Asthma Program Extension Proposal

Tax ID number for Ryan-NENA: 13-2884976

Description of the Organization, Project Goals, Activities, Leadership, and how proposed Project fits in organizational mission.

The Ryan-NENA Community Health Center was founded in 1968 (then called the NENA Comprehensive Health Center), in order to bring high quality, affordable health care to residents of the Lower East Side (LES) of Manhattan. In 1988, NENA joined with the William F. Ryan Community Health Center, and was renamed under the auspices of the Ryan Network, adopting the shared mission that health care is a *right*, not a privilege. As part of the Ryan Network, Ryan-NENA continued its commitment to the provision of accessible health care.

Today, Ryan-NENA continues to primarily serve members of the LES community, while welcoming patients from all over Manhattan and surrounding boroughs, many of whom work or obtain services in the LES community. Ryan-NENA offers a full range of comprehensive health services, including pediatrics, adolescent health, adult medicine, women's health (including family planning and Ob/Gyn), dental, ophthalmology/optometry, medical specialty services, mental health (including psychiatry), nutrition counseling, health education, a Women Infants and Children (WIC) Supplemental Food Program, laboratory, radiology, and 24-hour phone access to practitioners. Ryan-NENA also participates in the Network's pharmaceutical plan, which allows uninsured patients to purchase medications with a low copayment; uninsured homeless patients receive them for free. The Network absorbs the uncovered prescription drug costs for these patients. The Ryan-NENA Community Health Center's annual budget is approximately $11.5 million; the total Ryan Network budget is approximately $44 million, which includes Ryan-NENA, as well as 15 other Ryan service sites. *Please see attached, the William F. Ryan Community Health Center's letter of incorporation and audited financial statements.*

The Ryan-NENA Community Health Center is located at 279 East 3rd Street (between Avenues C and D) in the Lower East Side of Manhattan, an area where nearly 1 in 4 residents is living below the poverty level (NYCDOHMH). Of the 10,878 patients that Ryan-NENA served in

2013, 92 percent live at or below 200 percent of the federal poverty line, and nearly 40 percent are from the 10009 zip code, in the immediate area around the Con Edison plant at 14th Street and Avenue C. Communities with significant poverty levels, such as those served by Ryan-NENA, experience health disparities relating to asthma; children living below 200 percent of the federal poverty level in New York City are twice as likely to be diagnosed with asthma as those in wealthier households.[1] Racial and ethnic minorities are also disproportionately affected, with Black and Hispanic children under 12 years old experiencing triple the rates of asthma diagnoses as White children.[2] Nearly 1,200 patients at Ryan-NENA have been diagnosed with asthma, a number that includes more than 10 percent of NENA's total patient population. Uncontrolled asthma is a driver for avoidable emergency department (ED) visits, especially among children. This problem is especially prevalent in New York City, which has significantly higher rates of ED visits due to uncontrolled asthma compared to the rest of the State.[3] Exposure to pollution (such as particulates) are a common and serious trigger for asthma exacerbation; the New York City Environmental Public Health Tracker rates the Lower East Side as having worse outdoor air quality than Manhattan and New York City as a whole, defined by levels of fine particulate matter in the air.[4] Asthma can be controlled by taking anti-inflammatory medicines which require regular check-ups and management. With control, most asthmatics can lead normal, active, healthy lives.[5] Good medical management of asthma can prevent many asthma-related hospitalizations, and patients can work with health care providers to better control their asthma.

In order to help Ryan-NENA patients and the surrounding community improve their health, the Center is requesting funding ***to continue and extend its Asthma Care Team Program for an additional 12 months, through March 2016***. Due to the vacancy of the Asthma Care Team Coordinator position, which has been previously reported, the Program currently projects that current grant funding will support the Program through March, 2015. This application requests additional funding to continue the Program for an additional 12 months, through March, 2016.

[1] NYCDOHMH, NYC Vital Signs, *Preventing and Treating Childhood Asthma in NYC*, July 2012.
[2] *Id.*
[3] New York State Department of Health, *Prevention Agenda*, 2012.
[4] New York City Environmental Public Health Tracker, Environment & Health Data Portal, *Report: Lower East Side: Asthma and the Environment*; air quality defined as (PM2.5) – (µg/m3).
[5] Asthma Initiative, NYCDOHMH.

Even with the vacancy of the Coordinator position since July, however, the Care Team has reached hundreds of LES residents during its initial seventeen months of operation, and with additional funding, could continue to make crucial inroads into assisting populations on the Lower East Side with asthma management. The Asthma Care Team's main goals are to 1) help asthmatic patients take control of their health and wellbeing, and 2) screen and find new cases of asthma in the target area. The overall goal of the Program is to help impacted LES community residents gain control over their asthma, thus improving their health and ameliorating quality of life problems.

The Asthma Care Team, as part of its current activities, has provided 28 screening events and 49 workshops over the first seventeen months of its operation, reaching over 1,800 individuals thus far, including 1,274 reached in workshops and 488 reached during screening events. During these in-reach and external events, the Team distributes information concerning asthma, and assesses individuals to determine the symptoms and severity of their asthma using a peak flow meter. Depending on the results of the peak flow test, which measures how well air is breathed out of the lungs and may indicate whether asthma symptoms are in control or worsening, a member of the Care Team explains the readings to the individual and informs them of recommended "next steps." During the workshops, Care Team members explain asthma and its symptoms, and demonstrate proper medication use. Workshops address these conditions and provide local residents with information and action plans to reduce health impact. During the first seventeen months of the project, the Team has also provided 125 targeted asthma kits to high-need, low-income patients, and conducted 441 Asthma Control Tests (ACTs) on asthmatic patients (a standardized assessment tool of asthma's impairment which can be measured and tracked overtime). Based on the strong response from the community and the clearly identified need, Ryan-NENA proposes extending the program through March 2016, and modifying the previously set deliverables as follows:

Proposed Deliverables for Extended Program (through March 2016)

Original Deliverables (7/01/2013 – 3/31/2015)	**Modified Deliverables (7/01/2013 – 3/31/2016)**	**Timeline**	**Site/Staff**	**Current Progress (through mid-December 2014)**
32 on-site and off-site free asthma screening events	**72 on-site and off-site free asthma screening events and/or workshops**	At least three events each month	LPN/RN	28 asthma screening events
1,200 individuals screened for asthma during free screening events	**1,080 individuals screened for asthma during free screening events**	15 individuals per screening event	LPN/RN	488 individuals screened for asthma during free screening events
150 new Asthmatic patients at Ryan-NENA	**Ryan-NENA proposes removing this as a deliverable, as it is difficult to ascertain whether the Asthma Care Team is a direct and proximate cause of attracting new patients to the Center.**			
750 new and current Asthmatic patients to receive targeted asthma kits	**300 Asthmatic patients to receive targeted asthma kits**	Distribute about 20 kits each month to high need, low-income patients	LPN/RN	125 new and current Asthmatic patients received targeted asthma kits
5,500 Asthma Control Tests (ACTs) conducted on each patient	**870 Asthma Control Tests (ACTs) conducted on enrolled patients**	Depending on when the new patient begins being seen at Ryan-NENA, they will receive between one and six ACTs	Provider conducting test. LPN/RN gathering and analyzing data.	441 Asthma Control Tests (ACTs) conducted on patients
750 before and after surveys conducted	**Ryan-NENA proposes removing this as a deliverable, as improvement in health can be more accurately and clinically tracked through Asthma Control Tests, which indicate whether the patient has their asthma under control.**			

As seen above, Ryan-NENA is requesting a modification in several of the deliverables. Original projections were determined to be unrealistic, and reaching such numbers would not allow current Asthma Care Team members to spend the focused, individualized attention, especially

including one-on-one case management needs, that patients require for optimal outcomes. The new modified deliverables reflect more realistic and appropriate goals, that are designed to be reached by the end of the new extended project period, in March, 2016. In addition, the Program recommends removal of two previously identified deliverables: increasing new asthmatic patients at Ryan-NENA, and administering before and after surveys. In terms of the first deliverable, experience demonstrated that it was difficult to assess during new patient intake if patients were joining Ryan-NENA because of the Program; staff also found that the Program was very useful to current Ryan-NENA patients, who were unable to maintain control of their asthma and could benefit from the extra attention. Program staff believe that attraction of new patients alone does not demonstrate the effectiveness or reach of the Program. As for the second deliverable, before and after surveys are not as demonstrative as the ACTs in determining whether patients are on a positive trend in maintaining control of their asthma. In addition, surveys would be difficult to compare in aggregate data form, as some participants exit the program after only meeting with the RN/LPN a few times, while others benefit from a more long-term intervention. This limits the usefulness of the surveys in determining the strengths and weaknesses of the Program, and determining future areas of improvement.

Based on the needs identified during the first seventeen months of the Program, the Asthma Care Team will also focus more heavily on reaching the community through workshops and screening events in the next year period, in order to address priority needs that have been identified, including 1) ensuring that individuals are aware of their asthma status and are taking an active role in their healthcare to maintain control, and 2) providing medication demonstrations in the community. The Team has discovered that the majority of individuals encountered use their asthma medication incorrectly, and thus, experience exacerbated symptoms and decreased quality of life. Indeed, many individuals report that correct medication usage has never been explained to them by either their primary care provider or their pharmacist, and are left to self-determine the proper use and dosage for themselves. Thus, they do not receive the full benefits of their medication. Many individuals have reported ceasing to use their asthma medication entirely, as they no longer believe that it works for them. By addressing these concerns, Care Team Members are able to greatly improve the quality of life for these individuals by giving

them the tools to effectively evaluate, medicate, and control their condition and experience an improved quality of life.

As part of the proposed expansion program, the Care Team will also continue to work to coordinate patient care, remind patients of upcoming appointments, and overall, help patients navigate the health care system by creating an individualized treatment plan based on the each individual's triggers, symptoms and the medications they have been prescribed. Newly diagnosed patients will continue to receive asthma kits, which include a peak flow meter, a calendar to help track appointments, a spacer tool that assists with optimal medication delivery directly to the lungs, and educational materials on asthma. To help identify unknown cases of asthma, Ryan-NENA will expand its provision of on-site and off-site free asthma screenings and referrals for care to Ryan-NENA patients and members of the Lower East Side community. These screenings/workshops have been, and will continue to be, available at partner organizations in the neighborhood and at Ryan-NENA during specified hours, including evenings and weekends as necessary. During the initial seventeen months of the Program, partnerships have been utilized with the following organizations/agencies, to provide events at: Jacob Riis Houses, University Settlement, Good Ol' Lower East Side (GOLES), the Manhattan Charter School for Curious Minds, PS 15, Grand Street Settlement, the Baruch Elders Service Team (B.E.S.T. Program), Jacob Riis Child Care Center, the Boys' Club After School Program, the Sirovich Senior Center, Henry Street Settlement, Meltzer Houses, and the Hispanic Federation. If expanded for an additional year, the Asthma Care Team will continue to reach out to and foster new collaborative relationships with other Community Based Organizations (CBOs) to ensure maximum reach of the Program to all those in the Lower East Side who might need asthma care coordination resources. Program staff are also currently in talks with Campos Plaza, in the immediate vicinity of the Con Edison plant, and Jacob Riis Houses, for additional collaborations, including a series of workshops to be held in the area. Contact has been established with the Campos Plaza Tenant Association, and efforts continue to be made to collaborate on providing workshops and other services.

The development of the individualized treatment plan includes a comprehensive review of how asthma affects an individual's body, the triggers which instigate symptoms of asthma, and how

to reduce or eliminate triggers, as well as recognize the ones which affect each individual. Patients need to know and recognize the symptoms of asthma, and what to do once the symptoms occur. The sooner a patient can identify an on-coming attack, the sooner the patient will be able to work to prevent symptoms from worsening. The patient and provider must identify the appropriate treatment among the various medications available. Ryan-NENA staff will also provide free screening services both on-site and off-site at partner organizations and appropriate health fairs. Individuals identified as having asthma will be referred for care at Ryan-NENA for follow-up services, including one-on-one case management to tailor individual treatment plans, including developing an Asthma Action Plan, and a referral to the Center for ongoing care. The Care Team will link families to primary care and help patients overcome any barriers they face to asthma control.

During the first seventeen months of the Program, the Asthma Care Team has provided nearly 130 one-on-one case management sessions. There has already proved to be a high need for such services in the community, especially with the recent changes that have occurred as part of the Affordable Care Act (ACA). Care Team members have uncovered that as part of the new ACA changes, insurance companies have also changed their formularies so that primary care providers are often prescribing medications to their patients that are no longer covered by their new insurance plans. Consequently, patients believe they are unable to receive covered asthma medication, and elect to go without treatment. However, the Asthma Care Team has been able to assist the patients in communicating with both their primary care providers and pharmacists to determine alternate medications that are covered, and to assist patients in getting access to medications and back on an asthma management care plan.

The Care Team is overseen by Kathy Gruber, Executive Director, who has been at the Ryan Center since 1981 and provides administrative leadership for the Asthma Care Team members. Over the course of the last 25 years, Ms. Gruber has played a major role in reviving the Ryan-NENA Community Health Center to become a major provider of comprehensive high quality primary health care in Manhattan's Lower East Side. Ms. Gruber is a member of the Advisory Committee of the Center's School Based Health Programs and a member of both the Finance and Nominating Committees of the Community Health Care Association of New York State

(CHCANYS). During her tenure at Ryan-NENA, Ms. Gruber has been a member of the Health Advisory Committee of University Settlement and the Lower Manhattan Healthcare Coalition. In 2013, she was elected to the Executive Committee of LES Ready, a coalition of 26 community groups and organizations that came together in response to Hurricane Sandy. While Ms. Gruber will be retiring from her position at Ryan-NENA in the next month, a qualified replacement has already been identified. Her resume is attached as an addendum to this application. Shalene Ortiz, the Asthma Care Team assistant, is a bilingual (Spanish) Licensed Practical Nurse (LPN) that works with the team to achieve program goals. Currently, the position of Asthma Care Team Coordinator (RN) is vacant, but aggressive recruitment is ongoing to fill this position, and to continue providing services through this high-need program. Indeed, Ryan-NENA is committed to the success of the Asthma Care Team Program and believes that it serves a crucial need in the LES community.

As a complement to Ryan-NENA's current range of education and outreach services to patients, the Asthma Care Team provides patients with much-needed care management services, helping patients and community residents with new asthma diagnoses and/or who are unable to manage their asthma. As mentioned above, the Care Team also provides appointment reminders, asthma care kits, support services, and assistance navigating the health care system. Implementation of the Program thus far has revealed that these services are very much in demand within the surrounding community, and that a large need exists for the targeted asthma care coordination services. As such, Ryan-NENA is requesting additional funding in order to support the Program for an additional 12 months, through March, 2016, to ensure that this demand is met and all Lower East Side residents are able to take advantage of these care coordination services.

Monitoring and Data Analysis.

In order to quantify effectiveness, the project includes monitoring of a number of data parameters, including monitoring each individual's asthma control (frequency of symptoms, attacks, hospitalization, and medication use) throughout the duration of the Program via Asthma Control Tests.

Although only in effect for seventeen months thus far, the Program has already seen a quantifiable need demonstrated through the Asthma Control Tests, which are administered each time the patient meets with Program staff. An analysis conducted midway through the initial program period demonstrated that eighty-three percent (83%) of patients who completed an Asthma Control Test (ACT) received a score of 19 or below, indicating that their asthma may not be under control. Significantly, the effectiveness of the Program can already be seen on a preliminary basis. For those patients that had been enrolled for at least five months in the Program, and have received four or more ACTs from which we can analyze whether any correlative effect has taken place, the majority (75%) have already seen a positive trend in the results of their ACT, and half have seen the values of their ACT test move from 19 or below (indicating possibly uncontrolled asthma) to scores of 20 or above (indicating likely well-controlled asthma). The proposed extension would allow additional time to ensure that as many patients as possible are able to benefit from long-term intervention facilitated by the Program.

Patients seen at the Center and diagnosed with asthma are followed by a practitioner in keeping with the guidelines of the National Heart Lung and Blood Institute and operating in a team based model. Nurses and other staff members work with patients and families to educate them on appropriate asthma control and proper use of asthma-related devices. Pediatric patients are generally given Asthma Action Plans, which are scanned into the electronic medical record, and are reassessed every three to four months. At schools where Ryan-NENA operates School Based Health Centers (PS 188 and PS 64), the Nurse Practitioner currently follows up with the patients to ensure their asthma is stable and to treat them for exacerbations. Patients needing pulmonary consult are referred to Mt. Sinai Beth Israel, Ryan-NENA's back up hospital.

Proposed Extension Project Timeline

Time Period	**Activity**	**Staff Responsible**
January 2015 (*or upon notification of funding*)	Recruit highly qualified candidate for the Asthma Care Team Coordinator position (RN)	Executive Director, Ryan-NENA

Ongoing	Continue to identify existing patients who would benefit from more dedicated services (i.e., patients who currently do not have their asthma under control)	RN, Project Manager; LPN, Project Assistant
Ongoing	Continue to conduct screenings on-site and at existing community based partner sites	RN, Project Manager; LPN, Project Assistant
Ongoing	Maintain existing relationships and create new partnership with organizations in the community for screening services	RN, Project Manager; LPN, Project Assistant
Ongoing	Continue meeting with new asthmatic patients, as well as current patients who are not in control of their asthma (one on one case management)	RN, Project Manager; LPN, Project Assistant
Ongoing	Ongoing evaluation of Program, including chart reviews, patient surveys, and monthly meetings with the Care Team	RN, Project Manager

Detailed Project Budget.

The proposed Asthma Care Team will markedly improve the level of care that asthmatic patients receive, and improve coordination of services. As discussed earlier, the Program is projected to be able to continue to operate with current grant funding until March, 2015, due to the recent vacancy of the Asthma Care Team Coordinator position. This application seeks new funding to extend the Program for an additional year, through March, 2016. The personnel included in the budget include 1) the Asthma Care Team Coordinator, an RN (preferably also a Certified Asthma Educator); 2) a Program Assistant, Shalene Ortiz, LPN; 3) the Center's Community Relations Coordinator, Jillian Moya (*in-kind support*); and 4) Ryan's Medical Director, Dr. Carolyn Chu, who will provide clinical oversight to the Program (*in-kind support*). Program materials will include educational pamphlets to inform patients and the community on how to manage their asthma, and items to distribute to patients as needed, including spacers and peak flow meters to distribute to patients, and two tablet computers to allow the Asthma Care Team to web-enable patients, thus enabling better communication between individuals and the Care Team, during outreach and/or workshop events.

Program Budget	Total Cost	Requested Support	In-Kind Support
Personnel (including fringe benefits)	**$179,200**	**$166,000**	**$13,200**
1 FTE **Asthma Care Team Coordinator, RN** (12 months)	$98,000	$98,000	$0
1 FTE **Shalene Ortiz, LPN** (12 months)	$68,000	$68,000	$0
0.10 FTE **Jillian Moya, Community Relations Coordinator** (12 months)	$4,200	$0	$4,200
.05 FTE **Carolyn Chu, Medical Director, Ryan** (12 months)	$9,000	$0	$9,000
Program Materials	**$9,000**	**$3,000**	**$6,000**
Equipment	**$9,000**	**$3,000**	**$6,000**
Staff Training	**$4,000**	**$0**	**$4,000**
Sub-total	**$201,200**	**$172,000**	**$39,200**
Indirect Costs (10% of budget)	$20,120	$3,000	$17,120
Total Budget	**$221,320**	**$175,000**	**$46,320**

Other Funding and Sustainability.

Third-party revenue obtained from providing medical services to new patients will help bolster the Program to ensure the continuation of services. As with all of its grant-funded activities, Ryan diligently seeks alternative funding for all programs providing services to the Centers' patients. Ryan has previously received support for similar care coordination services and will continue these efforts to ensure future sustainability.