

 <p data-bbox="446 174 716 233">Center for Home Care Policy & Research</p>	<p data-bbox="1060 134 1430 165">MASTER PROJECT LIST</p> <p data-bbox="1200 210 1430 241">1995-PRESENT</p>
<p data-bbox="305 281 1317 312">Projects on analyzing and informing public policies that affect home-based care</p>	

Qualitative Interviews with Clinicians who Provide Care to GAP Patients

In this project, Research Center staff will interview 50 VNSNY clinicians who provide care to VNSNY patients that are undergoing gender affirmation surgery. The purpose of the project is to learn more about clinicians’ knowledge and training, as well as their attitudinal awareness and comfort level in working with this population, and how these factors impact care.

Sponsor: NYC City Council
 Dates: 12/01/21-06/30/22
 VNSNY P.I: Oberlink, Mia, M.A.

Family caregiving in home health care during the COVID-19 pandemic: A qualitative descriptive study

The aims of the study are to: 1) explore caregivers’ experiences managing the care of older adults who received skilled HHC services following hospitalization for COVID-19; and 2) examine caregivers’ preferences for training and support to assist with the multiple care needs (i.e. physical functioning, medical, and/or nursing tasks

Sponsor: Missouri University, Intramural grant
 Dates: 2/10/2021-10/10/2021
 VNSNY P.I: McDonald, Margaret, MSW

Leveraging Home Health Aides to Improve Outcomes in Heart Failure

The goal of the proposed project is to develop, and pilot test a novel intervention for home health aides caring for patients with heart failure, in order to avert avoidable readmissions and improve patient outcomes. VNSNY investigators are advisors to this study and will help with the logistics of pilot testing of the intervention.

Sponsor: National Heart, Lung, and Blood Institute (NHLBI); *subcontract with Weill Medical College of Cornell University*
 Dates: 12/15/19-11/30/24
 P.I: Madeline R Sterling, MD, MPH, MS
 VNSNY P.I.: Feldman, Penny H., Ph.D

WIO Ladders to Value: HHA Core Curriculum and Health Coach Training Initiatives – Evaluation

NYS has funded several Workforce Investment Organizations (WIO) throughout the state to build programs to support the long-term healthcare workforce. The Research Center is evaluating the Partners in Care enhanced home health aide and health coach training initiatives.

Sponsor: New York State, subcontract with 1199
 Dates: 07/01/18–03/30/21
 P.I.: Ryvicker, Miriam, PhD.

Ensuring the Safety of the Home Health Aide Workforce and the Continuation of Needed Client Services During COVID-19: Lessons and Recommendations for Future Preparedness





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The ultimate goal of this project is the dissemination and adoption of effective, equitable and sustainable workforce practices and policies applicable to the challenges of providing ongoing care for people with disabling conditions, advanced illness or physical limitations in the context of current and/or newly emerging communicable diseases.

Sponsor: Altman Foundation
Dates: 02/26/21-12/23/21
P.I.: Feldman, Penny H., Ph.D

Addressing Disparities in Healthcare Access and Outcomes among Chronically Ill Older Adults: Assessing the Feasibility of an Agent-Based Modeling Approach

This developmental study will assess the feasibility of using an advanced method – Agent-Based Modeling and Simulation (ABMS) – to investigate the complex factors contributing to racial and socio-economic disparities in the health of older adults with chronic illness. The long-term goal of this research to develop a decision support tool that can be used by policymakers and health care administrators to guide interventions to improve the health of underserved populations of older adults with chronic illness and, in turn, reduce health disparities.

Sponsor: National Institute on Aging (NIA)
Dates: 06/01/2017 – 10/31/2019
P.I.: Ryvicker, Miriam, PhD.

Promoting Integrated Care for Dual Eligibles (PRIDE)

This project addressed a set of organizational challenges that high performing plans must resolve in order to scale up to serve larger numbers of dual eligibles. The project established a small Consortium of successful plans that: 1) extracted and shared lessons about their key challenges and success factors, 2) further defined the characteristics of high performing plans and delineated best practices, 3) provided a sounding board and potential test sites for new performance metrics, and 4) worked toward plan-specific expansion targets, building on “lessons learned” from other consortium members.

Sponsor: The Commonwealth Fund
Dates: 05/01/2012 – 11/30/2013
P.I.: Feldman, Penny H., Ph.D

Medicaid Long Term Care in New York City: Comparing Patient Characteristics and Outcomes across Service Delivery Models

The goal of this study, which examined Medicaid long-term care programs in NYC through different service delivery models (Managed Long Term Care-MLTC, Long Term Home Health Care - LTHHC, and Home Attendant Program-HAP), was the development of an analytical foundation for comparing the beneficiaries of the different home care programs. Since VNSNY provides these Medicaid services through the Family Care Service (a HAP), CHOICE (an MLTC) and Lombardi (LTHHCP); the agency is in a unique position to conduct this research study. The service models were compared based on case-mix adjusted outcomes and costs, which were derived from analysis of patient characteristics and Medicaid utilization spending records. This observational study utilized standard assessment instruments





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(Outcomes and Assessment Information Set - OASIS and Semi-Annual Assessment of Member - SAAM) to obtain demographic, clinical and functional information on patients in the three different service delivery models, with the intention of identifying similarities and differences in the patient populations enrolled in the programs. Medicaid claims data were then linked to patients in the various programs to identify differential patterns of service use and Medicaid costs.

Sponsor: New York Community Trust Foundation
Sponsor: United Hospital Fund
Dates: 01/01/2009 – 12/31/2009
P.I.: Rosati, Robert J., Ph.D.

Medicare Post-Acute Care Payment Reform Demonstration: Project Implementation and Analysis

The Deficit Reduction Act of 2005 directed the Centers for Medicare and Medicaid Services to develop a Medicare payment reform demonstration. The demonstration was designed to collect standardized patient information to examine the consistency of payment incentives for Medicare populations treated in four post-acute care (PAC) settings: (1) Home Health Agencies; (2) Skilled Nursing Facilities; (3) Inpatient Rehabilitation Facilities; and (4) Long Term Care Hospitals. Patient data were collected on admission and discharge from PAC providers in 11 market areas in the United States as well as at discharge from acute care hospitals. These data will be used to examine several key questions including the extent to which the four PAC settings differ in: (1) patients treated; (2) resources used to care for patients; and (3) patient outcomes. A report on the demonstrations is to be submitted to Congress in 2011.

Sponsor: Centers for Medicare and Medicaid Services
Dates: 02/01/2007 – 06/30/2011
P.I.: Gage, Barbara, Ph.D., Research Triangle Institute (RTI)
VNSNY P.I.: Murtaugh, Christopher M., Ph.D.

Study of LTC Utilization Patterns among New Yorkers who Fail Medical Underwriting to Purchase Partnership Policies

The purpose of this project was to provide the New York State Partnership for Long- Term Care with the following estimates: a) a profile of the group of New Yorkers who can afford Partnership insurance but would fail medical underwriting; b) their rate of LTC use; and c) the underwriting criteria which currently prohibits insurers from issuing coverage but, had coverage been issued, would have resulted in LTC use similar to that of the underwritten population.

Sponsor: New York State Department of Health
Dates: 01/01/2007 – 08/29/2008
P.I.: Murtaugh, Christopher M., Ph.D.
Co-P.I.: Spillman, Brenda C., Ph.D., The Urban Institute

Medicare Post-Acute Care Patient Assessment Instrument Development

Sponsor: Centers for Medicare and Medicaid Services



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Dates: 11/01/2006 – 09/29/2012
P.I.: Gage, Barbara, Ph.D., Research Triangle Institute (RTI)
VNSNY PI: Murtaugh, Christopher M., Ph.D.

As part of the Medicare Post-Acute Care Payment Reform Demonstration, a standardized patient assessment instrument was developed for use at acute care hospital discharge, and on admission and discharge from four post-acute care (PAC) settings. The instrument was named the Continuity Assessment Record and Evaluation (CARE) tool and assesses patient status in four major domains: medical, functional, cognitive, and social/environmental. The tool includes a range of measures that document variation in a patient's level of care needs including factors related to treatment and staffing patterns. It includes two types of items: (1) core items asked of every patient regardless of condition; and (2) supplemental items only asked of patients with specific conditions. The CARE tool is designed to measure outcomes in physical and medical treatments while controlling for other factors that affect outcomes. Evaluation of the instrument to date has included extensive analysis of the reliability of CARE tool items.

United Hospital Fund's Medicaid High-Cost Care Initiative

Nationally, individuals with five or more chronic conditions account for two-thirds of all Medicaid expenditures. In New York State (NYS), 28% of Medicaid enrollees have one or more chronic illnesses and account for over 80% of total NYS Medicaid expenditures. Home health care patients are included in this high cost Medicaid group and are also at particular risk for hospitalization. VNSNY has set a priority to develop and test care management interventions that can result in improved quality of care and reduced hospitalization for our patients, and can result in savings to both State and Federal payer groups. Yet not much is known about the predictors of hospitalization among particular sub-populations of home care patients. This project developed and evaluated tools that can be used to identify patients at high risk for hospitalization as the target population for subsequent interventions. Interventions may include medication management, mental health services, nurse practitioner visits or linkages to community-based providers, as examples. VNSNY and the United Hospital Fund worked closely to facilitate the collection of the right information from the start, and to define agreed upon analytic criteria and parameters to evaluate the effectiveness of algorithms to identify high-risk patients in both dually eligible and Medicaid-only populations.

Sponsor: United Hospital Fund
Dates: 04/01/2006 – 12/31/2007
P.I.: Rosati, Robert J., Ph.D.

Assessing Home Health Care Quality for Post-Acute and Chronically Ill Patients

Home health agencies serve patients with a range of health care needs including those with short-term post-acute needs and the chronically ill with more long-term needs. The purpose of this project was to examine the current approach to public reporting of Medicare home health agency quality with a particular focus on how quality measures perform for the diverse home health population. Four key analytic questions were addressed:

1. Can clinically meaningful groups of patients be identified (e.g., post-acute, chronically ill)?
2. To what extent do agencies serve different types of patients?

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3. Do these patients differ in publicly reported outcomes; and
4. To what extent does risk adjustment reduce (eliminate) any differences in outcomes?

All OASIS discharges in calendar years 2004 and 2005 with a matching OASIS admission assessment were analyzed (N=6,493,623). Five mutually exclusive and exhaustive patient groups were identified. The groups differed in the relative distribution of sociodemographic and clinical characteristics on admission as well as average home health length of stay. Agency size, ownership, control and geographic location were associated with the share of each type of patient served. The magnitude of differences in *unadjusted* health status outcomes among the five patient groups was more than 20 percentage points in some cases. Results suggest that risk-adjustment at the aggregate level generally is good despite statistical measures indicating poor performance of some models. However, there also was evidence of systematic bias in risk-adjusted outcomes.

Sponsor: Office of the Assistant Secretary for Planning and Evaluation (ASPE)
 Dates: 10/01/2005 – 10/31/2008
 P.I.: Murtaugh, Christopher M., Ph.D.

Alternative Risk Adjustment Approaches to Assessing the Quality of Home Health Care

The purpose of this project was to develop and test alternative risk adjustment approaches to assessing the quality of home health care. There are a total of 41 home health quality measures in the Outcome-Based Quality Improvement (OBQI) program developed and implemented by the Centers for Medicare and Medicaid Services (CMS). The statistical modeling approach currently used to risk adjust these measures so that agencies serving different types of patients can be compared, is a data-driven “stepwise” approach with a separate set of risk factors used for each OBQI measure. This project developed a theory- and evidence-based modeling approach where a common set of risk factors was used for all OBQI measures, supplemented by additional risk factors specific for each indicator where necessary. Findings from the project contributed to CMS’s subsequent plans for continued refinement of risk adjustment and outcome measures. The findings also were instrumental in supporting efforts to streamline the OASIS instrument by identifying the relative contribution of each OASIS item in risk adjustment models and outlining what items could be excluded from the instrument without jeopardizing the reliability of the risk-adjusted quality indicators and explanatory power of the risk adjustment models.

Sponsor: Office of the Assistant Secretary for Planning and Evaluation (ASPE)
 Dates: 10/01/2003 - 06/30/2005
 P.I.: Murtaugh, Christopher M., Ph.D.

Impact of the Medicare Home Health Prospective Payment System on Beneficiaries and Program Costs

Congress profoundly changed Medicare payment policy for most participating providers over the past two decades by replacing fee-for-service reimbursement with prospective payment systems. Under fixed payment systems there are incentives for providers to operate more efficiently as well as to stint on services, shift some services to other settings, upcode diagnoses or procedures, and engage in risk selection. The introduction of these payment systems, therefore, has the potential not only to change provider behavior but to substantially affect individuals’ access to services and quality of care. This project used a pre-post quasi-experimental design to examine the effect on agency practices and beneficiary outcomes of the introduction of the Medicare home health PPS in October of 2000. Center for

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Medicare and Medicaid Services (CMS) data files created to evaluate home health PPS were analyzed by the project team. Our goal was to answer key questions in the following areas:

- How have PPS incentives affected access to and the cost of Medicare home health services?
- Are patient outcomes worse after the implementation of PPS?
- What effect has home health PPS had on post-acute care outcomes?

The project built on and expanded the literature on how third party payment incentives affect care delivery and patient outcomes in a setting where providers have responded strongly to financial incentives. It provides critically needed information for policymakers charged with designing and adjusting payment systems and could improve the lives of the millions of Medicare beneficiaries who need home health care

Sponsor: Robert Wood Johnson Foundation
 Dates: 09/01/2003 - 08/31/2006
 P.I.: Murtaugh, Christopher M., Ph.D.

Lifetime Risk of Disability and Long Term Care

The project used the 1993 National Mortality Followback Survey and methodology developed in previous studies to address several key questions of importance to older adults, practitioners and policymakers:

- What proportion of the elderly population will suffer from chronic diseases that often cause disability, what proportion will actually become disabled, and how much of remaining life will be spent with disability?
- What is the risk and duration of different levels of disability, for example, how long can a current retiree expect to be disabled before and after meeting commonly used criteria for insurance benefits?
- How many years of home care and nursing home care can current retirees expect to need and what proportion will face an extended period of long term care that could be financially catastrophic?
- What are the cost implications for individuals and in the aggregate, and how do costs vary by socioeconomic status?

We found that for women, Blacks, and non-Blacks, arthritis is the most common condition among the seven studied and has the longest average duration, followed by diabetes and COPD. Among men, diabetes duration is longest, followed by COPD. Those very overweight most of life and persons with dementia have the greatest disability risk and relatively long disability durations. Slightly more than half of long term care need after age 65 will occur before meeting commonly used functional criteria for insurance benefits. As a result, both individuals and policymakers may overestimate the extent to which private long term care insurance will cover actual disability costs. Policymakers and others may need to look beyond long term care financing to other policies, such as the development of community resources to support the maximum level of independence for a growing number of older Americans.

Sponsor: Robert Wood Johnson Foundation
 Dates: 11/01/2002 – 07/30/2007
 P.I.: Spillman, Brenda C., Ph.D., The Urban Institute
 VNSNY P.I.: Murtaugh, Christopher M., Ph.D.

Trends in Medicare Home Health Care Use: 1997-2001

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The purpose of the project was to describe recent changes in beneficiary use and federal spending on the Medicare home health benefit. It built on an earlier study funded by the Robert Wood Johnson Foundation in which Laguna Research Associates analyzed changes in access to and use of the benefit as well as federal spending on Medicare home health care during 1997, 1998 and 1999. The analysis included the period 2000-2001 to determine the extent to which trends in use and federal spending changed following the introduction of the home health prospective payment system in October of 2000. The project analyzed claims data from the one percent sample of Medicare beneficiaries together with information from Medicare eligibility files. The results of the analyses provide policymakers and consumers with information critical to understanding how federal policy changes have affected access to and use of the Medicare home health benefit during a five-year period when two new payment systems were introduced.

Sponsor: Robert Wood Johnson Foundation
 Dates: 06/01/2002 - 11/30/2002
 P.I.: Murtaugh, Christopher M., Ph.D.

Information Brokering in Long-Term Care

Researchers and long-term care decision makers speak different languages. These "cultural" and "linguistic" gaps affect the ability of researchers to conduct research that is relevant to policymakers and providers. Likewise, they affect the ability of policymakers and providers to understand the implications and limitations of research that has been conducted. Thus there is a great need for effective "information brokering" among long-term care researchers, policy makers, private sector service providers, and consumers. The purpose of this initiative was to improve the accessibility of policy-relevant research and technical information to state and local decision makers whose actions affect the availability of long-term care services and the ways in which they are organized and delivered. The project aimed to fulfill an information-brokering function by:

- Synthesizing, translating, and disseminating the findings of researchers and other technical experts working on selected long-term care issues
- Bringing members of the research and technical communities together with state and local decision makers and opinion leaders to develop a shared language for examining long-term care problems and a common understanding of the knowledge base available for addressing them
- Providing venues for researchers and policy makers to formulate and examine policy options and identify policy-related research and demonstration needs and opportunities

In its information-brokering role, the project:

- Commissioned papers
- Planned and conducted issue- or problem-focused meetings
- Issued special reports
- Produced practical briefs synthesizing the findings of these activities
- Employed sophisticated electronic, print, and face-to-face techniques to reach its target audiences with timely and user-friendly information
- Convened national meetings to discuss state strategies aimed at sustaining, expanding and improving home- and community-based services (HCBS) for a growing population of older persons with disabilities and improving linkages between housing and long-term care services

Sponsor: Robert Wood Johnson Foundation



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Dates: 03/01/2002 - 03/01/2004
P.I.: Feldman, Penny H., Ph.D.

Clarifying the Definition of Homebound and Medical Necessity Using OASIS Data

This study assessed the feasibility of using information routinely collected as part of the Outcome Assessment and Information System (OASIS), as well as other patient data, to develop objective and consistent tools for evaluating a beneficiary's homebound status and his or her need for skilled care under the Medicare home health benefit. The project developed and tested two OASIS-based computer algorithms and two medical record review tools for assessing whether patients meet the homebound and medical necessity criteria. Six home health agencies provided data to test the algorithms and record review tools.

Sponsor: Office of the Assistant Secretary for Planning and Evaluation (ASPE)
Dates: 10/01/1999 – 05/21/2000
P.I.: Donelson, Sarah M., M.A.
Dates: 06/01/2000 – 03/31/2001
P.I.: Murtaugh, Christopher M., Ph.D.

Impact of State Spending for Home Care on Frail Elders

This project sought to determine how state investment in home-and-community-based services (HCBS) and expenditure control strategies (i.e., Medicaid and Medicare maximization programs) affect frail elders' access to home care. The project was designed to provide federal and state policy makers, as well as consumers, with information on the impact of HCBS policy, and to foster financing strategies that make efficient use of public resources while responding to elders' preference for community care.

Sponsor: Commonwealth Fund
Dates: 05/01/1998 - 09/30/2001
P.I.: Murtaugh, Christopher M., Ph.D.

An Investigation into the Advantages of Combining Long-term Care Coverage and a Life Annuity into a Single Retirement Plan Income Option

This project investigated the potential benefits of combining an immediate income annuity with long-term care disability insurance. Particular emphasis was placed on the role of underwriting in determining the price and size of the potential market for annuities and private long-term-care insurance sold separately, compared with the price and potential size of the market for a combined income and disability annuity.

Sponsor: TIAA-CREF Institute
Dates: 01/01/1998 - 12/31/2003
P.I.: Murtaugh, Christopher M., Ph.D.
Co-P.I.: Spillman, Brenda C., Ph.D., The Urban Institute

State Options for Allocating Resources to Home and Community-Based Care





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This project examined current state efforts to reallocate long-term care (LTC) resources and expand home-and-community-based services (HCBS) for elders. There were three main study components: (1) a phone/mail survey of State Units on Aging and Medicaid Departments conducted in 1998, (2) visits to 6 case-study states in 1998, and (3) an analysis of state expenditures on LTC services used by elders during the 1992-1997 time period. These data were used to identify state LTC policy priorities, examine LTC expenditure patterns and allocation strategies, and identify barriers to implementation and tradeoffs among alternative approaches to allocating resources to HCBS.

Sponsor: Robert Wood Johnson Foundation
Dates: 01/01/1997 - 08/31/1999
P.I.: Murtaugh, Christopher M., Ph.D.
Co-P.I.: Feldman, Penny H., Ph.D.

Home Care Concepts: Commissioned Papers

This project, part of the Home Care Research Initiative, supported a series of commissioned papers prepared by nationally prominent experts in home care. The papers were intended to advance the conceptual underpinnings of home and community-based services. The first series of papers addressed four main questions: 1) What should be the fundamental goals of home and community-based services and what should be their place in the spectrum of long-term care?; 2) How can or should the Home and Community-Based Services (HCBS) system be designed to accommodate differences in individual needs and preferences over the course of the life cycle?; 3) What factors should define or determine the nature of public and private responsibilities for individual care and well-being?; and 4) How can efficiency and cost-effectiveness be defined in meaningful and operational terms to allow comparisons across different populations, service settings and modalities of care? The Research Center managed the process of author selection, editing and dissemination of the papers. All papers were completed and published in a special supplement to the Journal of Aging and Health.

Sponsor: Robert Wood Johnson Foundation
Dates: 01/01/1997 - 12/31/2003
P.I.: Feldman, Penny H., Ph.D.

Home Care Research Initiative (HCRI)

The Center for Home Care Policy and Research served as the National Program Office for this Initiative of the Robert Wood Johnson Foundation. In this role, the Center solicited grant proposals from outside investigators, managed the review process, administered grants that were awarded and conducted dissemination activities. The purpose of the Initiative was to support research and activities designed to develop better information for allocating home and community care dollars and targeting services to those most likely to benefit from them and to improve service efficiency.

Sponsor: Robert Wood Johnson Foundation
Dates: 12/01/1995 - 08/31/2006
P.I.: Feldman, Penny H., Ph.D.





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