



**Care Navigator Apprenticeship Pilot (CNAP)** **2016-17**

**CLINIC APPLICATION**

**This application and attachments are due on April 28 at 5 p.m.**

##

**Name of Clinic Organization:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Tax ID Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Main or Corporate Street address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City and State \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**9-digit** Zip code\_\_\_\_\_\_\_\_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_(**Req.)**

Service delivery address(es) if different from above: This address will be used to determine the Care Navigator deployment site.

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Name **and** title of President, Executive Director, or CEO

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Telephone(s) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

E-mail address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Website\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name **and** title of project contact if different from above:

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E-mail address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Did your organization meet all of the baseline criteria outlined in the Request for Applications? □ Yes □ No If not, explain:**

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***Maximum proposal narrative is seven (7) pages, including this page.***

1. NFORMATION

This application is limited to eight pages with required attachments excluded from this limit. Use a minimum 11 point font. Please submit this application in Word or Excel. We cannot accept PDF formats. Please do not bold responses.

1. NARRATIVE

The objective of CNAP is to assist community clinics improve care for complex patients with multiple chronic conditions by: (1) preparing and deploying Care Navigators into primary care and (2) providing targeted education to the medical team to promote Care Navigator integration. ***Attachment A – Selected Care Navigator Care Models*** provides examples of Care Navigators programs providing team-based care in the health care safety net nationwide.

**Leadership Commitment**

1. Describe the executive and clinical leadership support for CNAP. **Required**: *Attach supporting documentation, such as previous projects with a Community Health Worker/Care Navigator or strategic planning documents on the intent to use Care Navigators in team-based care.*

**Team Engagement and Team Based Care/Patient Centered Medical Home Model.**

**Refer to *Attachment B – CNAP Roles* for more information.**

1. CNAP requires Care Navigators to be embedded into care teams led by a clinician (i.e., physician, nurse practitioner, registered nurse) while collaborating with clinical and non-clinical staff. Describe the lead clinician assigned to your care team, his/her role within the care team, and the level of engagement he/she has with other staff members of the care team.
2. CNAP requires selected clinics to identify a committed clinician to serve as a Preceptor/Mentor to the Care Navigator for the duration of pilot. Describe the staff member that your clinic will appoint to serve as a Preceptor/Mentor and how he/she will function in this role.
3. Describe your clinic’s team-based care delivery model. **Required:** *Attach supporting documentation, such as a list of team members, roles, responsibilities, goals and objectives, and outcome measure(s).*

**Eligible Patient Population. Refer to the RFA, *Section I. L.A. Care’s Care Navigator Apprenticeship Pilot, Page 3* for criteria that the CNAP will be using to select eligible community clinic patients.**

1. Provide the approximate number and key characteristics of your clinic’s population of patients who require complex care and are high cost, high utilizers of emergency department and inpatient hospital services using the CNAP eligibility criteria. Include information indicating the identified conditions of high cost/high utilizers and methods used to serve this population.

**Clinic Referral Coordination Process, Data Collection, and Onboarding/Training Infrastructure**

1. Describe your Clinic Referral Coordination Process, including who initiates referrals on behalf of patients, to whom are referrals requested of and what kind of follow up do you provide for patients, including timeframes of when patients are notified of approved referrals?
2. Describe your clinic’s Electronic Medical Record system, including name of system, in what capacity it is used in care coordination teams, and its functionality for data analysis.
3. Describe the onboarding process for new employees and addressing training needs on an ongoing basis.

**Value-Based Programs**

1. Does your clinic have value-based programs to facilitate connection to and coordination of community-based services and social supports? [ ]  Yes [ ]  No

If yes, then describe the level of outreach/referral your clinic provides to the patient population served.

**Financial Sustainability**

1. Do you have a financial sustainability plan in mind to continue supporting a Care Navigator post-pilot? If so, describe your financial sustainability plan to employ Care Navigators post pilot period.

II. ORGANIZATIONAL LEGAL/LICENSURE

1. Please list any pending or prior allegations or actions questioning or challenging propriety of tax-exempt status.
2. AUTHORIZING SIGNATURE

Print name and title \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature Date

**Proposal narrative ends at seven (7) pages.**

**See RFA for submittal guidelines**