PART I - FACE SHEET

APPLICATION FOR FEDERAL ASSISTANCE

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

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

2a. DATE SUBMITTED TO CORPORATION FOR NATIONAL AND COMMUNITY SERVICE (CNCS):	3. DATE RECEIVED BY STATE: 10-NOV-10	STATE APPLICATION IDENTIFIER:
2b. APPLICATION ID: 11AC123575	4. DATE RECEIVED BY FEDERAL AGENCY:	FEDERAL IDENTIFIER: 09ACHNY0010013

5. APPLICATION INFORMATION

LEGAL NAME: Community Health Care Association of NYS

DUNS NUMBER: 166505982

ADDRESS (give street address, city, state, zip code and county):
Community Health Care Association of NYS
535 8th Avenue, 8th floor
New York NY 10018 - 2487
County: New York

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

NAME: Sajjadur Rahman

TELEPHONE NUMBER: (212) 710-3804

FAX NUMBER: (212) 279-3851

INTERNET E-MAIL ADDRESS: srahman@chcanys.org

6. EMPLOYER IDENTIFICATION NUMBER (EIN):
132690296

7. TYPE OF APPLICANT:
7a. Non-Profit
7b. Community-Based Organization

8. TYPE OF APPLICATION (Check appropriate box).

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

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

A. AUGMENTATION B. BUDGET REVISION

C. NO COST EXTENSION D. OTHER *(specify below):*

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

10a. CATALOG OF FEDERAL DOMESTIC ASSISTANCE NUMBER: 94.006

10b. TITLE: AmeriCorps State

11.a. DESCRIPTIVE TITLE OF APPLICANT'S PROJECT:
CHCANYS Community HealthCorps

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

12. AREAS AFFECTED BY PROJECT (List Cities, Counties, States, etc):
The CHCANYS Community Health Corps (CCHC) will target and serve low-income New York City communities within Northwest Brooklyn, East Harlem in Manhattan, Hunts Point, and Mott Haven in the Bronx; and Albany, Schenectady, Warren and F

13. PROPOSED PROJECT: START DATE: 09/01/11 END DATE: 07/30/12

14. CONGRESSIONAL DISTRICT OF: a.Applicant NY 014 b.Program NY 014

15. ESTIMATED FUNDING: Year #: 2

a. FEDERAL	$ 359,978.00
b. APPLICANT	$ 354,298.00
c. STATE	$ 0.00
d. LOCAL	$ 0.00
e. OTHER	$ 0.00
f. PROGRAM INCOME	$ 0.00
g. TOTAL	$ 714,276.00

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

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

DATE:

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

17. IS THE APPLICANT DELINQUENT ON ANY FEDERAL DEBT?

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

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

a. TYPED NAME OF AUTHORIZED REPRESENTATIVE:	b. TITLE:	c. TELEPHONE NUMBER:
David Davis		(212) 710-3809

d. SIGNATURE OF AUTHORIZED REPRESENTATIVE:	e. DATE SIGNED:
	05/10/11

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Executive Summary

The CHCANYS Community HealthCorps program is a perfect match with the Healthy Futures national service priority area. Our program places trained health educators, patient services associates and case managers into our partnering Community Health Centers where they perform direct service with underserved populations. Our members help clients increase access to health care services, carry-out disease prevention, health education, health literacy and health promotion initiatives in economically depressed areas of New York state.

Rationale and Approach

Rationale and Approach

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Compelling Community Need

The CHCANYS Community Health Corps (CCHC) serves low-income New York State residents living in Northwest Brooklyn, East Harlem (Manhattan), Hunts Point and Mott Haven (Bronx), and Albany, Rensselaer, Schenectady, Warren and Orange Counties (upstate New York). According to the New York State Department of Health (NYS DOH) and the New York City Department of Health and Mental Hygiene (NYC DOHMH), low-income residents in these communities experience a disproportionate share of poor health outcomes including diabetes, cardiovascular illness, cancer, HIV infection and

other conditions. However, most of these chronic health conditions are preventable or could be better managed with timely diagnosis and treatment. Research shows that improving access to quality primary care is essential to improving the health status of residents in these and similarly underserved communities.

Federally funded community health centers (CHCs) provide high quality, culturally competent primary care to low-income communities. Unfortunately, many barriers still keep CHCs from achieving their fullest potential. Many CHCs lack the resources required to address all of the health needs their communities face. Additionally, many at-risk New Yorkers lack a good understanding of the capabilities of CHCs, and how to access CHC services. A common problem resulting from this dearth of knowledge is that many low-income residents seek medical treatment in inappropriate and more expensive settings, such as hospital emergency rooms. Often such treatment is sought out only after a patient's medical condition has reached a point where it can no longer be treated in the primary care setting. As such, a critical need in these communities is to improve community residents' access to and understanding and utilization of health services offered by local CHCs.

Specific Community Needs

The CHCANYS Community HealthCorps program (CCHC) targets three regions and several counties within each region. These regions and counties are: Region 1: Albany, Schenectady, Rensselaer and Warren counties; Region 7: Orange county; and Region 10: Bronx, Kings and New York counties. All CCHC target communities are characterized by moderate to high levels of poverty. In addition, individuals in these communities bear a greater burden of poor health outcomes than other New York City and State residents. The New York City Department of Health and Mental Hygiene (NYC DOHMH) produces regular Community Health Profiles on 42 New York City neighborhoods, including reports on the communities of Mott Haven and Hunts Point in the South Bronx, East Harlem in Manhattan and Northwest Brooklyn. The data provided below are drawn from the 2006 editions of these profiles (the

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most current data available). The information on Albany and Rensselaer counties comes from New York State Department of Health (NYS DOH).

Hunts Point and Mott Haven, Bronx, New York (Region 10)

Hunts Point and Mott Haven are neighborhoods in the South Bronx, a borough of New York City. Almost half of this community's 130,000 residents live below the federal poverty level. Approximately 73% of the community are Hispanic (including large numbers of immigrants), and 24% are African American (US Census 2000). Health outcomes are among the worst in New York City. More than a third of residents lack a regular doctor and 16% rely on emergency rooms for their medical care. Ten percent of babies are of low birth weight and one in three mothers does not receive adequate pre-natal care. Seventeen percent of adults -- the highest proportion in New York City -- have diabetes. Premature death rates (i.e., deaths occurring before age 75) from cancer, heart disease, HIV/AIDS and drug/alcohol abuse are much higher than in New York City as a whole. Risky behaviors like smoking, poor nutrition, physical inactivity; alcohol/drug use, and unprotected sex are prevalent.

East Harlem, Manhattan, New York (Region 10)

The Manhattan neighborhood of East Harlem is home to nearly 110,000 New York City residents. Fifty-five percent of residents are Hispanic and 33% are African American (US Census 2000). The neighborhood is characterized by poverty (38% of residents live below the federal poverty level), poor health outcomes, and difficulties accessing appropriate health services. Thirty percent of residents do not have a regular doctor and more than 20% rely on hospital emergency rooms for their health care. Nearly 10% of babies are of low birth weight and 13% of residents have diabetes. Heart disease, HIV and cancer (primarily lung, prostate and colon) account for nearly half of premature deaths. Only one other New York City neighborhood has a higher premature death rate. High risk behaviors like smoking, poor nutrition, lack of exercise, alcohol/drug use and unprotected sex are prevalent among the community.

Northwest Brooklyn, New York (Region 10)

Northwest Brooklyn (220,000 residents) is larger and more diverse than the neighborhoods described

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previously. In addition to lower income communities like Fort Greene, Clinton Hill and Red Hook, Northwest Brooklyn includes the relatively affluent neighborhoods of Brooklyn Heights and Park Slope. These disparities account for the fact that a smaller proportion of residents (20%) live below the federal poverty level. About half of community residents are white while half are minorities, predominantly African Americans (US Census 2000). Twenty percent of residents lack a regular doctor, and the incidence of diabetes, low birth weight and inadequate prenatal care are similar to rates in New York City overall. However, the rates of premature deaths, especially those due to cancer, heart disease, HIV, and the number of "avoidable" hospitalizations are much higher. Smoking, poor nutrition and unprotected sex, along with alcohol/substance use, are the leading preventable risk factors.

Albany, Rensselaer, Warren and Schenectady Counties, New York (Region 1)

Albany, Rensselaer, Schenectady and Warren Counties cover over 2,200 square miles in eastern New York State, and are commonly referred to as part of the "Capital Region". Nearly 295,000 people live in Albany, the vast majority of whom are white (83%), with 11% African American, 3% are Hispanic and 3% are Asian/Pacific Islander (US Census 2000). Ten percent of residents live below the federal poverty level, including 13% of children. Rensselaer County's 152,000 residents are 91% white, 5% African American, 2% Hispanic and 2% Asian/Pacific Islander. Slightly less than 10% of residents live below the federal poverty level, including 11% of children. Schenectady county's 151,400 residents are also primarily white (84%) as are Warren county's; approximately 10% of residents in these counties live below the poverty line.

The region as a whole includes the cities of Albany, Cohoes, Watervliet, Rensselaer, Schenectady, Warren and Troy, as well as dozens of smaller towns, villages and rural districts. These counties do not survey broad health indicators like those reported by New York City, as a result health status is harder to gauge. Available data indicates several serious health challenges relative to those experienced throughout the rest of the state. The rate of diabetes, for example, is at least twice as high in the region as in New York State as a whole. The incidence of cancer is similarly elevated. For Albany County, HIV

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infection rates are 13 times greater than the state average. Poor sexual and reproductive health is also evidenced by the large proportion of teen pregnancies.

Orange County, New York (Region 7)

Orange County covers over 800 square miles in southern New York State with nearly 400,000 residents (US Census 2000). They are primarily white (70%), 11% are African American, 16% are Hispanic/Latino and 2% are Asian. Over 10% of residents live below the poverty level. Similar to other upstate areas, Orange County does not survey broad health indicators like those reported by New York City, therefore health status is harder to gauge. Data gathered by the New York State Department of Health (NYS DOH) Community Need Index (CNI) published in 2006 reports information specified into zip codes. The zip codes where our partnering CHCs are located expericence high rates of teen pregnancy (24%) and the highest amount of cases of cocaine, and Opioid drug use in the county. These communities also have the highest rates of sexually transmitted diseases, including HIV and AIDS cases, in the county.

Financial and Non-Financial Barriers to Primary Health Care

Community health centers (CHCs) are located within all of the previously described communities. By their mission and mandate (CHCs' Boards must be comprised of at least 51% consumers), CHCs respond to local health challenges, especially among low-income and uninsured residents. However, the existence of a CHC does not necessarily guarantee that residents in a community will access them. Some of the most significant barriers to primary care utilization are outlined below. Many of these barriers, e.g., lack of health insurance, are related to financial constraints, but a surprising number are due more to lack of knowledge or access than to fiscal limitations.

Lack of health insurance

Although CHCs serve all residents regardless of their ability to pay, many additional health care costs (e.g., prescriptions, hospital and specialty-based referrals, laboratory tests) may cause hardship for uninsured, low-income patients. Those who lack health insurance coverage, including large numbers of children in New York who qualify for free or low cost insurance, may forego seeking primary care

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altogether, and use emergency rooms as their sole source of medical treatment. In the event that all residents who qualify for health coverage and related assistance obtain it, many CHCs lack adequate staff resources to serve all potential patients.

Lack of health-related knowledge

A general low level of knowledge about the importance of primary health care in maintaining good health and how to maximize health care resources to improve health is a frequent barrier even among those with adequate health coverage. Due to limited resources, many CHCs only invest in a small number of health education activities.

Language barriers

Among speakers whose first language is not English, problems communicating with and understanding health care providers may be paramount. Many CHCs do not have resources to engage interpreters for all patients who need them.

Problems keeping appointments

Research shows that many low-income individuals do not attend scheduled appointments with health care providers. Reasons cited for no-shows include stress, time and resource constraints. Patients may not be able to obtain transportation to their appointments, for example, or may be unable to arrange for child care. Physical or emotional disability can also be a factor. With the exception of the sickest individuals, many CHCs do not have resources to investigate and address no-shows.

Subjective and cultural/community factors

Feelings of fatalism, shame and distrust for health authorities are often more prevalent in low-income communities. Many of these feelings may be associated with broader cultural and community stigmas attached to specific diseases like HIV/AIDS, depression and drug/alcohol abuse. With the exception of the most critical situations, many CHCs lack the resources to address these barriers.

Description of Activities and Member Roles

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Removing Financial Barriers to Care

Members assist community residents with applying for free and low-cost health coverage. This includes explaining coverage options, translating application instructions and eligibility requirements, and helping residents gather required documentation. Members also help patients navigate the requirements to maintain coverage. As a result of these activities, eligible patients receive health coverage which permits them and their dependents to receive comprehensive, ongoing, high quality primary care. In addition, members also help uninsured or underinsured patients receive free medications from pharmaceutical companies that offer Pharmacy Assistance Programs, by helping to explain program options, complete required paperwork and gather necessary documentation. Members track the progress of these applications and ensure that the patient receives needed medications in a timely fashion.

Removing Non-Financial Barriers to Care.

Members address linguistic barriers by providing patients with translation services before, during and after their appointments. CHCs currently utilizing members as translators have noted that the number of no shows has decreased significantly. On-site translations also lower the risk of misdiagnosis and misunderstanding of treatment plans, resulting in improved quality of care.

Members address another major barrier by reminding patients about their upcoming appointments. By contacting patients after they have received health care services, members also help ensure that patients attend follow-up appointments and adhere to their prescribed treatment plan. Furthermore, members help facilitate patients' utilization of CHCs by linking or providing them with transportation services.

To reduce fatalism, distrust and other psychosocial barriers to care, members act as patient advocates and liaisons. They help by connecting patients with other available social services in their communities. In the past, these have included those with pro bono legal services, tenant associations, food pantries, and day care programs.

Finally, members provide health education to increase CHC patients' health-related knowledge and

skills. Members conduct regular group and individual educational sessions with patients on topics such as sexual and reproductive health, drug/alcohol abuse, pre- and post-natal care, well-baby care, nutrition and physical activity; and, for patients with specific chronic illnesses like early stage diabetes, instruction in monitoring and self-management.

Member roles

CCHC members become integral to improving the care and services offered by CHCs, and their work on no shows is an example. Members identify these patients, contact them, assess the reasons for their absence, help them reschedule their appointments, arrange for transportation, translation or other needed services, and conduct post-visit follow up. Members also provide health education, developing their own tools and curricula and offering the sessions themselves. A member whose focus was on health education stated, "The biggest impact I had this year was through the various tools I have been able to develop that offer patient education without increasing the number of providers a patient sees in any one visit."

Members visit housing projects, community centers, schools and shopping malls to distribute information and answer questions. This outreach to identifying and working with residents who require health education or assistance obtaining health coverage. One CHC administrator noted that the role of CCHC members assigned to his facility was "continuously improving the health status of our underserved communities."

Program Structure

CHC participation begins during the spring recruitment period and each CHC can apply for up to 5 members. Each member is assigned a Site Supervisor at the CHC, typically a senior member of the staff, who is trained by the CCHC Program Director. His/her primary responsibilities include: participation in member selection; on-site program development, member orientation and training; program reporting; and providing day-to-day supervision of the member. The Program Director for CCHC is located in

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CHCANYS' main office in New York City, with access to Penn Station and other public transportation. Members travel to CHCANYS bi-monthly for one-on-one meetings.

The Program Director's primary responsibilities include member and service site recruitment, training, mentoring and supervision, developing project descriptions, negotiating Memoranda of Understanding with the service sites, providing training and technical assistance to Site Supervisors, and analyzing and reporting performance data. Finally, although members are placed at scattered sites, the program still provides a cohesive team experience through regular group trainings, combined service projects, social outings and other activities. The Program Director also conducts monthly visits to each site, and communicates daily with Site Supervisors. Alignment of member slots with program design

CCHC prides itself on building a diverse team of members. To date, members have included single parents, those with another part-time job and full-time students. As a result, the program seeks to retain flexibility, especially with regard to scheduling. The program is, therefore, requesting twenty-four full-time slots (11 months or 46 weeks with flexible scheduling). CHCANYS' experience suggests that this flexibility will allow us to recruit members who can commit to eleven months of full-time service, and ensure that all members have a valuable and enriching personal and professional development experience while also improving the health of the communities they serve.

Compliance with rules

Program rules and prohibited service activities are covered in member orientation trainings, as well as ongoing monthly team trainings. Before members start their service, a written Member Agreement is signed, which outlines program rules and prohibited activities. In addition, the Program Director requires members to submit bi-weekly narratives detailing all activities. By reviewing these narratives with members in one-on-one meetings and conducting site visits as appropriate, any problems are identified early and are quickly addressed.

Measurable Outputs and Outcomes

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"Improving Utilization of Primary Care" is CCHC's aligned primary performance measure. As part of the CCHC program, twenty-four full-time HealthCorps members provide services 7 hours per day, 4 days per week, affecting approximately 10,000 community residents. It is anticipated that at least 75% of community residents engaged by members will report an improved familiarity with insurance plan options and services offered by their local CHC, a better understanding of health issues and the importance of regular primary care, and/or increased knowledge about how to live a healthy lifestyle. In addition, we expect that at least 50% will report improved utilization of primary health care services (including: enrollment in health insurance plans, registration as CHC patients, making and keeping appointments and adhering to illness self-management and other treatment plans).

Volunteer Generation is a secondary performance measure. CCHC members develop strategies for recruiting, selecting and training volunteers and coordinating volunteer activities to manage 15 service projects each program year. Volunteers serve a total of 700 hours annually in one-time service projects and ongoing initiatives.

Member Development is another aligned secondary performance measure. In addition to mentoring by their Site Supervisor, members receive additional trainings and attend the National Association of Community Health Care Centers' (NACHC) annual Community Health Service Forum. Eighty percent of members are expected to increase work-related knowledge and skills and 75% are expected to report a desire to acquire permanent employment in the community health care/social services setting and/or pursue education in the field of health care/social services.

Plan for Self-Assessment and Improvement

CCHC's performance measures are primarily quantitative to facilitate the detection of specific problems or challenges in meeting performance goals. Planned self-assessment and improvement efforts will also continue to benefit from CCHC's collaboration with the NACHC Community HealthCorps and Project Star (CNSC's contracted technical assistance provider).

Members are trained in the collection and reporting of program information at orientation. Data is then

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collected and reported to the Project Director every other week. If it appears that the program may fail to meet these targets, actions are taken to correct the deficiency. In the past, apparent deficiencies in performance have been addressed with additional training and reappraisals of member functions.

Continuous program improvement

CCHC has found that having a close relationship with its members and CHC partners is paramount to identifying broader strengths and weaknesses. The relatively small scale of CCHC is conducive to close communication, permitting weekly meetings with members and monthly visits to their program sites. Further, as an affiliate partner of NACHC Community HealthCorps, CCHC will continue to engage the latter's technical assistance and guidance for program improvement.

Finally, we will continue to assess our systems, procedures and instruments to increase program efficiency and effectiveness. The value of this activity was demonstrated in 2006 when CCHC completed an intensive review of the performance measures with Project STAR which resulted in the clarification of measures, stronger data collection and reporting tools, and the improved ability to participate in a national reporting system. In coming years, CCHC will continue to use Project STAR for technical assistance to identify program enhancements and procedures for program evaluation.

Community Involvement

Identifying needs and activities

CCHC uses a joint needs assessment process to elicit CHC knowledge about their community's needs, and to propose viable member activities to address them. The Program Director and the partner CHC subsequently develop detailed descriptions of these activities, which will be further reviewed by the Program Director to ensure that they promote the mission and aims of AmeriCorps.

Ongoing engagement, roles and responsibilities of community partners

As the actual service sites, CHC partners will continue to be closely involved in ongoing program development and administration. Responsibilities of the partner CHCs include providing concrete activities for the members to help address community needs on a broader level.

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Relationship to other National and Community Service Programs

CCHC is an affiliate member of the National Association of Community Health Centers (NACHC) Community HealthCorps and enjoys a close collaboration with that program. CCHC and NACHC collaborate on various member trainings, including the "Ten Core Competencies for a Health Care Provider." More advanced-level training and information sessions for CCHC members are provided at NACHC's annual Community Health Service Forum. The Forum also provides a unique opportunity for members to share resources and experiences with peers from other HealthCorps sites across the county. Finally, the CCHC Program Director participates in NACHC's annual HealthCorps Program Director Development Institute. CCHC also provides technical assistance to other AmeriCorps programs. We are currently in the process of planning collaborations with GreenApple Corps, City Year New York, Ramapo for Children and the New York City Coalition Against Hunger (all of whom we have worked with previously).

Potential for Replication

Individual CCHC-developed service efforts have already been replicated by many service sites during the current grant cycle. CCHC began with just four sites in partnering CHCs. In the current program year nine additional sites decided to replicate the program, bringing the number of partnering CHCs to thirteen. When asked in evaluation surveys if they would recommend participation to another health center, the South Bronx CHC replied, "Yes, we are all for HealthCorps!" and Urban Health Plan CHC noted, "Yes indeed! They [the CCHC members] are gems...". South Bronx CHC further recommended that other sites replicate the HealthCorps experience in activities that involve "outreach, projects that improve utilization of the health centers, providing health education, [and] Reach Out and Read projects," and Urban Health CHC noted that the most useful replication efforts would be "anything patient-oriented or having to do with case management or patient tracking."

Organizational Capability

Organizational Capability

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Sound Organizational Structure

Ability to Provide Sound Programmatic and Fiscal Oversight

Established in 1971, the Community Health Care Association of New York State (CHCANYS) is the voice for community, migrant and homeless health centers as leading the providers of patient-centered primary care in New York State. Recognized as a strong and effective primary care association by national peers and the federal government, CHCANYS is the "go-to" organization in New York State for guidance and analysis on community health policy and regulatory reform. The success and strength of our collaborations has made CHCANYS a pivotal partner for policy makers and community-based organizations wanting a stronger primary and prevention-based system. CHCANYS represents more than 70 community, migrant and homeless health centers that provide primary, preventive and dental care, as well as mental health, substance abuse and other community based services to anyone in need regardless of their insurance status or ability to pay. In New York State, CHC's provide high quality health care to more than 1.3 million residents at 445 sites statewide.

The National Community HealthCorps (NCHC) provided the impetus for the program. CHCANYS is a close partner with the National Association of Community Health Centers (NACHC), the organization overseeing the CCHC program. While CCHC is independent of NACHC, they are a frequent and close collaborator and partner. To date, the program has provided community health work opportunities and experience to over 60 members, working in 20 CHC sites throughout New York State. The program has grown into an integral part of CHCANYS' other workforce development efforts. These include an Internet-based job posting service and statewide professional and clinical conferences convened by CHCANYS each year. CHCANYS' capacity to manage federal funds is evidenced by its current, multiple federal grants, including a long-term cooperative agreement with HRSA Bureau of Primary Care as the Primary Care Association for NYS, CHCANYS' internal supervision, reporting, accounting and bookkeeping are closely aligned with federal grant performance and reporting measures. CHCANYS

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undergoes an annual financial audit, including a required A133 audit. In the past four years, CHCANYS' internal capacity has been significantly enhanced with the additions of many key staff including an Account Manager and a Researcher.

CCHC contributes to CHCANYS' mission in several ways: it offers CHCs capacity to pilot and innovate projects and activities to increase health care access; it helps those who need CHC services understand the roles these institutions play in promoting their health; it exposes dedicated individuals to the community health careers; and, by consistently leveraging existing infrastructure, its impacts outlast any given program cycle. CCHC's own ability to work with multiple service sites stems from the fact that they are all member CHCs of CHCANYS itself, meaning that they literally constitute the organization and participate in its administration and governance. As a result, the relationships between CCHC and the service sites reflect one aspect of the total collaboration CHCANYS cultivates with its members and helps ensure that member contributions are aligned with broader public health priorities. Because of those existing close relationships, CCHC does not need to conduct exceptional activities to develop connections between service sites, or ensure that their work is properly aligned as both are intrinsic to their membership in CHCANYS. The mechanisms CCHC uses to recruit and select sites and to monitor compliance with program requirements has already been addressed. To summarize, in the spring of each year, the CCHC communicates with CHCANYS' CHC members to describe the program and set out participation requirements (including all the requirements specified in 45 CFR § 2522.475). It then communicates further with interested site administrators to assess suitability. The CHCs ultimately selected are required to enter into a Memorandum of Understanding with CCHC that specifies mutual responsibilities. In particular, the sites agree to allocate a qualified Site Supervisor to receive program training and work directly with one or more members. They must also agree to ongoing monitoring for compliance, including monthly site visits by the Program Director, and to report performance data.

Board of Directors, Administrators, and Staff

CHCANYS' work is performed by 25 professional staff with offices in New York City and Albany, the two

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locations proposed for continuing to site CCHC members. CHCANYS is led by a Chief Executive Officer, assisted by a Chief Operating Officer and several Director-level positions. CCHC is a discrete program, and its full-time Director reports directly to CHCANYS' COO. Further support is provided by administrative and clerical staff and consultants skilled in program development, evaluation and fundraising. Fiscal oversight is provided by a Director of Finance, and a Researcher assists in analyzing the Performance Measures. CHCANYS' 29 member Board of Directors is comprised of CEOs and clinicians from its member CHCs. It constitutes an additional resource for CCHC with respect to providing suggestions and guidance for designing specific member activities and sharing program information throughout CHCANYS' constituency.

Plan for Self-Assessment or Improvement

CHCANYS fulfills self-assessment and improvement functions in many ways, including through board and other governance committees, staff supervision, other grant monitoring and reporting, and by retaining skilled consultants. Over the past four years, CHCANYS has strengthened its internal assessment, program monitoring and quality improvement capacity by growing its professional staff from 7 FTEs to 25.

Plan for Effective Technical Assistance

CCHC has benefited from the relationship with NACHC's HealthCorps program through the interchange of advice, experiences, resources and other technical assistance (TA). CCHC has also availed itself of TA offered by Project Star to develop its new Performance Measures, and has already begun to implement them. In coming years, the program will continue to utilize both resources as available. Coupled with the new program monitoring and evaluation capabilities within CHCANYS itself, these resources make CCHC well prepared to diagnose and respond to any TA needs it may encounter. Responding to the TA needs identified by the CHCs themselves is also core to the CCHC program. CCHC assesses these needs beginning with site recruitment, prequalification and selection, and continuing through orientation and training of Site Supervisors and monthly site visits. To the extent any site experiences training and TA

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needs to which CCHC cannot respond itself, other CHCANYS organizational resources, including its own TA and Training staff, can be called into service.

Sound Record of Accomplishment as an Organization

Volunteer Generation and Support

While the majority of CHCANYS' work is performed by staff, the organization would be unable to achieve its mission without the valued support of scores of volunteers. Volunteers include professionals who work at and represent CHCANYS CHC members and patients. These individuals fulfill a large number of roles, including helping CHCANYS plan events and conferences, lead public policy advocacy, lead and comprise board-level committees and provide governance for CHCANYS as board leaders. CHCANYS utilizes multiple strategies to support and recognize its volunteers, including providing scholarships to attend skills-building events and conferences as well as publicly recognizing outstanding volunteers at its annual conference.

Organizational and Community Leadership

CHCANYS is a 38-year-old nonprofit association whose mission is to ensure that the medically underserved living in New York State have access to quality community-based health care services. CHCANYS is a membership organization of Federally Qualified Health Centers (FQHCs), Look-Alikes and other health centers throughout the state. CHCANYS' member organizations provide primary care to over 1.3 million vulnerable New Yorkers at 445 sites. CHCANYS represents its members' interests in New York State, convenes and coordinates them for the purpose of information-sharing, education, training and advocacy and offers services to improve efficiency and effectiveness. CHCANYS is part of a national network of Primary Care Associations, which are coordinated through the National Association of Community Health Centers (NACHC) and the federal Health Resources and Services Administration (HRSA).

Leaders at CHCANYS, including board members and staff, have received numerous awards and other

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recognition for their public health leadership. CHCANYS' CEO, Elizabeth Swain, is highly regarded in the state as well as the country for her work on primary care safety net issues and public policy.

Success in Securing Match Resources

As noted in other sections of this application, CHCANYS has secured more than the required match resources for CCHC in the current grant cycle, largely because of the value the program brings to participating CHCs. Because of these strong commitments, CCHC has not had to seek private resources to sustain its work. However, in the coming year, CCHC will approach a small number of corporate funders to solicit additional program support.

One challenge that has previously been encountered is an assumption that AmeriCorps costs are fully covered and/or should be the responsibility of government. CHCANYS plans to counter this challenge with funder education about the AmeriCorps program goals, and the ability of CCHC to leverage sustainable improvements in community health.

Success in Securing Community Support

Collaboration

CHCANYS' primary collaborative activity is with its 50+ community-based CHC members. But the organization also works with many other groups, including Greater New York Hospital Association, United Hospital Fund, New York Academy of Medicine, Family Planning Advocates of New York, Primary Care Development Corporation, the New York State Area Health Education Center System (NYS AHEC), the New York Chapter of the American College of Physicians, the New York State Academy of Family Physicians, SUNY Albany, Columbia University, the New York State Association of County Executives, the New York City Department of Health and Mental Hygiene, the New York State Department of Health, and the National Association of Community Health Centers.

Local Financial and In-kind Contributions

In addition to receiving federal grant support, CHCANYS is sustained largely by the direct membership contributions by its CHC members. Over the past 3 years, these dues payments have increased on an

average of 5% annually. In addition, the organization has received greater private support, including major commitments from the New York Community Trust, Ira W. DeCamp Foundation and the Altman Foundation.

Wide Range of Community Stakeholders

As noted, CHCANYS network of community stakeholders is already extensive. For example, every year since the spring of 2007, CHCANYS has conducted an annual advocacy event to bring hundreds of CHC patients and other community stakeholders to Albany. This activity has created a new, consumer-driven cadre of CHCANYS volunteers, dedicated to helping the organization implement advocacy campaigns in response to emerging community health needs.

Cost Effectiveness and Budget Adequacy

Cost Effectiveness and Budget Adequacy

Cost Effectiveness

The proven dedication by CHCs to provide support to AmeriCorps members and, in many cases, their willingness to hire them after their service completion, is a clear indicator of the cost-effectiveness and value of the CCHC program. In fact, given an overall cost per full time equivalent of $15,000 per member service year (MSY) and the benefits produced as a result, it might be classified among one of the most cost-effective approaches in the health care sector -- especially when the future costs for acute and hospital-based care that the program helps reduce are considered. Sponsor Sites currently dedicate $11,000 per MSY in New York City and $5,000 at Upstate locations (over 30% of the total matching cost towards the program). In 2010, the amount for New York City will remain the same while the amount for the Capital Region centers will increase to $8,000. Since its inception, a sustainable match has been a foundation of the program. In the first two years, Sponsor Sites matched 20% of the member support costs, a number which increased to 30% in 2006, to 36% in 2007, to 38% in 2008, and 40% (to date) in 2009. Additionally, Sponsor Sites commit non-federal, in-kind contributions to support members' costs. Further, although the program is, in many ways, not large enough to attract significant private

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fundraising support, CHCANYS will still approach potential funders about its work in the coming year, in conjunction with an ongoing and, so far, successful expansion in the organization's overall fundraising capacity.

Budget Adequacy

CHCANYS' past experiences with CCHC has provided a very sophisticated understanding of all program expenses, both direct and indirect. This experience also enables CHCANYS to maximize financial contributions from all sources. In addition, CHCANYS has invested heavily over the past three years in its fiscal management and other capabilities, such that the budget has also been created and reviewed by the Director of Finance and Chief Operating Officer, both with extensive federal, state and local grant budgeting and fiscal management experience. For all these reasons, we are confident that the proposed program budget is adequate and appropriate to achieve the program goals and objectives, including the necessary training, staff time, administration and other resources allocated for program design, implementation, evaluation, and ongoing improvement.

CHCANYS operating budget is a mixture of funding from private sources (foundation grants, dues, etc), government grants and contracts and general funds. General funds comprise 21% of CHCANYS budget and these funds are derived largely from conference and meeting revenues. CHCANYS uses these funds to provide additional support to the Americorps program.

Evaluation Summary or Plan

Evaluation Summary or Plan

Evaluation is a critical aspect of both health care delivery programs and national service programs. Through a well-designed, systematic evaluation, the essential components of success can be identified and replicated, and less effective elements can be modified. Evaluation is an invaluable tool for continuous quality improvement. Further, evaluation results provide funders and stakeholders with evidence of the impacts of the program, which is a critical component of program sustainability.

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CCHC conducts evaluation of the program through collaborations with the New York State Commission on National and Community Services (to track Volunteer Generation activities and outcomes and program management and outcomes) and with NACHC (to evaluating HealthCorps program impact and outcomes). CCHC participated in New York State's independent statewide evaluation focused on mobilizing more volunteers. In an effort to increase volunteer recruitment, training, and support by AmeriCorps programs, the evaluation identifies links among volunteer characteristics, recruitment strategies, service activities, etc. At the program level, this enables CCHC to best target our efforts and effectively increase volunteer mobilization. This evaluation is conducted by the Center for Human Services Research (CHSR) in collaboration with the New York State Commission on National and Community Service, the NYS Office of Children and Family Services, and all other programs within the NYS Commission's portfolio. CCHC was responsible for directly entering that information into a web-based Management Information System (MIS). Data is available on a statewide basis and is disaggregated on a program level. The statewide database identifies strategies that CHCANYS Community HealthCorps utilizes to recruit, train and manage volunteers. Data was collected to identify effective practices for both continuous and episodic volunteers. The statewide evaluation was developed and implemented with input from New York State program directors. Reports were generated by the CHSR; CHCANYS Community HealthCorps will utilize those reports in developing effective strategies related to Mobilizing More Volunteers. NACHC, in partnership with the evaluation contractor, identified the outputs and outcomes to measure which may include, for example: access to health care (including enrollment in health insurance programs), utilization of health care services, and availability and impact of health education. NACHC will utilize this evaluation to focus program design and track and measure intermediate and end program outcomes as well as outputs. To measure and evaluate HealthCorps' outcomes and to improve administrative and evaluation systems (i.e., improved integration of HealthCorps measurement activities into health center systems), the evaluation will include understanding the CHC's capability for capturing data from existing systems such as the Uniform Data

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System and Practice Management System. The NACHC evaluation plan is to evaluate:

1) Evaluating Community HealthCorps program impacts and outcomes

2) Making recommendations to improve HealthCorps-related systems and increase positive program outcomes

3) Identify and quantify the impact of the Community HealthCorps services on residents of Medically Underserved Areas

4) Identify best practices in existing systems and tools that best measure, track and reinforce program impacts and/or integrates Community Health Corps into CHC's existing systems

5) Develop recommendations that can deepen the program's impact/outcomes by refining the design and coordination of the Community HealthCorps program to reflect the changing priorities and capabilities of community health centers

6) Better understand the effectiveness of Community HealthCorps management systems and program practices (identify what is working and what could be improved)

7) Better understand the effectiveness of the Community HealthCorps Program nationwide including which member activities have the greatest value-added for patients, service provision, and overall health center capacity

8) Develop a final report, including systems and program recommendations, and present results to a group of key stakeholders.

Amendment Justification

There are no amendments.

Clarification Summary

1) In our rationale and approach section we have thoroughly explained the target population is the underserved communities of New York State. These underserved communities are served by our Community Health Centers and by definition we must service the underserved populations of New York State. Please see subsection Specific community needs. In the subsection Member Activities and

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Member roles we explain how the member involves clients. Members provide health education sessions, translation services, transportation assistance and coordination, case management and follow-up services, help clients get access to Pharmacy assistance programs and members help clients obtain health insurance or help establish a sliding scale fee for the services they receive. The members directly work with patients in providing these services.

2) Our desired program and member enrollment period start date is September 1, 2011. After completing all the necessary paperwork and submitting all required documentation, members are enrolled into our program. They will then go through our comprehensive HealthCorps Pre Service Orientation (PSO).

3). Members are trained during PSO on a wide variety of topics and a general overview of each function area. So members are trained in case management, health education on asthma, diabetes, reproductive health, hygiene, mental health, financial health literacy, nutrition etc. Once a member gets to their host site they are then trained specifically by the Community Health center more in-depth on the specific service function they are performing, all before they are interacting with clients. This ensures members ability to successfully complete the tasks/service duties of the program. Civic engagement is also part of the core competencies members perform. In addition, our program was selected by the New York Council for the Humanities to participate in a program called Meaning of Service. The program manager was trained by the New York Council for the Humanities (NYCH) to conduct a reading and reflection series with the AmeriCorps members on the meaning of service. Members read articles selected by the NYCH and the program manger facilitates these discussions during our team training days. These Meaning of Service sessions occur at least 8 times a program cycle (as required by NYCH) but more accurately over a dozen times per program cycle.

Our members come from diverse backgrounds. We define diverse backgrounds as those who are from

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varying socio-economic backgrounds, varying language abilities, parents and non-parents, varying age groups, local community members to national recruitment and from varying racial and ethnic backgrounds. Our team has always lived up to this definition but we do not categorically define and track members racial and ethnic backgrounds.

4) CHCANYS is a an organization that provides policy, advocacy and organizational capacity building for all Federally Qualified Health Centers in New York State. We help CHC's organizational capacity building through the services just mentioned and additionally through our programming. One of these programs for the last several years has been the CHCANYS-Community HealthCorps program. The program fills critical service gaps that exist in our Health centers. One example is our ability to provide members that can help clients process health insurance applications. The members have the time to work one-on-one with clients and aid them through step by step. This in return allows the health centers to bill for the medical services they provide for these clients.

5) Each member is assigned a Site Supervisor at the CHC, typically a senior member of the staff, who is trained by the CCHC Program Director. His/her primary responsibilities include: participation in member selection; on-site program development, member orientation and training; program reporting; and providing day-to-day supervision of the member. The Program Director for CCHC is located in CHCANYS' main office in New York City, with access to Penn Station and other public transportation. Members travel to CHCANYS bi-monthly for one-on-one meetings.

The Program Director's primary responsibilities include member and service site recruitment, training, mentoring and supervision, developing project descriptions, negotiating Memoranda of Understanding with the service sites, providing training and technical assistance to Site Supervisors, and analyzing and reporting performance data. Finally, although members are placed at scattered sites, the program still provides a cohesive team experience through regular group trainings, combined service projects, social

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outings and other activities. The Program Director also conducts monthly visits to each site, and communicates daily with Site Supervisors. Program rules and prohibited service activities are covered in member orientation trainings, as well as ongoing monthly team trainings. Before members start their service, a written Member Agreement is signed, which outlines program rules and prohibited activities. In addition, the Program Director requires members to submit bi-weekly narratives detailing all activities. By reviewing these narratives with members in one-on-one meetings CHCANYS is able to provide proper oversight of multi-sites. CHCANYS has a program manager and a program coordinator for the HealthCorps program. The coordinator reports to the manager and the manager reports directly to the Chief Operating Officer of CHCANYS. CHCANYS builds relationships with specific program/department directors at Community Health centers to establish work plans. These Community Health center staff members are the direct site supervisors for the AmeriCorps members who sign and date all timesheets and can appropriately validate the members service hours.

6) The maximum per MSY according to the RFP we received is $15,000 not $13,000. We have met these guidelines. The sites are required to pay the match contribution and we incorrectly wrote request. This has been our program model since its inception and it has always been a requirement for participation. CHCANYS also receives additional revenue from CHC's as they pay membership dues. We have provided greater match total than 2007 and our match has always exceeded our required amount (current CNCS requirement is 38% we are at 49%). Due to the economic recession we are not able to increase what we charge our host sites for match. We received ARRA funding to help us get through these past two years. We believe the increase participation exemplifies the commitment CHC's have for the program but due to the recession were unable to contribute more towards match. We believe once the economy rebounds we will be able to raise the match contribution requirement for sites.

7) We will conduct both criminal background checks and sex offender checks on all staff and

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AmeriCorps members. This will include an FBI fingerprint check in addition to the state registry check and the NSOPR for anyone with recurring access to vulnerable populations. This policy willl be implemented and all files and results will be placed in a locked file cabinet for further recording and verification. These files will be audited annually by both the State Commission and our own evaluation consultants.

8) The very first line of our grant refers to our selection and alignment of the Healthy Futures Priority Area. We also selected it when we first submitted our proposal on eGrants. We believe we perfectly match with the Healthy Futures Priority area and are proud that we have been fulfilling this mission for several years. We did opt-in and are unsure why CNCS has asked this question. Please let us know what we need to complete in order to "opt-in".

Continuation Changes

We are not proposing any continuation changes. We will be repeating our current program scope.

Performance Measures

SAA Characteristics

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

Priority Areas

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

Grand Total of all MSYs entered for all Priority Areas 19.2

Service Categories

Service-Learning	Primary [ ]	Secondary [ ]
Community-Based Volunteer Programs	Primary [ ]	Secondary [x]
Hospital and Clinical Support Services including Rehabilitation	Primary [x]	Secondary [ ]

Improving Utilization of Primary Care.

Service Category: Hospital and Clinical Support Services including Rehabilitation

Measure Category: Needs and Service Activities

Strategy to Achieve Results

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

CHCANYS Community HealthCorps (CCHC) members will act to remove financial and non-financial barriers to primary care provided by CHCs so that the latter can better fulfill their intended roles improving the health of low income residents and their communities. CCHC members will accomplish this end by helping CHCs provide several non-medical services to community members that, by virtue of their limited resources or experience, the CHCs themselves do not provide. These services will include: assistance obtaining and maintaining public health coverage and other benefits; ; helping patients keep appointments by providing reminders, assistance with transportation, linkages to child care and other appropriate interventions; acting as patient advocates and liaisons to reduce distrust and help address other limiting factors in patients' lives; and providing individualized, group and

Briefly describe how you will achieve this result (Max 4,000 chars.)
community health education. As a result, CHCs will be able to provide better quality and more timely services to more of the low-income patients who need them, and reduce inappropriate utilization of hospital emergency rooms and other acute health care resources.

Results

Result: Output
Twenty-Four (24) HealthCorps members will do outreach to 8,000 residents of medically underserved communities. HealthCorps members will assist community members in obtaining and maintaining health coverage and other benefits, provide information about community health center services and assist residents in enrolling in community health centers, and help patients keep appointments by providing reminders

Indicator: beneficiaries
Target: 8000 Community resident contacts.
Target Value: 8000
Instruments: Members will collect data weekly. Members will record data on tally sheets and sign-up sheets. Members will report the data bi-weekly to the program director.
PM Statement: Twenty-four (24) full time HealthCorps members, providing services 7 hours per day 4 days per week, will reach out to at least 8000 community residents.
Prev. Yrs. Data

Result: Intermediate Outcome
There will be an increase in community residents awareness of community health center services, insurance plans and other benefits, and upcoming appointments.

Indicator: beneficiaries
Target: 6000 of the 8000 community residents that members make contact with will report increased awareness.
Target Value: 6000
Instruments: Members will collect data weekly using pre/post tests, feedback surveys and evaluation forms. Members will report the data bi-monthly to the program director.
PM Statement: 6000 of the 8000 community residents that members will make contact with will report an increase in awareness of health insurance coverage and other benefits, information about community health center services, and upcoming appointments
Prev. Yrs. Data

Result: End Outcome
There will be an increase in the amount of Community residents that either attend appointments and/or enroll in community health centers or insurance plans.

Indicator: beneficiaries
Target: 5000 of the 8000 community residents that members will make contact with.
Target Value: 5000

Result: End Outcome

Instruments:	HealthCorps members will collect data weekly using appointment rosters, enrollment forms and health survey. Members will report their data bi-monthly to the program director.
PM Statement:	5000 of the 8000 community residents that members will make contact with will attend appointments and/or enroll in community health centers and insurance plans
Prev. Yrs. Data	

National Performance Measures

Priority Area: **Healthy Futures**

Performance Measure Title: Number of clients receving Health Education

Service Category: Hospital and Clinical Support Services including Rehabilitation

Strategy to Achieve Results

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

CHCANYS Community HealthCorps (CCHC) members will act to provide health education services thus improving the health of low income residents and their communities. CCHC members will accomplish this end by helping CHCs provide several health education services and workshops to community members. These services will include health education sessions including but not limited to: Asthma, Diabetes, Hypertension, Reproductive Health, Hygiene, Nutrition, HIV/AIDS. By providing individualized, group, and community health education, CHCs will be able to provide better quality and more timely services to more of the low-income patients who need them, and reduce inappropriate utilization of hospital emergency rooms and other acute health care resources.

Result: Intermediate Outcome

Result.

Community members will gain a greater understanding of health education topics covered in individual, group and community workshop sessions.

Target : 3000 Community members

Target Value: 3000

Instruments: Members will utilize Pre/Post Test Surveys, to determine the number of participants who increased their knowledge.

PM Statement: 3000 of the 4000 Community members who will receive health education on topics covered in individual, group and community workshop sessions will gain a greater understanding of health education topics covered in individual, group and community workshop sessions.

Result: Output

Result.

Community members will receive health education on topics covered in individual, group and community workshop sessions.

Indicator: H4: Clients participating in health education programs.

Target : 4000

Target Value: 4000

Instruments: Members complete a bi-weekly reporting log. This log will tally the number of health education sessions members conducted as well as the number of people in the sessions.

PM Statement: 4000 Community members will receive health education on topics covered in individual, group and community workshop sessions.

Priority Area: **Healthy Futures**

Performance Measure Title: Community members will receive Culturally and linguistically appropriate language translation services.

Service Category:

National Performance Measures

Hospital and Clinical Support Services including Rehabilitation

Strategy to Achieve Results

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

Community members will receive linguistically appropriate language translation services at Community Health Centers located in underserved areas throughout New York State. Community members often experience language barriers and not all providers at CHC's speak multiple languages. Community HealthCorps members will fill this critical service gap by providing critical language translation and interpretation services. This will lead to an increase in patient satisfaction with the health services that they receive.

Result: Intermediate Outcome

Result.

4000 of the 5000 Community Members who receive language translation and interpretation services will show an increase in satisfaction with the health services that they receive.

Target : 4000 of 5000 Community Members who receive language translation services

Target Value: 4000

Instruments: Members will utilize a Medical translation and Interpretation bi-weekly report log to track patients who they have provided these services to by name. They will then utilize this log to collect data on these patients by conducting feedback surveys. Members will report the data bi-weekly to the program director.

PM Statement: 4000 of the 5000 Community Members who receive language translation and interpretation services will show an increase in satisfaction with the health services that they receive.

Result: Output

Result.

Community members will receive language translation and interpretation services.

Indicator: H7: Clients receiving language translation services.

Target : 5000 Community members

Target Value: 5000

Instruments: Members will utilize a Medical Translation and Interpretation bi-weekly reporting log. This log will tally the number of community residents by name that members provide translation services to.

PM Statement: 5000 Community members will receive language translation and interpretation services

Required Documents

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