ABSTRACT

Project Title: Patient Navigator Project
Organization Name: Lutheran Family Health Centers of Lutheran Medical Center
Address: 6025 6th Avenue, Brooklyn, NY 11220
Project Director: Kathy Hopkins
Phone: 718-630-7171 Fax: 718-630-7295 Email: khopkins@lmcmc.com http://www.lmcmc.com

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Abstract Narrative:
The proposed initiative will employ the services of Patient Navigators to build upon the services provided to high risk diabetic patients by Lutheran Family Health Centers' existing Care Management program, that has utilized a community health worker and care management framework to serve adults and children with Diabetes and Cardiovascular conditions.

The Patient Navigators (PN) hired for this initiative will play an essential role in helping high risk patients access quality health services, embrace positive health behaviors, and navigate complex treatment regimens. Hired because of their unique access to Southwest Brooklyn communities and the trust they enjoy with community residents, PNs will be able to integrate health information about prevention/management of disease and the health system into the community's culture, language, and value systems.

The PN model has been found particularly effective in programs that seek to create positive change in health seeking behaviors among vulnerable and underserved populations, such as the one served by LFHC. The proposed PN program will serve the medically underserved, ethnically diverse contiguous southwest Brooklyn neighborhoods of Sunset Park, Bay Ridge, Dyker Heights, and Bensonhurst. There are approximately 25,000 individuals who have diabetes. Another 59,000 individuals are obese while 74,000 have high blood pressure, two obvious risk factors for type II diabetes. Of particular concern for the target population is the apparent rise in the prevalence of childhood diabetes. The appearance of a spike for the service population is consistent with recent projections by the Centers for Disease Control (CDC) that one in three children born in the US in 2001 is expected to become diabetic, with even worse outcomes for Hispanic and Asian children

The proposed program will employ the services of seven patient navigators to serve an anticipated 650 patients belonging to two high risk cohorts– Adult diabetics with an A1c value $\geq$ 9.0 and children with a family history of diabetes and a probable diagnosis of obesity. The primary goals of this initiative are to eliminate barriers to care, ensure timely delivery of services and reduce the morbidity and mortality associated with diabetes among this high-risk patient population.

The program will partner with Columbia University's Mailman School of Public Health and the 1199 Training Fund to train patient navigators and to evaluate the outcomes of this initiative.

The program is requesting funding preferences due to a high proportion of its target patient population being culturally, linguistically and socio-economically marginalized, resulting in significant barriers to accessing adequate care to effectively managed their diabetes.

ABSTRACT

Project Title: Chronic Disease Prevention & Management (CDPM) Patient Navigator Program
Organization Name: Goodwin Community Health Center, Inc., dba Coastal Medical Access Project (CMAP)
Address: 900 Bay Street, P.O. Box 1357, Brunswick, Georgia 31521
Project Director: Patricia J. Kota, RN, MSPL, Chief Executive Officer
Phone: 912-554-3559, ext. 11 **Fax**: 912-554-8344 **Email**: pkota@cmapga.org
Website address: www.cmapga.org
Project Period: October 1, 2008 through September 30, 2010

Abstract Narrative: Goodwin Community Health Center, Inc., dba Coastal Medical Access Project (CMAP), in Brunswick, GA proposes the establishment of a Chronic Disease Prevention and Management (CDPM) Patient Navigator (PN) program designed to improve health care outcomes for uninsured adults residing in Camden, Glynn and McIntosh counties in southeast Georgia. CMAP operates two free primary and specialty health care clinics that serve uninsured adults in the three target counties since 2002, and CMAP provides access to free and low-cost medications. CMAP is the only provider of these services in the target area. The three counties, with a population of 151,880, are partially rural and have significant rates of poverty and lack of health insurance. The area faces significant health issues that contribute to poor health outcomes of residents. Obesity, tobacco use and physical inactivity are lifestyle concerns that contribute to the development of chronic diseases. The region also has health disparity concerns, such as higher rates of diabetes among African Americans, and higher death rates from cardiovascular disease than both state and national rates. More than 15% of residents in the three counties do not have health insurance.

The CDPM PN program is building on a long history of informal and successful chronic disease case management by nursing staff at the clinics. To increase the impact of the case management services on the population of patients with chronic disease, CMAP is developing a formal and comprehensive CDPM program for patients with chronic disease, including implementation of a patient navigator model. The CDPM pilot program was launched at the St. Marys clinic early this year with 16 clinic patients with diabetes. Patient navigators are a critical part of the CDPM program's future growth. CMAP plans to incorporate both social workers and trained lay persons in the patient navigator role. The Patient Navigator program will initially focus on patients with diabetes or cardiovascular disease, and will expand to other chronic diseases based on the incidence of those diseases among the CMAP patient population. The CDPM Patient Navigator program targets uninsured adults with chronic disease within the 200% Federal Poverty Level guidelines and residing in the three counties. Plans to expand services to include employer groups and large employers that are self-insured are also under development and are key to the program. Revenue from contracts with employers will generate funds that will support the program by 2011. The PN program will recruit, train, employ, assign and manage six patient navigators over the two-year grant period. The patient navigators will provide patient assessment, case management, health literacy and education, psychosocial support, and self-management education and support (Stanford Model and Motivational Interviewing). CMAP requests statutory funding preference on the basis of the targeted population that will be served (low income, uninsured with limited transportation alternatives).

ABSTRACT

Project Title: Palmetto AccessNET

Organization Name: Palmetto Project

Address: 1031 Chuck Dawley Blvd, Suite 5, Mount Pleasant, SC 29464

Project Director: Laura S. Morris
Phone: 843-577-4122 Fax 843-723-0521 E-mail ppaccessnet@aol.com

Website: www.palmettoproject.org

Project Period: September 30, 2008 – August 31, 2010

Abstract Narrative: The Palmetto Project is a 501c(3) organization, established in 1984 by business leaders in South Carolina to implement innovative solutions to the state's most pressing social and economic problems.

The purpose of this application is to secure funding through which the Palmetto Project, utilizing its existing provider consortium and patient navigator network, can implement new programming to (1) reduce health disparities by increasing enrollment of uninsured minorities with risk factors for chronic disease in patient navigation, including assignment to medical homes and participation in pharmaceutical assistance programs; (2) expand navigation services into two rural counties with near epidemic rates of cardiovascular disease and diabetes among its minority population; (3) create a replicable model of effective interaction between a health care consortium with patient navigator services and a community-based health education and disease prevention program targeted to minorities at greatest risk of cardiovascular disease and diabetes; (4) document improved clinical indicators for navigated patients with diabetes and/or cardiovascular disease; and (5) document reductions in costs to hospital emergency department and in-patient visits through improved access and care coordination, combined with community-based programming in health education, disease prevention, and self-management.

The Palmetto Project proposes to implement the project in five coastal counties with sizeable minority populations with documented risk factors for cardiovascular disease and diabetes. This proposal would fully engage at-risk communities in health education & chronic disease prevention, provide care coordination and patient navigation to uninsured minorities with risk factors for CVD and diabetes, support local collaborations among providers and at-risk populations to reduce barriers to care, and create a replicable program model.

Nowhere in any other state is there as compelling a need for immediate, dramatic intervention to reduce health disparities. The Palmetto Project's extensive track record in creating innovative, nationally recognized health initiatives makes it an ideal candidate to implement the legislated goals of the Patient Navigator Outreach & Chronic Disease Prevention Act of

2005.

A Funding Preference is requested in the format requested.

ABSTRACT

Project Title: *Transformacion Para Salud:* Using *Promotores* to Improve Chronic Disease Management
Organization Name: The School of Nursing, Texas Tech University Health Sciences Center
Address: 3601 4th Street, Lubbock, TX 79430
Project Director: M. Christina R. Esperat, RN, PhD, FAAN
Phone : 806-743-3052 **Fax** 806-743-1622 **E-mail** Christina.esperat@ttuhsc.edu
Website Address: www.ttuhsc.edu/son
Project Period:

Abstract Narrative:

The purpose of this application is to implement the **Transformacion Para Salud (TPS)** Program to improve health care outcomes for vulnerable individuals in Lubbock county. Using a cadre of certified Promotores with Community Health Worker Certification as Patient Navigators, the application aims to coordinate comprehensive health services for patients in need of chronic disease care and management for the following health conditions: cancer, diabetes, hypertension, obesity and asthma. The nexus of this application emanates from the Larry Combest Community Health and Wellness Center (LCCHWC), a 501c3 primary care center owned and operated by the School of Nursing (SON) at the Texas Tech University Health Sciences Center (TTUHSC). The target population to be served is economically and medically vulnerable patients with the identified health conditions. Using 4 (four) trained Promotores, the proposal aims to serve a maximum of 250 patients currently enrolled in the LCCHWC chronic disease management programs over the two year project period. The Transformation for Health conceptual framework developed in the SON will be used as a foundation for the enhanced Promotores training curriculum, and layered on will be the Chronic Disease Management curriculum that will serve to provide the knowledge base required for the Promotores practice.

During the second year of the funding period, the project team will investigate the potential for disseminating the CHW/Promotores training program to surrounding rural counties. Starting with needs assessments, for outreach using community health workers, of selected rural communities, the team will issue reports to stakeholders within those communities to determine program priorities, and if indicated, will work with those stakeholders to develop the training program for those communities.

Funding preference is requested for this application, on the basis of the medically-underserved populations and areas, targeted for the program. In addition, the Center is located in a health professions shortage area of the county of Lubbock, which is a designated partial-HPSA county.

NON-FEDERAL EXPENDITURES

FY 2007 (Actual)	FY 2008 (Estimated)
Actual FY 2007 non-Federal funds, including in-kind, expended for activities proposed in this application. If proposed activities are not currently funded by the institution, enter $0.	Estimated FY 2008 non-Federal funds, including in-kind, designated for activities proposed in this application.
Amount: $ 0	**Amount**: $ 0

Abstract

Project Title: Cancer Patient Navigator Program HRSA-08-130
Organization Name: Northeast Valley Health Corporation (NEVHC)
Address: 1172 North Maclay Avenue, San Fernando, California 91340
Project Director: Debra Rosen, MPH, RN
Phone: (818) 898-3467 ext. 41517 **Fax:** (818) 365-4031 **E-Mail:**DebraRosen@nevhc.org
Web Site Address: www.nevhc.org
Project Period: January 1, 2009 through December 31, 2010

In operation for 35 years, Northeast Valley Health Corporation (NEVHC), a Joint Commission Accredited Federally Qualified Health Center (FQHC) requests $500,000 to develop and implement a Cancer Patient Navigator Program (CPNP). If approved, this CPNP will a) target low-income, under/uninsured and predominately Latino adult residents of Los Angeles County Service Planning Area (SPA) 2, the San Fernando and Santa Clarita Valleys, and b) help facilitate 6,000+ female and male patients/users of NEVHC into preventive screenings for breast, cervical and colorectal cancer (per NEVHC clinical protocols and the recommendations of the U.S. Preventive Service Task Force, the Centers for Disease Control and Prevention, and the American Cancer Society).

NEVHC seeks to recruit and hire **four** bilingual (Spanish/English)/bicultural *promotora*-type patient navigators. Taking into consideration widely documented obstacles to health care, i.e. lack of health insurance, limited English proficiency, and/or transportation, as well as cultural stigma, we anticipate that the utilization of culturally sensitive *promotoras* will increase the likelihood that our targeted patients (including those considered to be high-risk) will not only follow through with the aforementioned screening services, but will also comply with further diagnostic/specialty care services, i.e. colposcopies, colonoscopies, X-ray services and/or surgical biopsies, and/or cancer treatment protocols, if necessary.

Our proposed CPNP will primarily utilize an ***inreach*** strategy to meet its overall goal of reducing cancer-related mortality in SPA 2. In doing so, an updated disease management registry, *i2iTracks*, and our Interactive Voice Response (IVR) telephone system will be programmed in such a way that, together, they will automate [what otherwise would be *extremely* time consuming and labor intensive] processes of identifying as well as notifying NEVHC patients who are due or overdue for mammography, pap smear and/or fecal occult blood test (FOBT)services, which will be available across five licensed NEVHC Health Centers in Canoga Park, Pacoima, San Fernando, Sun Valley and Valencia. Our four patient navigators will be immediately assigned to patients who –even after being notified by IVR – remain non-compliant with these important preventive services.

The NEVHC Cancer Patient Navigator Program will be geared towards the needs of medically indigent, primarily Spanish-speaking Latino residents of SPA 2 - a community where there is a documented *overuse* of hospital emergency room services and minimal access to affordable transportation.[1] Therefore, a **statutory funding preference** is requested.

[1] Valley Care Community Consortium, *Assessing the Community's Needs: A Triennial Report on San Fernando and Santa Clarita Valleys*, 2007.

ABSTRACT

Project Title: *Promoting Access To Healthcare Services* (PATHS)
Organization Name: South Broward Hospital District
Address: 3501 Johnson Street, c/o Planning and Grants Department, Hollywood, FL 33021
Project Director: Amy Pont, RN, BSN
Phone: (954) 276-3159 **Fax:** (954) 602-2808 **E-mail**: apont@mhs.net
Website: www.mhs.net
Project Period: 10/1/08 – 9/30/10

Abstract Narrative: Improving the accessibility of health care services is one of the principal hopes for the American health care system and a key element in community health initiative. *Promoting Access To Healthcare Services* (PATHS) will link a large, multi-facility, non-profit healthcare system with trusted community-based organizations in southern Broward County, Florida to demonstrate that a successful patient navigator program can reduce the burden of chronic diseases by removing socioeconomic, cultural and linguistic barriers to high quality health care services for our target population of high-risk, uninsured Blacks and Hispanics.

The South Broward Hospital District, the fourth largest public healthcare system in the nation, is the safety net provider for the proposed 135-square mile service area. Through PATHS, the South Broward Hospital District will partner with Hispanic Unity of Florida, the largest community-based organization serving the area's minority population, the Coalition for a Healthy South Broward, a grassroots community organization consisting of 400 individuals from more than 75 agencies, the Broward County Hispanic Bar Association, Nova Southeastern University, Broward Regional Health Planning Council, Broward County Health Department and Broward County Government to provide public health interventions that will increase access to acute, chronic and preventive healthcare, support healthier lifestyles and increase health literacy.

Promoting Access To Healthcare Services will train and utilize a diverse staff of five Healthcare Navigators recruited from the local community to decrease health disparities relating to heart disease, diabetes and cancer (colorectal, prostate, breast and cervical) for 2,200 uninsured Blacks and Hispanics during the 2-year implementation program. This quality improvement initiative will ensure that patient care is safe, timely, effective, efficient, patient-centered and equitable (STEEPE). This program will strategically place the Healthcare Navigators in four critical locations within the service area where the target population is at highest risk for "falling through the cracks" due to barriers in the existing system of care.

Request for Funding Preference: These services are necessary to overcome significant barriers in order to improve health care outcomes in the service area. Broward County, which became a minority-majority county in 2006, is one of the most highly diverse areas in the United States. Demographers attribute the unprecedented shift to the exploding Caribbean and Latin American populations. Since 2001, more Blacks have come to Broward each year than to any other county in the United States, increasing the county's Black population by almost 85,000 people between 2000 and 2005. And, the Hispanic population also continues to increase, growing faster than any other segment of the population. In addition, more than 30% of the population is foreign-born and more than 35% speak a language other than English in their home. More than **37%** of Blacks and Hispanics are uninsured and live below 200% of the Federal Poverty Level.