3="high." Significance tests were conducted using a two-way repeated measures analysis of variance (ANOVA). Differences are significant at ***p < .001.

NHC members affirmed these results when they were directly asked about the impact of NHC at post-service. At post-service, nearly all members (99%) reported that serving as an NHC member increased their knowledge of the public health field and social determinants of health "a lot" (75%) or "some" (24%; N=83).

Members improved their public health practice knowledge and skills.

NHC members and comparison group participants were asked about their public health practice knowledge and skills at pre- and post-service. Results of the ANOVAs indicate that there is a statistically significant interaction between participation in the NHC program and time on most areas of public health practice knowledge and skills (Figure 5).

That is, NHC members experienced a statistically significant increase in their knowledge and skills during their service year, above and beyond what was experienced by comparison group participants. Statistically significant differences were observed in 6 out of 8 areas of public health practice knowledge and skills assessed.

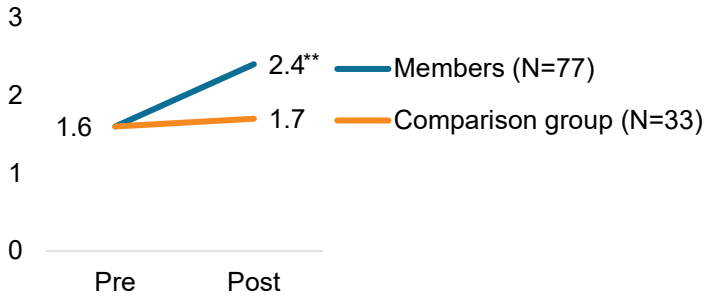
5. Variation in average public health practice knowledge and skills among NHC members and comparison group participants, pre- and post-service year

		Average knowledge		
		Members (N=76-77)	Comparison group (N=31-33)	p-value
Cultural responsibility and recognizing identity-based prejudice and discrimination	Pre	2.3	2.4	.059
	Post	2.6	2.4	
How to increase equity and inclusion in public health settings	Pre	1.9	1.8	.669
	Post	2.4	2.3	
Motivational interviewing models and techniques***	Pre	1.6	1.6	< .001
	Post	2.2	1.6	
Trauma-informed public health practices**	Pre	1.6	1.6	.001
	Post	2.4	1.7	
Crisis intervention strategies and resources**	Pre	1.6	1.8	.004
	Post	2.3	1.9	
Communication skills needed in public health settings*	Pre	2.2	2.3	.014
	Post	2.7	2.3	
How poverty, individual trauma, and collective trauma may have affected the experiences, strategies, morale, and survival behavior of your clients*	Pre	2.2	2.2	.029
	Post	2.7	2.3	
Effective cross-cultural communication, the tenets of cultural humility, and basic anti-racism consideration**	Pre	2.2	2.2	.006
	Post	2.6	2.3	

Note. Average knowledge can range from 0 to 3 with 0="none," 1="low," 2="medium," and 3="high." Significance tests were conducted using a two-way repeated measures analysis of variance (ANOVA). Differences are significant at *p < .05, **p < .01, and ***p < .001.

To further illustrate these changes, the results from one two-way ANOVA, on individuals' knowledge of trauma-informed public health practices, are shown in Figure 6 below. NHC members and comparison group participants self-reported their knowledge on a scale ranging from 0 (none) to 3 (high). At pre-service, the average knowledge score for both groups was 1.6, in between "low" and "medium" knowledge. At post-service, comparison group participants' average score was similar to their average score at pre-service (1.7), while NHC members' average score increased to 2.4, between "medium" and "high," a statistically significant increase in knowledge.

6. Average knowledge of trauma-informed public health practices, NHC members and comparison group participants, pre- to post-service



Note. Average knowledge can range from 0 to 3 with 0="none," 1="low," 2="medium," and 3="high." Significance tests were conducted using a two-way repeated measures analysis of variance (ANOVA). Differences are significant at **p < .01.

NHC members affirmed these results when they were directly asked about the impact of NHC at post-service. At post-service, nearly all members (99%) reported that serving as an NHC member improved their skills to help reduce health disparities and practice in the field of public health "a lot" (70%) or "some" (29%; N=83).

Members started their service with strong existing support from their social and professional networks, but self-reported that they increased their resources throughout their service year.

NHC members and comparison group participants were asked to rate their level of agreement about how their social and professional network has helped them at pre- and post-service. Results of the ANOVAs indicate that there were no statistically significant interactions between participation in the NHC program and time on any social and professional resources measured (Figure 7). For both NHC members and comparison group participants, their average agreement with each resource was already relatively high at pre-service: on average, both groups either "agreed" or "strongly agreed" that their social and professional network helped them in each area measured (average scores between 3 and 4). Both members and comparison group participants maintained their level of agreement from pre- to post-service.

7. Variation in average social and professional resources among NHC members and comparison group participants, pre- and post-service year

My social and professional network…		Average agreement: Members (N=75)	Average agreement: Comparison group (N=32-33)	p-value
Shows me that I matter to them	Pre	3.3	3.0	.652
	Post	3.5	3.3	
Challenges me to be my best	Pre	3.3	3.4	.512
	Post	3.5	3.4	
Listens to my ideas and takes them seriously	Pre	3.4	3.3	.748
	Post	3.4	3.3	
Helps me accomplish tasks	Pre	3.5	3.3	.668
	Post	3.5	3.3	
Introduces me to new experiences or opportunities	Pre	3.4	3.4	.126
	Post	3.6	3.2	
Provides me with useful information for pursuing my education or career goals	Pre	3.3	3.3	.559
	Post	3.4	3.3	
Supports me in developing or strengthening the skills needed to pursue my education or career goals	Pre	3.4	3.3	.728
	Post	3.5	3.4	
Connects me with other people who help me pursue my education or career goals	Pre	3.3	3.2	.926
	Post	3.4	3.3	

Note. Average agreement can range from 1 to 4 with 1="strongly disagree," 2="disagree," 3="agree," and 4="strongly agree." Significance tests were conducted using a two-way repeated measures analysis of variance (ANOVA). No differences were found to be statistically significant.

Members were also asked directly at post-service whether NHC had impacted their professional networks and resources. At post-service, the majority of members reported that their professional networks, resources, and skills increased as a result of their participation in NHC (Figure 8). Specifically, nearly all members agreed or strongly agreed that, to help them pursue their education and career goals, they have developed or strengthened skills they need (95%), have access to more useful information (94%), have more people who can help them (94%), and are connected with more influential people (90%; N=83). Because these questions specifically focused on the impact of NHC, they were only asked of NHC members.

8. Impact of National Health Corps on member professional networks and resources (N=83)

As a result of my participation in National Health Corps…	Strongly agree	Agree	Disagree	Strongly disagree
I have developed or strengthened skills needed to pursue my education or career goals	63%	33%	4%	1%
I have access to more useful information for pursuing my education or career goals	60%	34%	4%	2%
I have more people I can go to to help me pursue my education or career goals	52%	42%	4%	2%
I am connected with more influential people who are useful for pursuing my education or career goals	51%	40%	6%	4%

Note. Percentages do not total 100% due to rounding.

Members experienced leadership development throughout their service year.

NHC members and comparison group participants were asked about their leadership skills at pre- and post-service. Results of the ANOVAs indicate that there is a statistically significant interaction between participation in the NHC program and time on two areas of leadership skills measured (Figure 9).

That is, NHC members experienced a statistically significant increase in their leadership skills during their service year, above and beyond what was experienced by comparison group participants. Statistically significant differences were observed in members' level of agreement with feeling prepared to be a leader in the public health field ($p = .008$) and understanding how to be a leader that addresses oppressive systems and policies that exacerbate health disparities ($p = 0.01$).

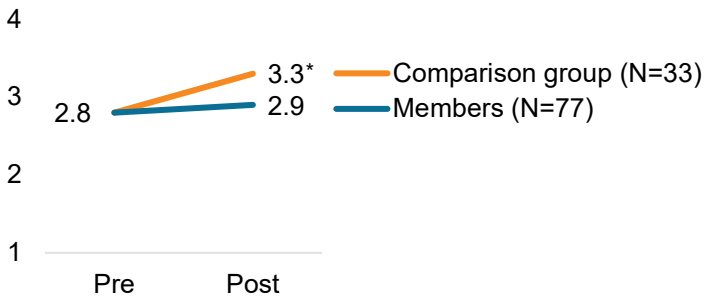
9. Variation in average leadership skills among NHC members and comparison group participants, pre- and post-service year

		Average agreement		
		Members (N=75-76)	Comparison group (N=33)	p-value
I am very motivated to succeed in a career in the public health field	Pre	3.5	3.4	.992
	Post	3.6	3.5	
I understand what it means to be a leader in the public health field	Pre	3.1	3.0	.120
	Post	3.5	3.2	
I feel prepared to be a leader in the public health field**	Pre	2.8	2.8	.008
	Post	3.3	2.9	
I think about what will happen as a result of my decisions	Pre	3.7	3.6	.497
	Post	3.7	3.5	
I believe I can make a real difference on issues that are important to me	Pre	3.5	3.3	.240
	Post	3.5	3.5	
I understand how to be a leader that addresses oppressive systems and policies that exacerbate health disparities*	Pre	3.0	3.2	.010
	Post	3.5	3.2	
I am confident in my ability to engage in the ongoing process of growth and learning	Pre	3.6	3.5	.645
	Post	3.7	3.5	

Note. Average agreement can range from 1 to 4 with 1="strongly disagree," 2="disagree," 3="agree," and 4="strongly agree." Significance tests were conducted using a two-way repeated measures analysis of variance (ANOVA). Differences are significant at *p < .05 and **p < .01.

To further illustrate these changes, the results from one two-way ANOVA, on individuals' agreement with feeling prepared to be a leader in the public health field, are shown in Figure 10 below. NHC members and comparison group participants self-reported their agreement on a scale ranging from 1 (strongly disagree) to 4 (strongly agree). At pre-service, the average knowledge score for both groups was 2.8, just below "agree." At post-service, comparison group participants' average score was similar to their average score at pre-service (2.9), while NHC members' average score increased to 3.3, between "agree" and "strongly agree," a statistically significant increase in knowledge.

10. Average agreement with feeling prepared to be a leader in the public health field, NHC members and comparison group participants, pre- to post-service



Note. Average agreement can range from 1 to 4 with 1="strongly disagree," 2="disagree," 3="agree," and 4="strongly agree." Significance tests were conducted using a two-way repeated measures analysis of variance (ANOVA). Differences are significant at $^{*}p < .01$.

Member applied knowledge, skills, and resources

Members frequently applied their gained knowledge, skills, and resources to their NHC positions.

At post-service, members were asked how frequently they applied their knowledge, skills, and resources to their NHC positions. At least two-thirds of members reported that they "often" applied their knowledge of social determinants of health (82%); leadership, problem-solving, and decision-making skills (70%); and information, resources, and connections through their professional network (66%; N=83; Figure 11). In each area surveyed, very few members (0% - 2%) reported "never" applying their knowledge, skills, and resources.

11. Member applied knowledge, skills, and resources (N=83)

How often did you apply the following knowledge, skills, and resources to your NHC position?	Often	Sometimes	Rarely	Never
My knowledge of the social determinants of health and other factors that contribute to health outcomes and disparities	82%	11%	7%	0%
My leadership, problem-solving, and decision-making skills	70%	28%	2%	0%
Information, resources, and connections through my social and professional network	66%	24%	7%	2%
My knowledge of ethical and values-based public health practice strategies	64%	28%	7%	1%
My knowledge of trauma-informed public health practices	45%	42%	12%	1%

Note. Percentages do not total 100% due to rounding.

Future education and career plans

NHC affirmed and refined members' education and career plans in public health.

At pre-service (N=129), nearly all members reported having plans to pursue a career (96%) or an education (94%) focused on reducing health disparities. At post-service, when asked to what extent their experience in NHC influenced or shaped their future health-related career or education plans (N=83), a majority of members (80%) reported that their experience with NHC affirmed their pre-existing health-related career or education plans.

These members were asked an open-ended question about how their experience with NHC affirmed their health-related career or education plans (N=54). Most often, members made comments that their experience with NHC:

- Affirmed what they value in a professional career (n=29), including:
  - Confirming that they want to work to serve underserved communities or in a community health setting (n=16)
  - Affirming the importance and their commitment to addressing health disparities, inequities, and the social determinants of health (n=8)
  - Finding their service year to be a meaningful experience (n=4)

- Affirmed that they want to be a health care provider (n=27) or work in public health (n=11).
- Gave them the tools, resources, and confidence they need to feel more prepared to reach their goals (n=7).
- Helped them understand the field of public health and health care, including through exposure to different career paths in the field (n=4).

> *I knew I would enter health equity and public health, and NHC showed me how much my labor and skills are needed in this field.*
>
> *It taught me about the social determinants of health and how the practice of healthcare can be changed to address them. It motivated me to continue pursuing a career in healthcare.*
>
> *I already intended on pursuing medicine prior to my service term, but my experiences here have confirmed that I would like to continue this path. I have seen how people in medicine can further serve as informed and reliable community leaders, and this experience has helped me form a greater vision of the kind of provider I would like to be.*
>
> *NHC helped me to understand the disparities that individuals face in accessing proper medical care and that I want to make a change in this by becoming a primary care doctor to underserved populations.*
>
> *My experience serving at my host site through the NHC gave me a unique opportunity to work in a healthcare setting where I witnessed the profound impact quality and compassionate care can have not only on individuals and families but also on communities.*

Fewer members reported that they made some changes to their future career or education plans (16%) or completely changed the direction of their future career or education plans (5%; N=83). These members were asked what changes they made, and why (N=17). Some members said that because of their experience in NHC, they were able to refine their area of interest within public health or health care (n=8), or they now want to pursue a career in public health and/or health care in underserved communities (n=4). Two members reported wanting to pursue a career similar to their host site position on a full-time basis.

A few members reported no longer wanting to pursue a career in public health (n=5), including due to pursuing interests in other fields, and having concerns about working conditions in the nonprofit field.

Members maintained or increased their commitment to pursuing service, volunteer, and other civic activities.

At post-service, all members reported having a high (70%) or medium (30%) level of commitment to pursuing service, volunteer, and other civic activities (N=83). Nearly all members (98%) reported that serving as an NHC member helped increase their

commitment to civic engagement "a lot" (63%) or "some" (35%; N=83). Just 2% of members reported that NHC increased their commitment to civic engagement "not at all."

Members are already volunteering in underserved communities, enrolling in public health education programs, and working to address health disparities.

At pre-service, nearly all members (89%) reported having plans to pursue service, volunteering, and other civic activities focused on reducing health disparities (N=129). At post-service, when asked about their activities following NHC service, 88% of members reported that they plan to volunteer in underserved communities within the next year (51%), or have already started (37%; Figure 12). Nearly half (48%) planned to provide community leadership in underserved communities in the next year, and an additional 22% said they already have. Sixty-six percent of members reported that they already have or will be enrolling in a health-related education program within the next year, and 23% have already found a job related to health disparities. Nearly half of members reported that they have already encouraged others to volunteer with AmeriCorps (46%) or National Health Corps (45%; N=83).

12. Members' future plans following NHC at post-service (N=83)

Please share your intention to do these activities following your National Health Corps service:	I have already started this	I plan to do this in the next year	I plan to do this in the future, but not in the next year	I do not intend to do this
Volunteer in underserved communities	37%	51%	11%	1%
Provide community leadership in underserved communities	22%	48%	25%	5%
Enroll in a health-related education program with a focus on health disparities	25%	41%	25%	8%
Find work in a job that focuses on health disparities	23%	29%	41%	7%
Encourage others to volunteer with AmeriCorps or similar service	46%	19%	23%	12%
Encourage others to volunteer with the National Health Corps	45%	25%	21%	10%

Note. Percentages do not total 100% due to rounding.

Long-term program impacts on members' education, employment, and volunteerism

One year after the 2022-23 service year, NHC alumni were invited to complete a survey assessing their long-term outcomes including education, employment, and volunteerism. At 12 months post-service, many alumni reported enrolling in postgraduate education, having secured public health employment, and continuing to volunteer in underserved communities. Alumni cited the numerous positive impacts NHC has had on their journey and growth as public health professionals.

Most NHC alumni are enrolled in postgraduate education programs a year after their service year.

In the 12 months since their NHC service year (N=45), two-thirds of NHC alumni (69%) reported having enrolled in a postgraduate education program. Among those alumni enrolled in a postgraduate education program (N=31), two-thirds (68%) reported enrolling in a program related to medicine or health care (e.g., nursing or medical school; Appendix Figure A8). Alumni also frequently reported enrolling in an education program related to public health, or a program related to both medicine and public health (26%). When asked to describe their education program (N=31), alumni most often specified that they were attending medical school (n=17), including Doctor of Medicine (n=11) and Doctor of Osteopathic Medicine (n=5) programs.

NHC alumni who sought public health-related employment secured a position and credit their NHC experience.

When contacted at 12 months post-service (N=45), about half (44%) of NHC alumni reported pursuing employment in the field of public health at the end of their service year. Among the 20 job-seeking alumni, 90% reported being able to secure public health-related employment. All employed NHC alumni (N=17) agreed that their experience in NHC helped them obtain their public health-related employment, including 71% who said it had helped "a lot."

When asked to describe their employment, alumni reported holding a wide range of public health-related roles (N=17). Alumni reported having roles as direct care providers (including community health workers, emergency medical technicians, and patient companions; n=5), public health researchers (n=4), service coordinator and navigators (n=4), health educators (n=2), and program coordinators (n=2).

Among employed alumni (N=17), nearly all (88%) reported that their employer provided opportunities for additional leadership development, including conferences, training, and mentorship.

Most NHC alumni report making a living wage, but some have a tight budget or struggle to make ends meet.

Most employed alumni (N=18) reported working full time (72%) and in paid positions (89%). Alumni who were paid hourly (N=10) reported hourly wages ranging from $14 to $26 per hour, with an average of $18.79 per hour. Alumni paid an annual salary (N=5) reported making $45,000 to $50,000 per year, with an average salary of $46,600.

When asked if they were paid a living wage in the community they lived in (N=16), most alumni said "yes" (75%). However, two-thirds of these alumni said that while they were paid enough to cover their basic needs, they had a tight budget (N=12). One-quarter of alumni said they were not paid a living wage and struggled to make ends meet (N=16). These responses are based on respondents' subjective perception of what constitutes a living wage in their community, the criteria for which could differ among respondents. It is possible that alumni's experiences are reflective of low wages in the public health field more broadly.[6]

Most NHC alumni continue to engage in service and volunteer activities.

NHC alumni were asked how many hours they had spent in the past 3 months on service and volunteer activities focused on addressing the social determinants of health that impact health disparities. Most NHC alumni (73%) reported spending at least some time engaged in service and volunteer activities, including 44% who reported spending over 20 hours volunteering in the past 3 months (Figure 13). Nearly one-quarter of alumni spent more than 40 hours volunteering in the previous 3 months.

13. Hours spent engaged in service and volunteer activities in past 3 months, 12 months after NHC service year (N=45)

Service and volunteer hours in past 3 months	Number	%
0 hours	12	27%
1 – 10 hours	6	13%
11 – 20 hours	7	16%
21 – 40 hours	9	20%
More than 40 hours	11	24%

[6] Berger, S. (2024, February 13). *Key government public health positions pay well below private sector.* Columbia University Mailman School of Public Health. https://www.publichealth.columbia.edu/news/key-government-public-health-positions-pay-well-below-private-sector

Alumni were asked to describe the public health-related service and volunteer activities they have participated in (N=33). Most often, alumni reported volunteering their time with organizations focused on food access and distribution (including free food pantries, banks, and kitchens; n=10), health care and medicine (including in hospitals, free clinics, hospice care, and street medicine; n=9), and health education and outreach (n=9). Some alumni also reported volunteering their time mentoring youth (such as through tutoring and coaching; n=6) and working with homeless shelters and unhoused populations (n=6).

Alumni were asked whether, compared to before NHC service, they spend more time, the same amount of time, or less time on volunteer activities (N=45). About half of alumni reported they either spend the same amount of time volunteering (22%) or more time volunteering (29%) compared to before NHC service. However, the other half of alumni (47%) reported they are spending less time volunteering. It is possible that, compared to before NHC service (when most members were students in undergraduate programs), alumni working full time or in postgraduate education programs (like medical school) have less time and flexibility to devote to service and volunteer activities.

NHC alumni cited numerous positive impacts of NHC on their journey and growth as public health professionals.

NHC alumni were asked to reflect on their NHC service, and describe how the program impacted their journey and growth as a public health professional (N=44). Alumni reflected on how NHC gave them important knowledge, professional and interpersonal skills, and motivation to pursue their work as public health professionals.

Most often, NHC alumni reported that their participation in the program gave them direction and purpose as a public health professional (n=23). Specifically, these individuals noted that NHC helped them to build their interest and passion for working with underserved communities (n=6), helped inform their interests and the areas of public health they want to work in (n=5), and helped them understand their purpose or their "why" (e.g., for becoming a doctor or going into public health; n=4).

> *My NHC service is my primary driver in further pursuing public health. During my service year, I saw firsthand how social determinants of health affect individuals. It made me realize how much more has to be done through advocacy and education to support those who are the most vulnerable.*
>
> *[NHC has] been incredibly important for me in figuring out why I wanted to pursue medicine. I talked about it heavily in my medical school applications and it helped me ultimately gain acceptance to medical school.*

Alumni reported that NHC helped them gain crucial knowledge and professional skills (including understanding root causes of social problems, problem solving, communication, active listening, resource navigation, and motivational interviewing skills; n=11). Alumni

also reported valuing the opportunities to gain direct experience, insights, and understanding of the real world, beyond what they could learn in the classroom (n=11). Additionally, some alumni noted that their NHC service helped them develop interpersonal skills, such as becoming a more empathetic professional and build and deepen relationships in the community (n=5).

> *[NHC] has informed a lot of how I view the world and my ability to empathize and connect. It developed my ability to discern root causes of issues and successfully target them with creative solutions. [NHC] strengthened my active listening and response skills.*
>
> *[NHC] has impacted [my journey] tremendously. I have gotten a lot of real-world experience working with patients and have learned much more about government assistance programs than I would have learned in class alone.*
>
> *[NHC] allowed me to form community connections that I continue to use [and] gave me experience working in the communities that I wish to continue serving, which often informs my work.*
>
> *NHC has definitely provided me better insight to the barriers that underserved communities face in accessing health care. It has given me a new perspective in understanding the holistic care needed for many of these individuals and the lack of services available to them. It has inspired me to be a provider that is empathetic to the various needs of a patient.*

Some alumni reflected that their experience in NHC had helped them apply to or get into graduate school (n=6), including medical school (n=4).

Member experiences with host sites and NHC

At post-service, members were invited to provide feedback in a series of open-ended questions about NHC's program strengths and areas for improvement. Key themes were identified across question responses and are summarized below alongside illustrative quotes. Members also provided feedback about their experience at their host site in a close-ended question grid; relevant findings are included throughout this section, and are provided in full in Figure A9 in the Appendix.

Program strengths

Members valued opportunities for ongoing learning and professional development.

When members were asked about the strengths of the NHC program, most often, they cited the numerous learning opportunities and trainings NHC provides. Members valued the immersive hands-on learning experiences and the opportunity to increase their understanding

of the public health field, community needs, systemic oppression, racism, and health disparities.

> *Members can be closely involved in an integrated health system at the host sites and gain valuable insights into the disparities that exist in the community that the host site serves.*
>
> *[NHC was] an immersive experience where I was able to engage with patients from underserved populations, which was eye opening.*
>
> *Being part of a cohort involved in such a wide range of service opportunities. Service days were so fun! The opportunities to get patient care experience and "on-the-job" training was also great.*
>
> *The staff was great in creating a space where members could feel comfortable with learning and growing during trainings.*

This feedback was echoed by members' responses to a close-ended question about their experiences at their host site. At the end of their service year, 94% of members agreed that their host site supported their personal and professional goals, including nearly half (48%) that "strongly agreed" (N=83; Figure A9 in the Appendix). Nearly all members felt that host site staff supported their role by explaining what resources were available to clients (93%), providing information about how the organization fit into the local health service system (93%), and providing training for specific skills they needed to serve clients (87%).

Members built important relationships and community connections.

Members also frequently reported valuing the relationships they built during their service year with other cohort members, their host sites, and the broader community. Members reported that they built valuable community connections and a stronger professional network during their service year. Members noted the importance of the relationships and community built amongst cohort members, and appreciated the support, care, and "heart" shown by host site and NHC staff.

> *I love how the NHC program provides you an experience at your host site AND a community with your operating site. I loved getting to know my fellow cohort members and the community-building aspect of operating sites is something that a regular job may not be able to offer, especially for folks who are new to the city.*
>
> *I think the cohort builds a strong community and fosters a stronger connection to community service.*
>
> *My operating site and host site staff are/were incredibly supportive and accommodating, they all provided me with opportunities to grow and explore my own interests while serving a community I care deeply about.*
>
> *[Host site and operating site staff] are incredible and really care about members. [They] do whatever they can to support us [and give us] access to professionals to network/learn/grow.*

Members appreciate NHC's mission and the opportunity to support underserved communities.

When asked about program strengths, some members noted the value they found in NHC's mission and the opportunity to provide meaningful service in underserved communities. These members appreciated the opportunity to gain experience in and exposure to work with underserved communities, and believe that their work mattered and was making an impact.

> *I think National Health Corps's strengths are members can be closely involved in an integrated health system at the host sites and gain valuable insights into the disparities that exist in the community that the host site serves. I also think the cohort builds a strong community and fosters a stronger connection to community service.*
>
> *[My operating site and host site] provided me with opportunities to grow and explore my own interests while serving a community I care deeply about.*
>
> *Service that matters and makes a difference.*
>
> *It is a great opportunity to learn how to uplift vulnerable communities and have first-hand experience with connecting folks to public health resources.*

Areas for program improvement

Members offered feedback to improve NHC and host site trainings.

When members were asked about areas for program improvement, most often, members noted some areas where NHC or host site training could be more effective, efficient, engaging, and interactive. Some members requested more in-person local trainings (rather than virtual) and further opportunities to learn about their host sites, cities, and local communities. Members also requested additional training in some areas, including on skills specific to their host site placement, their individual career goals, and their general professional skills (e.g., resumes, mock interviews, networking). In a close-ended question about their host site experience, 13% of members disagreed or strongly disagreed that their host site provided training for specific skills they needed to serve clients (N=83; Figure A9 in the Appendix).

> *Virtual trainings were not as effective as in-person trainings. I think scaling back on virtual meetings and finding local trainers in the city would make for a more meaningful experience to engage with the other members and the trainer.*
>
> *If there was a specific training plan laid out from the beginning, it would have been much easier to integrate into the position… I feel like I had a little training in the beginning but then got training throughout that I needed to start the position.*
>
> *I think the host site supervisor could have been more active in inquiring about the experiences we were looking for throughout the year and also making the effort to discuss not just member goals but also how to reach those goals.*

There is a need for clear and accurate communication about member roles and responsibilities.

When asked about areas where NHC or their host site could improve, members frequently highlighted some communication challenges amongst members, host sites, and NHC program staff. Some members felt that they hadn't received complete and accurate descriptions of the program, host site, and their specific position when they signed up for the program. Additionally, some members felt as though their position description wasn't up to date or reflective of their day-to-day work. In a close-ended question about their host site experience, 18% of members disagreed or strongly disagreed that the service they did matched their position description (N=83; Figure A9 in the Appendix).

> *In the beginning, the host site and I had trouble understanding what my position description was, and what I was doing did not really fit my goals as an NHC member. Throughout my term, however, better communication between the team helped establish my goals.*
>
> *Explaining the program better before joining would have been beneficial.*
>
> *Perhaps offer up a greater explanation on their expectations for the position.*
>
> *Make responsibilities about committees and extra things more clear before signing on. Wasn't aware of all the extra things I would have to do until I started.*
>
> *Better recruitment and informing applicants about the offerings of the program better. I was a bit confused as to what I would be doing before I started the program.*
>
> *Write accurate position descriptions… and provide ways for incoming members to actually understand what the day-to-day life is like.*

Some members expressed concerns that staff at their host site didn't fully understand NHC or the member's role within the organization. Members noted it would be helpful for host site staff to be better aware of NHC members' responsibilities, AmeriCorps requirements, and the role they fill within the organization. Some members suggested that further documentation of the member role and projects would better support member on-boarding and transitions from year-to-year.

> *After talking to other members, it seems to be a common theme that other staff members are unaware of what AmeriCorps members do, despite many cohorts passing through. Making regular staff more aware of our roles and collaborating would be beneficial. This eventually happened towards the end, but it would be nice for host site supervisors to bridge the gap and explain what our official roles are in terms of services we can provide.*
>
> *With department transitions, I think it would be best for more staff to be aware of what the member can do or is required to do in their term.*
>
> *[Host sites need to be] better informed on what are the expectations of NHC members and, from there, expectation management. I felt that I was often looked at as an intern that is able to help in all areas with grunt work rather than a member of the team with a specific purpose.*

Members requested further NHC leadership involvement and oversight in their host site placements.

Some members highlighted the need for NHC leadership to be further involved in members' host site placements. In a close-ended question at post-service, most members (88%) agreed that their host site was a suitable placement for future members (N=83, Figure A9 in the Appendix). However, some members expressed the need for NHC leadership to have increased screening, oversight, and accountability in making sure host sites are a good fit for the NHC member. For example, NHC leadership should make sure that the host site's focus and mission are well-aligned with the member's role and responsibilities, that there is enough work for NHC members to do throughout the year, and that members aren't assigned tasks that fall outside their position description. Some members noted the need for NHC leadership to be more responsive when members raise concerns about their host site placements.

> *There could be screening of the host site to ensure that there is adequate work to be done throughout the year by the NHC member.*
>
> *I cannot emphasize enough how inappropriate our host site was and inattentive our supervisor was. The clinic culture and staff were inadequate for AmeriCorps members.*
>
> *Transparency and accountability. The fact that it was known that my host site has had a history of problems with treating members appropriately is incredibly unfair to any member interested in professional development.*
>
> *I think there needs to be a more intensive vetting process for host sites and the opportunity to not continue placing members at certain sites where NHC knows they are not being given proper opportunities (from multiple years of member dissatisfaction).*

AmeriCorps and National Health Corps should reexamine members' working conditions.

Some members offered suggestions for improving members' working conditions. These suggestions including increased compensation or stipends for NHC members, improved work-life balance (including opportunities for self-care), and revisiting expectations around service hours, to make targets achievable and feasible within normal working hours. It is important to note that some of these working conditions are dependent on expectations and standards set by AmeriCorps overall, which are largely outside of NHC's control.

> *The living stipend needs to be increased. The fact that I was barely able to survive without outside support means that it is nearly impossible to recruit people from the underserved communities that we are supposed to be serving, which would be the best way to give back to those communities.*
>
> *It would be nice if the pay was better. Additionally, it was frustrating that there were so many added, required hours of service/training that were outside of our 40-hour work week that we were required to participate in, especially on our weekends off.*

> *Be more realistic on how you can achieve the 1700 hours without giving up your weekends or getting burnt out.*
>
> *Be aware of how little they are paying the members. There was a video played at the beginning of the year (at the first member retreat) about how money does not matter and it is important to follow your passions. While that can be true, I thought this was not the best video to play since we are all on a low stipend. I also think you have to have a lot of privileges to not care about money.*

Host site survey results

Host site characteristics

Organization characteristics (N=52)

- Host sites were most frequently nonprofit organizations or community-based health organizations (42%; Appendix Figure A17). Host sites were also commonly Federally Qualified Health Centers (21%), public health departments (15%), or hospitals (14%).
- Most host site organizations were large, with at least 51 employees (79%), including 62% with more than 100 employees (Appendix Figure A18).
- Most respondents reported that they hosted a member in previous years (85%; Appendix Figure A19). Two-thirds of respondents (69%) hosted a member for at least three years prior.

Supervisor demographics (N=32-35)

- Most frequently, host site supervisors identified as White (47%); Black, African, or African American (22%); and Asian or Asian American (19%; Appendix Figure A20).
- Host site supervisors reported growing up in a variety of geographic settings: 39% grew up in a suburban community, 36% in an urban community, and 33% in a rural community.
- Twelve percent of host site supervisors identified as having a disability.
- Nine percent of respondents identified as being a member of the LGBTQIA+ community.
- A majority of host site supervisors said that the highest level of education of the person or people who raised them was at least a 4-year college degree (74%), including nearly half (49%) whose parents or caregivers had a graduate or professional degree (Appendix Figure A21).

Knowledge

At pre- and post-service, host site supervisors were asked about their knowledge of social determinants of health and oppressive structures that create or perpetuate health disparities. At post-service, all host site supervisors reported that they had at least a "medium" level of knowledge of both topic areas (Figure 14).

At pre-service in the matched analysis, a majority of host site supervisors said they had a high level of knowledge of social determinants of health (18 of 23). One fewer supervisor rated their knowledge as "high" at post-service.

In matched pre-post analysis, 3 additional host site supervisors reported having "high" knowledge of oppressive structures that perpetuate health disparities at post-service (e.g., institutionalized racism, sexism, classism, ableism, xenophobia, and homophobia).

14. Host site supervisor knowledge of social determinants of health and oppressive structures, pre- and post-service (N=23; matched analysis)

How would you rate your knowledge of…		High	Medium	Low	None
Social determinants of health: the conditions where people live, learn, work, play, and age that impact health, well-being, and quality of life	Pre	18	5	0	0
	Post	17	6	0	0
	Change in "high"	- 1			
Oppressive structures that create and perpetuate health disparities, such as institutionalized racism, sexism, classism, ableism, xenophobia, and homophobia	Pre	8	14	1	0
	Post	11	12	0	0
	Change in "high"	+ 3			

Note. Host site supervisor results are presented as number of respondents rather than percentages because some analyses involved fewer than 20 respondents. Differences in the proportion of members reporting "high" knowledge or skills between pre- and post-service time points were tested using McNemar's tests. No differences were found to be statistically significant.

Organizational capacity

Host site supervisors self-reported their organizational capacity at pre- and post-service. From pre- to post-service, host site capacity remained relatively stable with regard to having adequate organizational infrastructure, sufficient financial resources, qualified staff with sufficient skills and knowledge, and access to knowledge and information to support evidence-based public health practice and decision-making (Figure 15). From pre- to post-service, slightly more host site supervisors said they had "high" capacity to collaborate with other organizations for effective public health practice. These differences were not statistically significant.

15. Host site capacity to address social determinants of health, pre- and post-service (N=22-23; matched analysis)

How would you rate your organization's capacity in the following areas?		High	Medium	Low
Adequate organizational infrastructure to carry out our public health activities, including having established systems, protocols, and processes	Pre	15	7	1
	Post	14	9	0
	Change in "high"	- 1		
Sufficient financial resources to carry out our public health activities	Pre	10	10	3
	Post	8	11	4
	Change in "high"	- 2		
Collaboration with other organizations for effective public health practice	Pre	12	10	0
	Post	15	5	2
	Change in "high"	+ 3		
Qualified staff with sufficient skills and knowledge, including training opportunities	Pre	15	7	1
	Post	16	7	0
	Change in "high"	+ 1		
Access to knowledge and information to support evidence-based public health practice and decision-making	Pre	18	5	0
	Post	17	5	1
	Change in "high"	- 1		

Note. Host site supervisor results are presented as number of respondents rather than percentages because some analyses involved fewer than 20 respondents. Differences in the proportion of members reporting "high" knowledge or skills between pre- and post-service time points were tested using McNemar's tests. No differences were found to be statistically significant.

Host sites have established their organizational capacity in some areas, but have encountered barriers in having adequate time or resources.

Host sites were asked at the beginning and end of members' service year to assess their organization's current capacity related to a variety of capacity-building areas. Figure 16 provides data on these two time points.

For some capacity-building activities, at both pre- and post-service, all host sites reported that they had already begun working on the activity, or that it was an established practice in their organization. Specifically, all host sites reported they have already begun work or have established practices related to developing new programs and services focused on addressing social determinants of health and reducing barriers to service delivery access among community members. At post-service, a slightly higher number of supervisors reported these activities as established practices in their organizations.

At post-service, slightly more supervisors indicated they had limited capacity for community engagement activities. Specifically, from pre- to post-service, more supervisors said they lacked time and resources to engage with community members to identify public health needs (from 1 to 3 out of 19), and to consult with community members before new programs are introduced in their community (from 1 to 3 out of 18). Fewer host sites also reported that they had begun working on these areas at the post survey (6 sites) compared to the pre-survey (10 sites). This may indicate that work in these areas has started and stopped over time due to capacity concerns.

Organizational capacity among other activities remained relatively stable across members' service year.

16. Current host site capacity-building activities, pre- and post-service (N=18-20; matched analysis)

To what extent is your organization currently engaging in the following activities?		We want to work on this, but we lack the time or resources	We have plans and appropriate resources to work on this, but haven't begun yet	We have begun working on this	This is an established practice within our organization
Developing new programs and services focused on addressing social determinants of health (N=19)	Pre	0	0	7	12
	Post	0	0	6	13
Reducing barriers to service delivery access among community members (N=19)	Pre	0	0	7	12
	Post	0	0	5	14
Increasing the number of clients served by the organization (N=18)	Pre	1	1	5	11
	Post	1	2	4	11
Engaging with community members to identify public health needs (N=19)	Pre	1	0	10	8
	Post	3	1	6	9
Consulting with community members before new programs are introduced in their community (N=18)	Pre	1	0	10	7
	Post	3	1	6	8
Providing opportunities for clients and residents to give feedback on services and programs (N=20)	Pre	1	0	8	11
	Post	0	2	7	11
Incorporating a new approach to services to improve quality/effectiveness (N=20)	Pre	1	0	5	14
	Post	0	0	7	13
Identifying and changing policies and practices in our organization that perpetuate structural oppression (N=20)	Pre	0	1	11	8
	Post	0	1	10	9
Assessing the potential impact of our organization's policy and practice changes on communities disproportionately impacted by health disparities (N=20)	Pre	0	1	9	10
	Post	0	1	10	9

Note. Host site supervisor results are presented as number of respondents rather than percentages because some analyses involved fewer than 20 respondents.

Changes to organizational practices

At post-service, host site supervisors were asked whether their organizations made any changes during the year to address biased or discriminatory institutional practices and policies (N=36). A majority of host site supervisors (58%) said that their organization had made changes. Host site supervisors who made changes (N=18) were asked to describe the changes to practice and policy their organization made this year. Most frequently, host site supervisors commented that their organization had created or increased their organization infrastructure and staffing related to diversity, equity, and inclusion (n=9). Host site supervisors also reported increased community outreach and engagement (n=5), improvements to internal human resources policies (e.g., offering paid parental leave, and revising their hiring and recruitment practices; n=4), and increasing their culturally-responsive outreach and programming (n=3).

Member roles

Members provided a wide variety of services and supports at their host sites.

At pre-service, host site supervisors were asked what work or projects they were hoping their NHC member would support during their service year (N=49). In open-ended responses, host site supervisors envisioned their NHC member supporting a variety of types of work, and across a number of different public health topic areas. Most frequently, host site supervisors reported wanting their NHC member to support community engagement and outreach (n=18), health education (n=15), and service coordination and navigation (n=12). They intended for members to work on topics including health care and medication access (n=12); food insecurity, access, and nutrition (n=11); social determinants of health (n=11); healthy lifestyles (including physical activity and smoking cessation; n=8); mental health (n=4); and COVID-19 (n=3).

At post-service, host site supervisors commented that members were leading and supporting a wide variety of work during their service year (N=30). Members led or supported health education (n=9); screening and referrals (n=5); community engagement and outreach (n=4); data collection (n=4); and service coordination and navigation (n=4). They worked in a variety of public health topic areas, including health care and medication access (n=10); food insecurity, access, and nutrition (n=6); social determinants of health (n=4); and healthy lifestyles (including physical activity and smoking cessation; n=2).

Members offer host sites a variety of important benefits related to client care and organizational capacity.

At post-service, host sites were asked to describe the most important benefits their organization experienced hosting an NHC member during their service year (N=31). Most frequently, in open-ended responses, host site supervisors commented that their NHC member helped provide and improve important client services (n=18), including increasing client access to programs and services (n=4). Host site supervisors also said that their NHC member helped increase their organizational capacity (n=14), including helping to expand or grow their current programming (n=6), increasing community outreach and engagement (n=3), and creating new programming or services (n=2). Host site supervisors also mentioned the value that NHC members bring through contributing new ideas and approaches to the organization (n=5).

> *The NHC member was key in assisting with implementing programs that were in the process but difficult to implement due to limited paid staff and resources.*
>
> *Our NHC member brought a lot of capacity to our organization and allowed us to screen and connect over 1,000 patients to resources, which may not otherwise have gotten services.*
>
> *Our organization was able to increase our capacity at our pop-up clinic and actually go from offering clinical services twice a month to once a week throughout the entire month.*
>
> *We were able to start clinic initiatives we'd been discussing for years, but did not have capacity to undertake! Patients reported feeling more supported during clinic visits and for medical follow up.*
>
> *The member was able to enhance our food insecurity program by adding produce.*
>
> *This generation [is] highly aware; advocat[es] for diversity, inclusion, and equity; and [feels] comfortable making constructive suggestions to our staff and leadership about ways we may want to improve.*

Host sites reported few challenges or downsides related to hosting an NHC member.

At post-service, host site supervisors were asked to describe any notable downsides or challenges their organization experienced by hosting an NHC member (N=28). In open-ended responses, most often, host site supervisors said there were no downsides or challenges (n=13). Among those who reported challenges, most frequently, supervisors noted the challenge of not having an NHC member year-round (n=7). Because there is a hiatus in NHC service during the transition between members, this may contribute to gaps in service delivery and increased burden on host site staff. A few supervisors also mentioned that some NHC requirements (like training days, or the "no fundraising" rule) impacts member availability and their experience at their host site (e.g., their ability to attend events that involve fundraising; n=3). Some host site supervisors mentioned facing challenges related to delays and uncertainty around member placement at their host site, or not having a

member placed at all (n=3). A couple of supervisors mentioned that host sites may not have capacity to provide sufficient support and oversight for their NHC member.

> *The only issue is the gap in work created by the member position when they leave service is really tough. I wish there was a way to overlap service so our team doesn't have to carry the extra work for several months. Otherwise, we love NHC!*
>
> *We continue to have both some critical staffing changes and gaps, which make the needed NHC oversight for members difficult to do as effectively as we would like. Some limitations of their service activities also limit our ability to grow their service positions or engage in strategies that could directly impact oppression and barriers to advocacy and self-care.*
>
> *Fortunately, we were able to get a member quickly last cycle. In other cycles, not getting a member, or the uncertainty of whether we'll get a member, is very stressful and has us on the edge of not participating with the program anymore.*

Client survey results

Client evaluation forms are completed by NHC members during eligible interactions with clients. The process of completing the form is designed to fit within a motivational interviewing approach while providing services to clients. Members are instructed to complete forms for interactions deemed meaningful (based on the type of service provided and amount of time spent with each client) and which address one of NHC's core focus areas. Only new clients or clients who are returning but seeking a new service are considered eligible.

Out of all client forms with at least the first question completed (N=1,890), 90% involved service interactions with new clients, and 9% involved service interactions with returning clients. For the remaining 1% of forms, members did not know or couldn't remember if they were a new or returning client.

Across all sites for the 2022-23 and 2023-24 service years, 1,616 client forms were completed in full. Of these 1,616 interactions, 17% indicated that an interpreter was present.

Members most often reported providing care coordination and patient navigation services.

Most often, members provided clients with information about health benefits, insurance and services, and how to enroll in these programs (65%; Figure 17). Members also frequently shared information about physical activity and nutrition (23%) and social support and independent living among clients 50 years old and older (17%). Members rarely shared information about opioid and prescription drug disorder prevention and response (3%) and COVID-19 prevention and response (1%).

17. Services provided to clients (N=1,616)

Topic covered during interaction	Number	%
Health benefits, insurance, and services	1,055	65%
Physical activity and nutrition	365	23%
Social support and independent living (ages 50+)	282	17%
Opioid and prescription drug disorder prevention and response	43	3%
COVID-19 prevention and response	21	1%

Note. Numbers add up to more than 1,616 and percentages add up to more than 100% because some members covered more than one topic per session.

Clients reported learning about medication supports; nutrition and food access; and health care insurance, financing, and service navigation.

At the end of a meaningful service interaction, members asked clients what they learned from their time together. Members summarized clients' responses in an open-ended question in the client evaluation form, and the open-ended responses were coded by Wilder staff to identify key themes. A total of 1,765 forms with responses to the open-ended questions were coded.[7] The most common learnings (5% or more of responses) are listed in Figure 18 below.

18. Client learnings from member services (N=1,765)

Coded theme	Number	%
Medication support, including Good RX, pharmacy resources, and pharmaceutical Patient Assistance Programs	385	22%
Nutrition and food access, including healthy eating, nutrition assistance programs (WIC, SNAP), food banks, and mobile food pantries	312	18%
Health care insurance and financing, including support with Medicaid and Medicare, understanding insurance coverage, applying for insurance, understanding how to finance health care	256	15%
Service and resource navigation, including setting up appointments (in general), understanding what services and resources are offered, paperwork, setting up with a new provider, using patient portals, and using medical transportation	241	14%
Chronic disease and pain management, including setting up specific appointments, and use of medical equipment	180	10%
Preventative health care (general), including screenings	179	10%
Maternity care, parenting, and OBGYN services, including pediatric care, education on safe sleep, baby supplies, home health services, birth control, car seats, breastfeeding education, birthing classes, and FMLA paperwork	168	10%
Non-medical benefits assistance, including housing, utilities support programs, and welfare benefits	124	7%

[7] Not all forms with open-ended responses completed the final question related to clients' increased knowledge. Incomplete forms were excluded from quantitative analysis.

Note. Numbers add up to more than 1,765 and percentages add up to more than 100% because some clients reported learning about more than one topic per session.

Most clients increased their knowledge of the topic discussed after working with NHC members.

Members were asked to determine whether or not they believe the client gained knowledge related to the topic of the interaction (Figure 19). A large majority of members (84%) reported that their client had increased their knowledge in at least one topic discussed.

Among the topic areas most frequently covered in client interactions (health benefits, insurance, and services; physical activity and nutrition; and social support and independent living), at least 98% of clients reported gaining knowledge in the topic area. Fewer members reported that their client gained knowledge related to the topic areas covered much less frequently overall, representing just 4% of all client forms completed (opioid and prescription drug disorder prevention and response, and COVID-19 prevention and response).

19. Percentage of clients who experienced an increase in knowledge, by topic area (N=1,616)

Increased client knowledge	Number	%
Health benefits, insurance, and services (N=1,055)	1,038	98%
Physical activity and nutrition (N=365)	356	98%
Social support and independent living (ages 50+; N=282)	279	99%
Opioid and prescription drug disorder prevention and response (N=43)	31	72%
COVID-19 prevention and response (N=21)	7	33%

Detailed client knowledge results by operating site can be found in Appendix A. Data are provided for each topic area in which operating sites had at least 10 completed forms. There was insufficient data to report on client outcomes from members in Central California.

Conclusions

Findings from the 2022-24 National Health Corps evaluation suggest that members gained a wide breadth and depth of knowledge and skills to prepare them for their future health-related careers. These changes were statistically significant, and above and beyond those observed in a comparison group of individuals who had applied to NHC, but did not end up participating in the program. This gives us, and NHC, confidence that the growth observed in members across the service year is attributable to their participation in the program.

When NHC alumni were contacted 12 months after the end of their service year, most were enrolled in a postgraduate education program. Among alumni who had sought public health-related employment, nearly all were able to secure a position. When asked for their feedback, NHC alumni cited numerous positive impacts NHC has had on their journey and growth as public health professionals.

Both members and host sites reported positive experiences with the NHC program. Members valued opportunities for training, professional development, and community building. Host sites reported that members increased the quality of client care and improved their organizational capacity. Most host site supervisors also reported making changes during their members' service year to address biased or discriminatory institutional practices and policies.

Clients reported learning about medication supports; nutrition and food access; and health care insurance, financing, and service navigation. Nearly all clients increased their knowledge after working with NHC members.

However, there are opportunities for NHC to continue to improve their program and members' experiences, including:

- Develop and refine trainings to make them even more useful and applicable to the skills members need at their host site placements and for their individual career goals.
- Reexamine member recruitment materials and position descriptions to ensure they are accurate and reflective of members' day-to-day roles.
- Work to ensure host sites and their staff understand the roles and responsibilities of NHC members.
- Provide further oversight of members' host sites to ensure they are a suitable placement for NHC members.
- Review and assess members' working conditions and make adjustments, to the extent possible within AmeriCorps expectations and guidelines, to increase compensation, improve work-life balance, and set reasonable expectations around service hours.

Overall, these findings suggest that NHC is making great strides towards their mission of building healthy communities while also developing future health and public health leaders.

Appendix

Supplementary data tables

Member data tables

A1. Member religious identification (N=124)

	Number	%
Agnostic	28	23%
Protestant	21	17%
Roman Catholic	20	16%
Atheist	15	12%
Hindu	10	8%
Muslim	7	6%
Buddhist	4	3%
Jewish	3	2%
Orthodox	1	1%
Something else	13	11%
Don't know	10	8%

Note. Numbers add up to more than 124 and percentages add up to more than 100% because some members selected more than one response option.

A2. Member self-reported disabilities and impairments (N=65)

	Number	%
Mental health disorder	13	20%
Learning disability (e.g., ADHD, dyslexia)	8	12%
Sensory impairment (vision or hearing)	4	6%
No disability or impairment (none of the above)	44	68%

Note. Numbers add up to more than 65 and percentages add up to more than 100% because some members selected more than one response option.

A3. Highest level of education completed by the person or people who raised NHC members (N=131)

	Number	%
Less than high school	4	3%
High school degree (diploma or GED)	10	8%
2-year college degree (AA or technical/vocational degree)	9	7%
4-year college degree (BA or BS)	42	32%
Some graduate school	6	5%
Graduate or professional degree (MA, MS, MD, JD, PhD, etc.)	60	46%

Note. Percentages do not total 100% due to rounding.

A4. Member knowledge of the public health field and social determinants of health, pre- and post-service (N=77; matched analysis)

How would you rate your knowledge of...		High	Medium	Low	None
How public health systems and organizations influence local, national, and global population health	Pre	21%	65%	14%	0%
	Post	51%	48%	1%	0%
	Percentage point change in "high"	+ 30%***			
Programs and services provided by public health organizations to improve the health of a community	Pre	17%	65%	16%	3%
	Post	61%	36%	3%	0%
	Percentage point change in "high"	+ 44%***			
Social determinants of health, and other factors that impact the health of a community	Pre	51%	46%	4%	0%
	Post	79%	21%	0%	0%
	Percentage point change in "high"	+ 29%***			
Identities that are impacted by structural oppression and resulting health disparities (e.g., race, ethnicity, sexual orientation, gender identity, age, and ability)	Pre	48%	47%	5%	0%
	Post	77%	22%	1%	0%
	Percentage point change in "high"	+ 29%***			
Efforts in public health practice to address health disparities and remaining gaps in service delivery	Pre	16%	61%	22%	1%
	Post	58%	40%	1%	0%
	Percentage point change in "high"	+ 43%***			

Note. Percentages do not total 100% due to rounding. Differences in the proportion of members reporting "high" knowledge or skills between pre- and post-service time points were tested using McNemar's tests. Differences are significant at ***$p < .001$.

A5. Member knowledge and skills in public health practice, pre- and post-service (N=77; matched analysis)

How would you rate your knowledge of…		High	Medium	Low	None
Cultural responsibility and recognizing identity-based prejudice and discrimination	Pre	39%	52%	9%	0%
	Post	58%	42%	0%	0%
	Percentage point change in "high"	+ 19%*			
How to increase equity and inclusion in public health settings	Pre	22%	51%	25%	1%
	Post	46%	53%	1%	0%
	Percentage point change in "high"	+ 24%***			
Motivational interviewing models and techniques	Pre	9%	55%	26%	10%
	Post	35%	51%	14%	0%
	Percentage point change in "high"	+ 26%***			
Trauma-informed public health practices	Pre	10%	49%	29%	12%
	Post	49%	39%	12%	0%
	Percentage point change in "high"	+ 39%***			
Crisis intervention strategies and resources	Pre	8%	55%	25%	12%
	Post	40%	49%	12%	0%
	Percentage point change in "high"	+ 32%***			
Communication skills needed in public health settings (e.g., active listening, de-escalation and conflict management, culturally-responsible communication, and strengths-based, person-centered communication)	Pre	31%	60%	9%	0%
	Post	69%	30%	1%	0%
	Percentage point change in "high"	+ 38%***			
How poverty, individual trauma, and collective trauma may have affected the experiences, strategies, morale, and survival behavior of your clients	Pre	39%	48%	12%	1%
	Post	69%	31%	0%	0%
	Percentage point change in "high"	+ 30%***			
Effective cross-cultural communication, the tenets of cultural humility, and basic anti-racism consideration	Pre	31%	56%	13%	0%
	Post	65%	34%	1%	0%
	Percentage point change in "high"	+ 34%***			

Note. Percentages do not total 100% due to rounding. Differences in the proportion of members reporting "high" knowledge or skills between pre- and post-service time points were tested using McNemar's tests. Differences are significant at *p < .05 and ***p < .001.

A6. Member social and professional resources, pre- and post-service (N=75; matched analysis)

My social and professional network…		Strongly agree	Agree	Disagree	Strongly disagree
Shows me that I matter to them	Pre	35%	64%	1%	0%
	Post	52%	47%	1%	0%
	% change in "strongly agree"	+ 17%*			
Challenges me to be my best	Pre	35%	64%	1%	0%
	Post	48%	51%	1%	0%
	% change in "strongly agree"	+ 13%			
Listens to my ideas and takes them seriously	Pre	37%	63%	0%	0%
	Post	45%	48%	7%	0%
	% change in "strongly agree"	+ 8%			
Helps me accomplish tasks	Pre	45%	55%	0%	0%
	Post	47%	52%	1%	0%
	% change in "strongly agree"	+ 1%			
Introduces me to new experiences or opportunities	Pre	49%	45%	5%	0%
	Post	59%	40%	1%	0%
	% change in "strongly agree"	+ 9%			
Provides me with useful information for pursuing my education or career goals	Pre	39%	55%	7%	0%
	Post	49%	45%	5%	9%
	% change in "strongly agree"	+ 11%			
Supports me in developing or strengthening the skills needed to pursue my education or career goals	Pre	44%	55%	1%	0%
	Post	49%	48%	3%	0%
	% change in "strongly agree"	+ 5%			
Connects me with other people who help me pursue my education or career goals	Pre	39%	55%	5%	1%
	Post	48%	45%	7%	0%
	% change in "strongly agree"	+ 9%			

Note. Percentages do not total 100% due to rounding. Differences in the proportion of members reporting they "strongly agreed" with each statement between pre- and post-service time points were tested using McNemar's tests. Differences are significant at $^{*}p < 0.05$.

A7. Member leadership development, pre- and post-service (N=75-76; matched analysis)

		Strongly agree	Agree	Disagree	Strongly disagree
I am very motivated to succeed in a career in the public health field	Pre	54%	46%	0%	0%
	Post	65%	34%	1%	0%
	% change in "strongly agree"	+ 11%			
I understand what it means to be a leader in the public health field	Pre	25%	59%	16%	0%
	Post	54%	42%	4%	0%
	% change in "strongly agree"	+ 29%***			
I feel prepared to be a leader in the public health field	Pre	13%	53%	33%	1%
	Post	42%	50%	8%	0%
	% change in "strongly agree"	+ 29%***			
I think about what will happen as a result of my decisions	Pre	65%	35%	0%	0%
	Post	68%	32%	0%	0%
	% change in "strongly agree"	+ 3%			
I believe I can make a real difference on issues that are important to me	Pre	47%	51%	1%	0%
	Post	53%	45%	3%	0%
	% change in "strongly agree"	+ 5%			
I understand how to be a leader that addresses oppressive systems and policies that exacerbate health disparities	Pre	27%	48%	25%	0%
	Post	52%	41%	7%	0%
	% change in "strongly agree"	+ 25%***			
I am confident in my ability to engage in the ongoing process of growth and learning	Pre	56%	44%	0%	0%
	Post	65%	35%	0%	0%
	% change in "strongly agree"	+ 9%			

Note. Percentages do not total 100% due to rounding. Differences in the proportion of members reporting they "strongly agreed" with each statement between pre- and post-service time points were tested using McNemar's tests. Differences are significant at ***$p < 0.001$.

A8. Type of postgraduate education enrollment, 12 months after NHC service year (N=31)

Postgraduate education program	Number	%
An education program related to public health (other than medical or health care-related programs)	7	23%
An education program related to medicine or health care (e.g., nursing or medical school)	21	68%
An education program related to both medicine/health care and public health	1	3%
An education program not related to health or public health	2	7%

Note. Percentages do not total 100% due to rounding.

A9. Member experiences with host sites at post-service (N=83)

	Strongly agree	Agree	Disagree	Strongly disagree
Host site staff supported my personal and professional goals	48%	46%	4%	2%
Host site staff explained what resources were available to clients	42%	51%	6%	1%
Host site staff provided information about how the organization fit into the local health service system	45%	48%	2%	5%
The host site is a suitable placement for future members	52%	36%	6%	6%
Host site staff provided training for specific skills I needed to serve clients	41%	46%	8%	5%
I think the host site staff understood the role of National Health Corps members	46%	41%	8%	5%
The service I did matched my position description	39%	43%	10%	8%

Comparison group data tables

A10. Comparison group religious identification (N=33)

	Number	%
Protestant	9	27%
Agnostic	7	21%
Jewish	4	12%
Muslim	4	12%
Atheist	3	9%
Roman Catholic	2	6%
Hindu	2	6%
Mormon	1	3%
Buddhist	1	3%
Something else	1	3%
Don't know	1	3%

Note. Numbers add up to more than 33 and percentages add up to more than 100% because some members selected more than one response option.

A11. Highest level of education completed by the person or people who raised comparison group participants (N=33)

	Number	%
Less than high school	0	0%
High school degree (diploma or GED)	4	12%
2-year college degree (AA or technical/vocational degree)	2	6%
4-year college degree (BA or BS)	7	21%
Some graduate school	2	6%
Graduate or professional degree (MA, MS, MD, JD, PhD, etc.)	18	55%

A12. Comparison group knowledge of the public health field and social determinants of health, pre- and post-service (N=33; matched analysis)

How would you rate your knowledge of...		High	Medium	Low	None
How public health systems and organizations influence local, national, and global population health	Pre	27%	58%	15%	0%
	Post	27%	64%	9%	0%
	Percentage point change in "high"	0%			
Programs and services provided by public health organizations to improve the health of a community	Pre	21%	58%	21%	0%
	Post	27%	49%	24%	0%
	Percentage point change in "high"	+ 6%			
Social determinants of health, and other factors that impact the health of a community	Pre	42%	58%	0%	0%
	Post	61%	39%	0%	0%
	Percentage point change in "high"	+ 18%			
Identities that are impacted by structural oppression and resulting health disparities (e.g., race, ethnicity, sexual orientation, gender identity, age, and ability)	Pre	55%	39%	6%	0%
	Post	61%	36%	3%	0%
	Percentage point change in "high"	+ 6%			
Efforts in public health practice to address health disparities and remaining gaps in service delivery	Pre	18%	58%	21%	3%
	Post	21%	58%	21%	0%
	Percentage point change in "high"	+ 3%			

Note. Differences in the proportion of comparison group participants reporting "high" knowledge or skills between pre- and post-service time points were tested using McNemar's tests. No differences were found to be statistically significant.

A13. Comparison group knowledge and skills in public health practice, pre- and post-service (N=31-33; matched analysis)

How would you rate your knowledge of…		High	Medium	Low	None
Cultural responsibility and recognizing identity-based prejudice and discrimination	Pre	52%	33%	15%	0%
	Post	46%	46%	9%	0%
	Percentage point change in "high"	- 6%			
How to increase equity and inclusion in public health settings	Pre	19%	47%	34%	0%
	Post	34%	59%	6%	0%
	Percentage point change in "high"	+ 16%			
Motivational interviewing models and techniques	Pre	25%	22%	44%	9%
	Post	13%	41%	41%	6%
	Percentage point change in "high"	- 13%			
Trauma-informed public health practices	Pre	22%	22%	47%	9%
	Post	19%	47%	22%	13%
	Percentage point change in "high"	- 3%			
Crisis intervention strategies and resources	Pre	22%	34%	41%	3%
	Post	16%	63%	19%	3%
	Percentage point change in "high"	- 6%			
Communication skills needed in public health settings	Pre	39%	48%	13%	0%
	Post	42%	48%	10%	0%
	Percentage point change in "high"	+ 3%			
How poverty, individual trauma, and collective trauma may have affected the experiences, strategies, morale, and survival behavior of your clients	Pre	38%	44%	19%	0%
	Post	44%	44%	9%	3%
	Percentage point change in "high"	+ 6%			
Effective cross-cultural communication, the tenets of cultural humility, and basic anti-racism consideration	Pre	44%	34%	22%	0%
	Post	31%	63%	6%	0%
	Percentage point change in "high"	- 13%			

Note. Percentages do not total 100% due to rounding. Differences in the proportion of comparison group participants reporting "high" knowledge or skills between pre- and post-service time points were tested using McNemar's tests. No differences were found to be statistically significant.

A14. Comparison group social and professional resources, pre- and post-service (N=32-33; matched analysis)

My social and professional network…		Strongly agree	Agree	Disagree	Strongly disagree
Shows me that I matter to them	Pre	18%	67%	15%	0%
	Post	39%	52%	6%	3%
	% change in "strongly agree"	+ 21%†			
Challenges me to be my best	Pre	42%	52%	6%	0%
	Post	42%	55%	3%	0%
	% change in "strongly agree"	0%			
Listens to my ideas and takes them seriously	Pre	34%	59%	6%	0%
	Post	44%	47%	9%	0%
	% change in "strongly agree"	+ 9%			
Helps me accomplish tasks	Pre	31%	66%	3%	0%
	Post	41%	53%	6%	0%
	% change in "strongly agree"	+ 9%			
Introduces me to new experiences or opportunities	Pre	42%	52%	6%	0%
	Post	36%	52%	12%	0%
	% change in "strongly agree"	- 6%			
Provides me with useful information for pursuing my education or career goals	Pre	33%	61%	6%	0%
	Post	42%	49%	6%	3%
	% change in "strongly agree"	+ 9%			
Supports me in developing or strengthening the skills needed to pursue my education or career goals	Pre	36%	58%	6%	0%
	Post	46%	49%	6%	0%
	% change in "strongly agree"	+ 9%			
Connects me with other people who help me pursue my education or career goals	Pre	30%	61%	9%	0%
	Post	39%	55%	6%	0%
	% change in "strongly agree"	+ 9%			

Note. Percentages do not total 100% due to rounding. Differences in the proportion of comparison group participants reporting they "strongly agreed" with each statement between pre- and post-service time points were tested using McNemar's tests. Differences are approaching significance at †p < .10.

A15. Comparison group leadership development, pre- and post-service (N=33; matched analysis)

		Strongly agree	Agree	Disagree	Strongly disagree
I am very motivated to succeed in a career in the public health field	Pre	52%	33%	15%	0%
	Post	58%	33%	6%	3%
	% change in "strongly agree"	+ 6%			
I understand what it means to be a leader in the public health field	Pre	27%	46%	24%	3%
	Post	39%	39%	18%	3%
	% change in "strongly agree"	+ 12%			
I feel prepared to be a leader in the public health field	Pre	24%	39%	27%	9%
	Post	36%	27%	30%	6%
	% change in "strongly agree"	+ 12%			
I think about what will happen as a result of my decisions	Pre	61%	39%	0%	0%
	Post	58%	39%	3%	0%
	% change in "strongly agree"	- 3%			
I believe I can make a real difference on issues that are important to me	Pre	46%	39%	15%	0%
	Post	55%	39%	6%	0%
	% change in "strongly agree"	+ 9%			
I understand how to be a leader that addresses oppressive systems and policies that exacerbate health disparities	Pre	42%	33%	21%	3%
	Post	42%	33%	24%	0%
	% change in "strongly agree"	0%			
I am confident in my ability to engage in the ongoing process of growth and learning	Pre	52%	42%	6%	0%
	Post	55%	39%	6%	0%
	% change in "strongly agree"	+ 3%			

Note. Percentages do not total 100% due to rounding. Differences in the proportion of comparison group participants reporting they "strongly agreed" with each statement between pre- and post-service time points were tested using McNemar's tests. No differences were found to be statistically significant.

Host site supervisor data tables

A16. Number of host site respondents per operating site at pre- and post-service time points

Operating site	Pre (N=52) Number	Pre (N=52) % of pre-service respondents	Post (N=39) Number	Post (N=39) % of post-service respondents
Central California	6	12%	3	8%
Chicago	7	14%	5	13%
Florida	10	19%	7	18%
Philadelphia	13	25%	11	28%
Pittsburgh	10	19%	10	26%
San Francisco	6	12%	3	8%

Note. Percentages do not total 100% due to rounding.

A17. Types of host site organizations, at pre-service (N=52)

Organization type	Number	%
Non-profit or community-based health organization	22	42%
Federally Qualified Health Center (FQHC)	11	21%
Public health department (not FQHC)	8	15%
Hospital	7	14%
Community health center (not FQHC)	4	8%

A18. Host site organization size, at pre-service (N=52)

Organization size	Number	%
Less than 25 employees	5	10%
25-50 employees	6	12%
51-100 employees	9	17%
More than 100 employees	32	62%

Note. Percentages do not total 100% due to rounding.

A19. Number of years host sites have hosted an NHC member before current cohort year, at pre-service (N=52)

Number of years	Number	%
0 years	8	15%
1 year	4	8%
2 years	4	8%
3-5 years	14	27%
More than 5 years	22	42%

A20. Race and ethnicity of host site supervisors, at post-service (N=32)

Race and ethnicity	Number	%
White	15	47%
Black, African, or African American	7	22%
Asian or Asian American	6	19%
Hispanic, Latinx, or Latino	4	13%
Middle Eastern or North African	2	6%
Another self-identification	2	6%

Note. Numbers do not add up to 32 and percentages do not add up to 100% because some supervisors identified with more than 1 race and/or ethnicity.

A21. Highest level of education completed by the person or people who raised host site supervisors, at post-service (N=35)

Highest level of education	Number	%
Less than high school	3	9%
High school degree (diploma or GED)	3	9%
2-year college degree (AA or technical/vocational degree)	3	9%
4-year college degree (BA or BS)	8	23%
Some graduate school	1	3%
Graduate or professional degree (MA, MS, MD, JD, PhD, etc.)	17	49%

Note. Percentages do not total 100% due to rounding.

Client data tables

A22. Percentage of clients who experienced an increase in knowledge, by topic area, Chicago

Increased client knowledge	Number	%
Physical activity and nutrition (N=129)	129	100%
Social support and independent living (ages 50+; N=14)	14	100%

Note. Data are provided for each topic area in which operating sites had at least 10 completed forms. At this operating site, data on client knowledge related to health benefits, insurance, and services; opioid and prescription drug disorder prevention and response; and COVID-19 prevention and response are excluded due to an insufficient number of completed forms.

A23. Percentage of clients who experienced an increase in knowledge, by topic area, Florida

Increased client knowledge	Number	%
Health benefits, insurance, and services (N=221)	214	97%
Physical activity and nutrition (N=93)	93	100%

Note. Data are provided for each topic area in which operating sites had at least 10 completed forms. At this operating site, data on client knowledge related to social support and independent living; opioid and prescription drug disorder prevention and response; and COVID-19 prevention and response are excluded due to an insufficient number of completed forms.

A24. Percentage of clients who experienced an increase in knowledge, by topic area, Philadelphia

Increased client knowledge	Number	%
Health benefits, insurance, and services (N=641)	641	100%
Social support and independent living (ages 50+; N=139)	138	99%
Physical activity and nutrition (N=66)	64	97%

Note. Data are provided for each topic area in which operating sites had at least 10 completed forms. At this operating site, data on client knowledge related to opioid and prescription drug disorder prevention and response; and COVID-19 prevention and response are excluded due to an insufficient number of completed forms.

A25. Percentage of clients who experienced an increase in knowledge, by topic area, Pittsburgh

Increased client knowledge	Number	%
Health benefits, insurance, and services (N=155)	145	94%
Social support and independent living (ages 50+; N=86)	84	98%
Physical activity and nutrition (N=61)	54	89%
Opioid and prescription drug disorder prevention and response (N=26)	17	65%
COVID-19 prevention and response (N=15)	1	7%

A26. Percentage of clients who experienced an increase in knowledge, by topic area, San Francisco

Increased client knowledge	Number	%
Health benefits, insurance, and services (N=29)	29	100%
Social support and independent living (ages 50+; N=40)	40	100%
Physical activity and nutrition (N=15)	15	100%

Note. Data are provided for each topic area in which operating sites had at least 10 completed forms. At this operating site, data on client knowledge related to opioid and prescription drug disorder prevention and response; and COVID-19 prevention and response are excluded due to an insufficient number of completed forms.

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