Organization	Neighborhood Family Practice (NFP)
Organization Type	Not-For-Profit
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DUNS #	013671987
Project/Program Name	Health Services
Total FY27 Project Budget	$1,360,192
FY27 CDBG Funding Request	$36,167

Neighborhood Family Practice

Health Services Program

CDBG Eligibility Criteria

Neighborhood Family Practice's Health Services Program satisfies the following eligibility criteria and is therefore suitable for CDBG funding consideration.

CDBG National Objective

Low-Moderate Income Limited Clientele (LMC): Activities that benefit either a specific group of persons at least 51% of who are documented as low-moderate income, or a clientele presumed by HUD to be principally low-moderate income (e.g. battered spouses, senior citizens).

CDBG-Eligible Activity Category

Public Services: The provision of public services including labor, supplies, materials, and the pro rata share of the facilities where these services are provided.

HUD-Designated Performance Objective

Create Suitable Living Environments

HUD-Designated Performance Outcome

- Availability
- Accessibility

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I. ABSTRACT

Neighborhood Health Care, Inc., dba Neighborhood Family Practice (NFP) requests $36,167 to support high quality, affordable primary care and behavioral health services for Lakewood residents at NFP's North Coast Community Health Center (NCCHC).

To better accommodate continued growth and community need, NFP moved NCCHC to a larger space in January 2022. Located on Madison Avenue in Lakewood, NCCHC is one of NFP's six community health centers (CHC) providing integrated primary care for patients of all ages, regardless of ability to pay. This move to the east end of Lakewood strategically placed NCCHC in close proximity to neighborhoods where there is a critical need for affordable health care and is accessible by both train and bus. Moving the NCCHC location has resulted in significant growth and increased access to care for residents of Lakewood and Cleveland – 2025 NCCHC visit data demonstrates a 114% increase in patients and 100% visit growth, when compared to 2019, when the former North Coast Health merged with NFP.

The team at NCCHC has the clinical expertise and skills necessary to respond to patients' complex health and social needs. Staffing at NCCHC includes one family medicine physician, one nurse practitioner, one physician assistant, a registered nurse, medical assistants, two behavioral health therapists, a community health worker, and medical office specialists (front desk). Additionally, NCCHC's site manager is a registered nurse who has worked at this location for 20 years. The integrated primary care and behavioral health (BH) available at NCCHC reflects NFP's continued commitment to treating patients' physical and mental well-being, which began shortly after our founding in 1980.

NCCHC provides important wrap-around services that remove barriers to accessing high value health care. Each NFP site employs a community health worker (CHW) who arranges services such as wellness counseling, clinical pharmacy services and referrals to hospitals, specialists and social service agencies as needed. The CHW is a vital part of NCCHC's integrated health care team and supports the staff with patient management, administrative support, and population health strategies. Their critical work involves identifying and removing barriers to increase access to care, enhancing the overall quality of care delivered, and improving health outcomes through patient connections with medical specialty referrals and social service resources. In 2025, the NCCHC CHW assisted 938 patients (including 160 Lakewood residents) through a total of 1,265 encounters, arranging supportive services such as transportation, language interpretation services, and financial assistance for those who qualify, and completing referrals for specialty services and connecting patients with basic needs.

In calendar year 2025, NCCHC provided a total of 9,533 visits to 3,395 unique patients of all ages, and NCCHC is projected to serve 3,590 unique patients through a total of 10,082 visits, including 8,349 medical visits and 1,733 BH appointments in FY26.

II. PROJECT NARRATIVE

1. Community Needs Addressed/Service Gaps Filled

The City of Lakewood demonstrates multiple needs for accessible, integrated primary care: The Center for Community Solutions reports that, as of 2024, 31% of Lakewood residents have public health coverage such as Medicaid, Medicare, or Tri-care, 7.7% are uninsured, and 29% live below 200% of the federal poverty level (FPL). Further, according to the City of Lakewood's 2022 Community Health Needs Assessment, 1 in 5 residents smoked or participated in binge drinking. Additionally, half of residents aged 75+ experience disability, and an older adult focus group noted a lack of physicians helping them navigate the healthcare system.

However, the need for affordable services is not uniform across the entire city of Lakewood. According to the 2018 Lakewood Community Health Needs Assessment, the Edge/Birdtown Neighborhood, where the NCCHC is located, is the neighborhood with the lowest household incomes and in which residents are least likely to have health insurance. The report details that this neighborhood has poor access to clinical resources and a very high disabled population (16%). Further, economic outcomes in the Edge/Birdtown Neighborhood are among the worst in the city with a very high poverty rate (31%) and a high rate of uninsured individuals (13%).

Cleveland Clinic Fairview Hospital 2019 Community Needs Assessment states access to affordable health care, addiction and mental health services, and chronic disease prevention and management are some of the most significant community health needs in Lakewood, which also exhibits relatively high rates of preventable hospitalizations, high mortality rates for drug poisoning, and prevalent chronic conditions such as diabetes and hypertension.

The Cuyahoga County Board of Health and Alcohol, Drug Addiction and Mental Health Services (ADAMHS) Board of Cuyahoga County report that the needs for BH care have increased significantly since the COVID-19 pandemic, and that a significant portion of communities across the county face BH workforce shortages to meet this need. NFP is part of a solution, delivering BH alongside primary care, with the expertise and resources available to make referrals to partner organizations and agencies for patients with needs exceeding our scope of services.

The data mentioned above demonstrates the critical need for effective, affordable and accessible integrated health care services, particularly care that is tailored towards our patients' social determinants of health – the conditions in which patients live and work which can impact their health, such as food insecurity or lacking reliable access to transportation.

2. Primary Goals & Objectives

Goal 1: Provide access to integrated primary care and behavioral health services

* Objective A: Provide services to 3,500 unique patients at NCCHC
* Objective B: Achieve a 60% retention rate of NCCHC patients (percentage of patients who had a visit at NCCHC and had at least one additional visit over an 18-month period)
* Objective C: Provide 8,300 medical appointments (virtual and in-person)
* Objective D: Provide 1,700 behavioral health appointments (virtual and in-person)

Goal 2: Improve health outcomes for patients with chronic conditions

* Objective A: 75% or more of adult patients with hypertension will have blood pressure less than 140/90
* Objective B: 80% or more of adult patients with diabetes will have A1c level less than 9%

Goal 3: Maintain high patient satisfaction

* Objective A: 90% of respondents to the patient satisfaction survey will recommend NFP to their friends and family

3. Program Design, Uniqueness & Innovation

NFP utilizes the patient centered medical home model, which includes centralized care delivery through which patient interactions and treatment are coordinated by their primary care provider, so that each patient receives the right care, when they need it, at a convenient location that will reduce barriers to consistent care. Each patient care team consists of a primary care provider (either a physician, nurse practitioner, or physician assistant) a nurse, community health worker, and medical assistants. Each care team member works with patients to develop and implement personalized care in a culturally sensitive manner. The hiring of a physician assistant who is new to the NCCHC and NFP presents an opportunity to further enhance NFP's collaborative approach to addressing patients' health care and wraparound services.

In addition to our own staff team, NFP highly values collaboration, working together with hospital systems, supportive service agencies, and other federally qualified health centers (FQHCs) in the Cleveland area in order to achieve stronger health equity, provide health care and wraparound services to all, and prevent costly emergency department (ED) visits and hospitalizations.

NFP adopts trauma-informed care (TIC) in all practices, recognizing that trauma is common, comes in many forms, and that all patients may have experienced it. With poverty being recognized as a form of trauma, and 73% of NFP patients having a household income below 200% FPL, NFP is working throughout 2025 to train our entire staff on TIC to foster a culture of safety, empowerment, and healing, and to prepare staff to take a trauma-informed approach to their collaboration with patients and other staff members.

NFP has provided integrated primary care and behavioral health (BH) since 1995. In recognition of the critical role that behavioral health has on physical health, NFP screens patients during primary care medical visits for depression. Patients who experience depression and other mood disorders, anxiety, and mental health distress can receive talk therapy with an NFP BH therapist. For patients with substance use disorders, NFP offers medication assisted treatment (MAT). Patients with additional behavioral health care needs can schedule appointments with NFP's psychiatrist or psychiatric nurse practitioner.

In addition to our current service lines and programs, NFP works to address expressed patient needs and care gaps identified by our team in order to better serve our patients. In response to patient needs, our BH team piloted a Chronic Pain Group program in 2025 to help patients increase their ability to function despite pain through group BH therapy, bolstered by additional strategies provided by a primary care provider. This group continues to run, with plans to facilitate a group in Spanish in 2027.

NFP recently redesigned our care coordination structure, introducing community health workers (CHW) into our model of care. This redesign increases efficiency in completing patient referrals for health care and supportive services and aims to increase patient health outcomes and meet their health-related social needs, such as food insecurity or medication access. CHWs will utilize the Pathways HUB – Community Health Record software platform to log patient risk factors being addressed, and needs being met, for example, medication adherence, mental health, oral health, pregnancy, and transformation. Completion of these processes, called "Pathways" will generate revenue based on positive outcomes achieved and risk factors reduced through the work of the CHWs.

4. Target Population(s)

The target population for NCCHC is individuals and families with low to moderate household income and who are unable to access and/or afford health care. While there are no geographic boundaries, most patients served will be residents of Lakewood and surrounding communities. NCCHC provides services to anyone in need including people who are uninsured, underinsured, and those covered by Medicaid, Medicare, and commercial insurance. Eight percent of NCCHC patients (271) are resettled refugees. To better serve this population, NFP now conducts the required health examination for those applying for U.S. Permanent Residency ("Green Card"), which refugees are eligible for five years after their initial resettlement, at NCCHC.

Further, in 2025, 23% of patients at NCCHC were best served in one of 32 languages other than English. Patients who do not speak English often face communication barriers to receiving health care. Many have low health literacy, risk being misunderstood by providers and staff, and may not understand diagnoses or treatment plans. Delivering culturally and linguistically appropriate health care to our patients is essential to the delivery of high-value care and improved patient outcomes and supports NFP's commitment to delivering care in an environment that makes patients feel welcome, heard, and respected.

The population NCCHC serves experiences several circumstances which can impact their health, including housing and food insecurity, unemployment or underemployment, being uninsured and underinsured, alcohol and chemical dependency, and often lack the resources with which to cope. In addition to providing health care, NCCHC's staff help patients with addressing these needs by connecting them with social service agencies for housing, domestic violence, access to food, and other basic needs.

5. Geographic Service Area

Located at 11906 Madison Avenue in Lakewood, NCCHC's service area predominantly includes the city of Lakewood, west side Cleveland neighborhoods, and suburbs bordering Lakewood. As of 2025, 32% of NCCHC's unique patients reside in Lakewood, representing 34% of all visits conducted at the site. NCCHC is easily accessible by bus, train, or on foot, making it a convenient location for patients to receive care via multiple modes of transportation.

6. Services Provided & Delivery Strategy

NCCHC's patient-centered medical home model of care uses a team-based approach to deliver the following core services:

- **Primary and preventive care**, including treatment and management of acute and chronic conditions. Childhood immunizations, lead screening and testing also are provided as part of primary care services.
- **Behavioral health (BH)** therapy and psychiatric services, which are available to established patients. Integrated primary care and BH result in improved overall health outcomes. Patients aged 12 and up are routinely screened for depression.
- **On-site laboratory services**
- **Financial Eligibility and Assistance Program**, which assists uninsured and underinsured patients with enrollment in NFP's financial assistance, Medicaid, and medication assistance programs.
- **Transportation and language interpretation services**
- **Referrals to other NFP community health centers** for dental care, midwifery care, and pharmacy services
- **Referrals to hospitals and private practices** for specialty healthcare and radiographic studies

NCCHC patients in need of dental or midwifery services are scheduled for appointments at NFP's W. 130th or Ann B. Reichsman CHCs, located in the Jefferson Park and Clark-Fulton neighborhoods of Cleveland, respectively, in close proximity to NCCHC. Transportation is provided as needed. CDBG funding would not be used to support services provided outside of Lakewood. NFP pharmacies are available at three sites, with a fourth opening in early 2027. Individuals in NFP's service area, including the city of Lakewood, have access to home delivery of affordable medications, decreasing gaps in medication adherence.

Interpretation services, provided via computer tablet from Propio Language Services, are available at no cost to patients at every point of contact including in-person and virtual appointments, and related pharmacy needs. Computer tablets dedicated for phone interpretation through a mobile app are available at all health centers so that staff have access to them when needed. Further, health care materials – such as prescription labels and patient educational items - are translated in multiple languages.

7. Client Outreach Strategies & Efforts

NFP's community engagement team works closely with community partners to ensure equitable access to healthcare, particularly for medically and economically vulnerable populations. Our Population Health team, which includes trained community health workers unified under the department, works diligently to contact patients to link them with cancer screenings, immunizations, and chronic condition screenings and management techniques according to their individualized needs. Our outreach strategies continue to evolve, with the goals of improving patient health outcomes and patient engagement in their health care. Finally, collaborative efforts with Catholic Charities – Migration and Refugee Services, Building Hope in the City, Lakewood Community Service Center, and Better Health Partnership help reach high-risk populations who otherwise would lack access to affordable healthcare.

8. Partnerships/Collaboration with Community Organizations Serving Low-Moderate Income Persons

NCCHC works closely with Cleveland Clinic Lakewood Family Health Center, Fairview and Lutheran hospitals, and MetroHealth and refers patients for specialty services and radiology. NFP physicians have admitting privileges and make patient rounds at Cleveland Clinic Lutheran Hospital. NFP's certified nurse midwives have birthing privileges at Cleveland Clinic Fairview Hospital. NFP serves as a member of the Cleveland Clinic Lakewood Family Health Center Community Advisory Council, Cleveland Clinic Fairview Hospital Community Advisory Council and Cleveland Clinic Lutheran Hospital Advisory Council.

In 2025, NFP worked with Cleveland Clinic Fairview Hospital to launch a pilot program with the goal of increasing access to primary care and reducing the number of emergency department (ED) visits for non-emergency patient care. The program connected patients discharged from the ED who did not have a primary care provider, as well as patients needing follow-up within 24-48 hours for conditions that might otherwise require hospitalization or a return to the ED, with an NFP provider. Over six months, the pilot demonstrated progress toward improved access and care continuity: 525 patients scheduled a visit with an NFP primary care provider; 289 completed their visit, and 104 returned for additional NFP visits within 90 days.

The NCCHC Community Health Worker frequently collaborates with Smart Development, Inc., and Partnership for Good Health, to provide wraparound services to our diverse patient population, particularly NFP's refugee and newcomer patients. Additionally, NFP collaborates with Cove Community Center and Lakewood Community Services Center to ensure that Lakewood residents have access to food, health care and social services and other basic needs.

NFP's President and CEO, and Vice President of Development engage with NFP's state and national associations for advocacy efforts, and NFP has solid relationships with Lakewood Mayor Meghan George and members of Lakewood City Council; Cleveland Mayor Justin Bibb and the members of Cleveland City Council; State Senator Nickie Antonio and Representative Tristan Rader; U.S. Senators John Husted and Bernie Moreno, and U.S. Representative Shontel Brown. NFP has strong partnerships with public sector agencies and is actively engaged with the Cleveland Department of Public Health and Cuyahoga County Board of Health.

Across the organization, many NFP employees work with patients and community partners to build and foster relationships to identify barriers and solutions, including collaboration with other FQHCs in the Cleveland area. Community partnerships rely upon relationships and trust, and are critical to stakeholder engagement, which is a strategic priority for NFP.

9. Project Staffing

Title	Hours/Week Devoted to Program	% CDBG-Funded	Qualifications & Responsibilities
Physician (1)	24	0%	Deliver primary medical care, provide referrals; collaborate with team to meet patient needs; work with Chief Medical Officer on care delivery & quality
Site manager/registered nurse (1)	40	0%	Manages clinical & operational components: workflow, staffing, training, supervision. Provides direct patient care.
Nurse practitioner (1)	36	0%	Delivers primary medical care; creates care plans & follow-up; provides referrals; collaborates to meet patient needs.
Physician assistant (1)	40	35%	Delivers primary medical care; creates care plans & follow-up; provides referrals; collaborates to meet patient needs.
Registered nurse (1)	40	0%	Educates patients on chronic condition management; telephone triage; phone encounters; health maintenance; medication administration.
Behavioral health therapists (2)	60	25%	Provides mental health assessments and counseling.
Medical assistants (2)	78	0%	Support providers with patient care – room patients, obtain vitals, assist with procedures, med administration, clean & stock rooms & equipment, patient follow-up calls.
Community health worker (1)	40	0%	Supports the care team with patient management & population health initiatives; processes referrals; connects patients to resources to help meet their basic needs.
Medical office specialists	120	0%	Conduct patient support services through the front office, including phone calls, welcoming patients and collecting co-payments, and educating patients on financial assistance.

10. Implementation Schedule

Milestone	Completion Deadline
Provide services to 345 Lakewood residents at NCCHC during Q1 of 2027	March 31, 2027
Provide services to 295 Lakewood residents at NCCHC during Q2 of 2027	June 30, 2027
Provide services to 314 Lakewood residents at NCCHC during Q3 of 2027	September 30, 2027
Provide services to 295 Lakewood residents at NCCHC during Q4 of 2027	December 31, 2027

11. Projected Beneficiaries (January 1 – December 31, 2027)

	Persons	Households
Total Unduplicated Persons & Households to be Served	3,590	N/A
Unduplicated Low-Moderate Income* Persons & Households to be Served	2,333	N/A

*< 80% Area Median Income

12. Program Evaluation (data collection & analysis, outcome measurement procedures & methodology)

NFP uses Epic, an electronic health record system, to collect patient demographics, clinical measures, and health outcomes. A patient satisfaction survey is administered continuously to benchmark patient feedback; this allows us to identify areas of strength and improvement. Further, NFP has a quality and performance team dedicated to collecting data and developing plans to continuously improve processes and health outcomes. A quality dashboard is used to provide a snapshot of performance metrics compared to goals. The team is able to quickly respond to areas of concern through weekly senior leadership meetings and monthly site meetings.

As a FQHC, NFP follows rigorous quality standards from the Health Resources and Services Administration (HRSA) Bureau of Primary Health Care. Every year, all FQHCs are required to submit a performance report using the measures defined in the HRSA Uniform Data System. Patient demographics and health outcomes are compared with other FQHCs nationally. NFP's quality scores rank in the upper quartile of community health centers across the U.S. NFP also participates in national and regional quality improvement programs and collaboratives focused on primary care and patients with chronic conditions.

13. Additional data/information that strengthens the organization's case for CDBG funding support.

III. FY27 PROGRAM BUDGET

i. Expenses

Expense Category	Total Project (A)	CDBG Funds (B)	CDBG As % of Total (B/A)
Personnel			
Salaries	$ 773,221	$ 27,894	3.6%
Fringe Benefits	$ 172,589		
Sub-Total Personnel	**$ 945,810**	**$ 27,894**	
Overhead & Operations			
Rent/Lease	$ 0		
Insurance	$ 9,434		
Materials & Supplies	$ 3,203		
Professional Services	$ 0		
Postage	$ 1,787		
Travel	$ 0		
Utilities/Telephone	$ 48,178		
Equipment	$ 10,444		
Repair & Maintenance	$ 14,270		
Medications and Medical Supplies	$ 208,907		
Language Interpretation	$ 33,092	$ 8,273	25.0%
Other	$ 85,067		
Sub-Total Overhead & Operations	**$ 414,382**	**$ 8,273**	
Total Project Costs/Program Budget	**$ 1,360,192**	**$ 36,167**	

ii. Funding Sources/Revenue

Source	Requested	Committed	Total
Agency Funds		$ 0	$ 0
CDBG FY26-FY27 CDBG Carry Forward Funds (est)		$ 0	$ 0
Other (Non-CDBG) Federal Funds		$ 167,417	$ 167,417
State Funds		$ 0	$ 0
Local Funds		$ 0	$ 0
County Funds		$ 0	$ 0
Private (Foundations, Individuals, Other) Funds	$ 10,000	$ 40,000	$ 50,000
Earned Revenue/Fees		$ 1,164,358	$ 1,164,358
In-Kind/Volunteer Support (@ $15/Hour)		$ 0	$ 0
FY27 City of Lakewood CDBG Funding Request	$ 36,167		$ 36,167
Total Funding Sources/Program Budget	**$ 46,167**	**$ 1,320,941**	**$ 1,367,108**

IV. FY27 BUDGET NARRATIVE

1. How will City of Lakewood CDBG funds will be utilized to support the proposed program.

City of Lakewood CDBG funds will be used to cover 25% of one 0.5 FTE Behavioral Health Therapist at NCCHC, a Licensed Social Worker with Supervisor designation. Further, CDBG funds will support 25% of anticipated costs for language interpretation, a service which is critical to serving the diverse NCCHC patient population but does not generate insurance reimbursement.

2. How will the proposed program function if the agency does not receive the full amount of requested funding.

If the full amount of requested funding is not received, the program will function as planned, using NFP's general operating dollars. NFP would pursue other philanthropic funding to cover costs, including individual and corporate donations and foundation grants.

3. Describe the agency's efforts to develop/leverage other sources of funding to support the proposed program.

NFP relies on diverse revenue streams, which include the support of philanthropic foundations, corporations and individuals, federal, state, and local grants, insurance reimbursements, and pharmacy revenue to support the operations of NCCHC.

NFP continues to pursue better patient health outcomes and reimbursement funds through value-based care, a system in which health care providers are paid based on patient care quality and health outcomes. Additionally, integrating Community Health Workers into our model of care allows for revenue generation through the Pathways HUB software platform, corresponding with meeting individual patient needs such as linking patients experiencing food insecurity with nutritious food and education.