**I. Projects on improving the quality, cost-effectiveness, and outcomes of home care services:**
**Start on Page 2**

**II. Projects on analyzing and informing public policies that affect home-based care:**
**Start on Page 42**

**III. Projects on supporting communities that promote successful aging in place:**
**Start on Page 52**

**Within each section – chronologically, beginning with recent projects**

# I. Projects on improving the quality, cost-effectiveness, and outcomes of home care services:

### Translating Data Science to Palliative Care Practice: Improving Integration of a Claims-Based Algorithm and Palliative Care Uptake

This pilot aims to engage Palliative Care (PC) experts to document their decision-making processes and identify factors important in determining PC eligibility and useful formats for integrating algorithm results into CBPC practice. It also aims to empirically test if feedback from this documentation is consistent with current practice using multivariate logistic regression analyses, and to complement an existing 12-month mortality algorithm with a second model that discriminates between geriatric members and those needing palliative care.

Sponsor: Rutgers University (NJ ACTS Pilot Program);
*Subcontract with Rutgers University*
Date: 01/01/23-12/31/25
VNS Health P.I: Bowles, Kathryn, RN, PhD, FACMI, FAAN

### IMPACT Collaboratory: Barriers to Hospice Care Transitions for Diverse Persons Living with Dementia

This pilot aims to explore perspectives of care partners, HHC staff and providers about barriers to hospice transitions for racially and ethnically diverse Persons Living with Dementia (PLWD), survey care partners, HHC staff, and providers about key components of a transitional care checklist intervention that will guide hospice transitions for diverse PLWD, and design a novel culturally sensitive hospice transitions checklist to guide transitional care to hospice from HHC for PLWD and their care partners.

Sponsor: National Institute on Aging (NIA);
*Subcontract with New York University*
Date: 01/01/23-12/31/25
VNS Health P.I: McDonald, Margaret, MSW

### Effects of Family Caregiver Availability and Capacity on Home Health Care for Older Adults with Alzheimer's Disease and Related Dementias

This study aims to characterize the caregiver role (including types of assistance provided, availability and capacity) during home healthcare for patients with Alzheimer's Disease and Related Dementias (ADRD). to determine the impact of caregiver availability and capacity on home health care delivery for patients with ADRD, and assess the impact of caregiver availability and capacity on home health outcomes for patients with ADRD.

Sponsor: National Institute on Aging (NIA)
Date: 09/01/22-08/30/24
P.I: Burgdorf, Julia, PhD

### REFLECTION (identify pREFerence of paLliativE care through ConversaTION)

The aims of this pilot are to identify palliative care (PC) preference contents in patient-case manager verbal communications, develop and test prediction algorithms to identify patients' PC preference, and explore associations between self-reported fatigue and pain and PC preference.

Sponsor: National Institute of Nursing Research (NINR):
*Subcontract with Columbia University*
Date: 06/01/22-05/31/23
P.I: Topaz, Maxim, PhD, RN, MA

### Challenges and Best Practices in Delivering Family Caregiver Training During Medicare Home Health

The purpose of this study is to provide essential information to help design a pragmatic clinical trial that focuses on issues related to communication and care coordination between home health care agencies and clinicians with providers who order and certify home health care services.
MC-ICON (Clinical Meaningful Concept in Communication)

Sponsor: Alliance for Home Health Quality and Innovation (AHHQI)
Date: 01/01/22-04/30/22
P.I: Burgdorf, Julia, PhD

**Consumer Health Information Technology to Engage & Support ADRD Caregivers: Research Program to Address ADRD Implementation Milestone 13.I**

Dr. Burgdorf will examine patient portal access among caregiver/older adult dyads with a particular focus on older adults experiencing dementia. In addition, Dr. Burgdorf will engage in a series of information gathering conversations within VNSNY to inquire about consumer health information technology capabilities and the potential to use existing digital platforms to engage dementia caregivers.

Sponsor: National Institutes of Health (NIH): (subcontract with Johns Hopkins University)
Date: 10/01/21-06/30/22
VNS Health P.I: Burgdorf, Julia, PhD

**Dementia Caregivers' Link to Assistance and Resources (DECLARE)**

The objectives of this study are to identify the supportive needs, including specific types of training, most commonly experienced by dementia caregivers during home health care. Further, to gather information regarding caregiver preferences and expectations regarding how home health staff can/should help meet these needs.

Sponsor: National on Aging (NIA) (subcontract with Weill Cornell Medicine)
Date: 01/01/22-09/30/22
P.I: Burgdorf, Julia, PhD

**Developing and piloting a multi-component technology-based care intervention**

This proposal seeks to develop, and pilot test a multi-component technology-based care intervention, i.e., Improving Home hospice Management of End-of-life issues through technology (I-HoME), that focuses on assessing and addressing patient symptoms and caregiver (CG) burden in the home hospice setting.

Sponsor: National Institute on Aging (NIA) (subcontract with Weill Cornell Medicine)
Date: 05/01/20-04/30/24
P.I: Phongtankue, Veerawat, MD
VNS Health P.I: Shah, Shivani MPH

**Developing and Pilot Testing Culturally Based Educational Videos for Puerto Rican and African American Home Hospice Caregivers**

This study aims to develop culturally tailored educational videos focused on symptom related issues to improve caregivers' comfort in managing these issues, preparedness and self-efficacy, factors which are associated with improved caregiver outcomes.

Sponsor: National on Aging (NIA) (subcontract with Weill Cornell Medicine)
Date: 09/08/21-09/07/22
VNS Health P.I: Shah, Shivani MPH

### Disparities in Infection in Home Health and Patients/Caregivers' Perceptions (Dis-Infection in HHC)

This multisite study is examining socio-economic disparities in infection events and will explore infection prevention and control related knowledge, attitudes, and practices among home healthcare patients and their caregivers. The final year of this study includes the pilot testing of an intervention to improve infection control practices.

Sponsor: Agency for Healthcare Research & Quality (AHRQ) (subcontract with Columbia)
Date: 09/03/21-08/31/26
P.I: Shang, Jingjing, PhD
VNS Health P.I: McDonald, Margaret, MSW

### Home Health Aide Continuity Among Home-Based Long-Term Care Clients and its Relationship with Health Outcomes

This is a retrospective cohort study that will describe home health aide continuity among a population of older adults receiving Medicaid-funded, home-based long term care. Client factors associated with greater continuity and the association between continuity and client health outcomes will be examined.

Sponsor: National Institute on Aging (subcontract with Mount Sinai Claude D. Pepper Older Americans Independence Center University)
Date: 07/01/21-06/20/23
P.I: Reckrey, Jennifer, MD
VNS Health P.I: Russell, David, PhD

### The Impact of COVID-19 on End-of-Life Care for Vulnerable Populations

The major goal of the study is to examine the impact of public health containment and mitigation policies implemented during the COVID-19 crisis in the United States on the experiences of patients at the end of life and their families. Hospice is the dominant model of home-based care for those at the end of life and this research will elucidate the ways in which hospices adapted their practices and implemented new policies in response to COVID-19 and in preparation for a broad range of future emergencies.

Sponsor: National Institute on Aging (subcontract with Mount Sinai Claude D. Pepper Older Americans Independence Center University)
Date: 07/12/21-03/31/24
P.I: Aldridge, Melissa, PhD
VNS Health P.I: McDonald, Margaret, MSW

### A Pragmatic Randomized Control Trial of Nurse-Delivered Brief Meaning Centered Psychotherapy for Homebound Palliative Care Patients

The primary aim of the proposed project is to determine if homecare nurses, the frontline clinicians who typically serve this vulnerable patient population, can effectively deliver meaning centered psychotherapy for palliative care and reduce psychological suffering in their advanced cancer patients.

| | |
|---|---|
| Sponsor: | National Institute of Nursing Research (NINR) (subcontract with Sloan-Kettering Institute for Cancer Research) |
| Date: | 09/01/21-07/31/23 |
| P.I: | Applebaum, Allison, PhD |
| VNS Health P.I: | McDonald, Margaret, MSW |

### Using Speech and Language to Identify Patients at Risk for Hospitalizations and Emergency Department Visits in Homecare

Building on Doyle pilot work done by M.Zolnoori and M.Topaz, this study expands the study of verbal communication between health providers and patients. Specifically, advanced artificial intelligence methods will be applied to explore whether audio recorded nurse-patient communication during routine home healthcare (HHC) visits can inform the identification of patients at risk for hospitalization or ED visits.

| | |
|---|---|
| Sponsor: | Amazon; subcontract with Columbia University |
| Date: | 01/01/21-06/30/22 |
| P.I: | Zolnoori, Maryam, PhD |
| VNS Health P.I: | Topaz, Maxim PhD, RN, MA |

### MC-ICON (Clinical Meaningful Concept in Communication)

This project involves NLP methods and annotation of clinical conversations and home health care (EHR) clinical notes, that aim to predict whether patients will experience deterioration and ultimately end up back in hospital or emergency department.

| | |
|---|---|
| Sponsor: | Amazon (subcontract with Columbia University) |
| Date: | 02/01/21-01/31/22 |
| P.I: | Topaz, Maxim PhD, RN, MA |

### Precision in Symptom Self-Management (PriSSM) Center – Pilot 5

In keeping with the P30 Precision in Symptom Self-Management Center's focus on Latinos, the goal of this pilot project is to bridge evidence gaps and explore nursing symptom documentation in homecare.

| | |
|---|---|
| Sponsor: | National Institute of Nursing Research (NINR) (subcontract w/ Mount Sinai) |
| Date: | 06/01/19-05/31/21 |
| P.I: | Topaz, Maxim, PhD, RN, MA |
| VNS Health P.I: | Ryvicker, Miriam, PhD |

### Making health care safer for older adults receiving skilled home health care services after hospital discharge – COVID-19 supplement

The goal of the supplement is to identify how the SARS-CoV-2 pandemic has impacted (1) care transitions experiences of older adults after coming home from the hospital and their home health providers, and (2) organizational structure and processes of participating SHHC agencies in two geographic areas.

| | |
|---|---|
| Sponsor: | Agency for Healthcare Research and Quality (AHRQ); (administrative supplement subcontract with Johns Hopkins University) |
| Dates: | 09/01/21–5/31/22 |
| P.I | Arbaje, Alicia, MD, MPH, PhD |
| VNS Health P.I: | Bowles, Kathryn, RN, PhD, FACMI, FAAN |

### Identifying Challenges in Dementia Caregiving for Community-Dwelling Patients with Dementia nearing End of Life

The study identifies challenges for hospice clinicians and family caregivers (FCG) in providing care and support to home hospice patients with dementia, the steps clinicians and FCG take to overcome those challenges, and gaps in care.

| | |
|---|---|
| Sponsor: | National Institute on Aging (NIA) (subcontract with Weill Medical College of Cornell University) |
| Dates: | 02/01/21-01/31/22 |
| P.I: | Jordan, Lizeyka, |

### I-TRANSFER: Improving TRAnsitions anD outcomeS oF sEpsis suRvivors

The purpose of this study is to advance the science of transitional care for sepsis survivors, the proposed study will test the effectiveness of the I-TRANSFER home health care early visit protocol intervention in the real world and study its implementation with a pragmatic, multi-center, Type 1 hybrid, stepped wedge randomized trial in partnership with five dyads of acute care and HHC providers (ten clinical sites in total).

| | |
|---|---|
| Sponsor: | National Institute of Nursing (NIH)/National Institute of Nursing Research (NINR) (subcontract with University of Pennsylvania) |
| Dates: | 12/01/20-11/30/25 |
| P.I: | Bowles, Kathryn, RN, PhD, FACMI, FAAN |
| VNS Health P.I: | Ryvicker, Miriam, PhD |

### Development and Testing of the Palliative Care related, Knowledge, Attitudes, & Confidence in the Home Health Care (PC-KAC in HHC) Questionnaires

This pilot project is aimed at developing and evaluating the psychometric properties of instruments that measure palliative care knowledge, attitudes, and confidence among clinicians, patients and informal caregivers in the home healthcare (HHC) setting.

| | |
|---|---|
| Sponsor: | Columbia University Intramural Grant |
| Dates: | 02/01/21-01/31/22 |
| P.I: | Shang, Jingjing, PhD |
| VNS Health P.I: | McDonald, Margaret, MSW |

### Care Partners Program

The specific aims are to evaluate the efficacy of a dyadic treatment (DT) intervention on caregiver outcomes and evaluate the efficacy the DT condition on outcomes for individuals with mild stage Alzheimer's Disease (CRs). VNSNY has been contracted to help identify and recruit the targeted population.

Sponsor: National Institute on Aging (NIA) (subcontract with Weill Cornell Medicine)
Dates: 01/01/20–09/30/21
P.I: McDonald, Margaret, MSW

### VNSNY Nursing Services at the 92nd Street Y

This project is an evaluation of VNSNY nursing services that will be provided at the 92nd Street Y. Activities performed will include providing or developing tools to help the nurse track clients' progress toward their health goals and evaluating this process to ensure that the information collected helps inform practice.

Sponsor: Young Men's and Young Women's Hebrew Association
Dates: 01/01/2020 – 12/31/2021
P.I: Oberlink, Mia, MA

### Nurses' documentation of patient diagnoses, symptoms and interventions for home care patients with Alzheimer's disease and related dementias (ADRD): A natural language processing study

This study will allow us to examine HHC nurses' practices, which are often difficult to observe systematically, and identify strategies to address the complex needs of their patients with ADRD and un-diagnosed patients who may be on a path toward ADRD diagnosis.

Sponsor: National Institute on Aging (NIA)
Date: 08/01/2020 – 05/31/22
P.I: Ryvicker, Miriam, PhD

### Incapacitated with No Evident Advance Directives or Surrogates (INEADS)

Determine what are the prevalence and characteristics of adults who are INEADS or at risk of becoming INEADS, and how clinical decisions are currently made for INEADS patients.

Sponsor: National Institute of Nursing Research (NINR) (subcontract w/ Mount Sinai)
Date: 08/28/2020 – 07/31/2022
P.I: Topaz, Maxim, PhD, RN, MA

### Home Health Discharge Decision Support: Impact on Patient Outcomes (HEADS-UP)

The purpose of this project is to demonstrate the feasibility of clinical expert elicitation methods as a first step in creating a clinical decision support (CDS) system to determine readiness for discharge to support home health (HH) clinicians as they make the critical decision to discharge.

Sponsor: Gordon & Betty Moore Foundation (subcontract w/ Villanova College of Nursing)

Dates: 11/01/2020 – 06/30/23
P.I: Bowles, Kathryn, RN, PhD, FACMI, FAAN

**Homecare CONCERN: Building risk models for preventable hospitalizations and emergency department visits in home care**

This study will further develop and validate a preventable hospitalization or ED visit risk prediction model (Homecare-CONCERN). Traditional and cutting- edge time-sensitive analytical methods for risk model development will be applied. In addition, the team will prepare Homecare-CONCERN for clinical trial via pilot testing.

Sponsor: Agency for Healthcare Research and Quality (AHRQ)
Dates: 09/30/2020 – 07/31/24
P.I: Topaz, Maxim, PhD, RN, MA

***Doyle:* Using artificial intelligence to identify homecare patient's risk of hospitalization and emergency department visits: speech-recognition feasibility study**

This feasibility study is the first step in exploring an emerging and previously understudied data stream - verbal communication between health providers and patients. We will apply advanced artificial intelligence methods to explore whether audio recorded nurse-patient communication during routine home healthcare visits can inform the identification of patients at risk for hospitalization or ED visits.

Sponsor: Eugenie and Joseph Doyle Research Partnership Fund of the VNSNY
Dates: 09/01/2020 – 08/31/2021
P.I: Zoolnori, Maryam, PhD
VNS Health P.I: Topaz, Maxim, PhD, RN, MA

***Doyle:* Identifying documentation of workplace violence towards home healthcare nurses in clinical notes: a text mining study**

In this pilot study, Type II WPV-related information from HHNs' clinical notes will be extracted and classified using a novel word-embedding-based natural language processing and machine learning approach to yield an estimate of WPV prevalence. This estimate will then be compared with prevalence estimates by established reporting systems.

Sponsor: Eugenie and Joseph Doyle Research Partnership Fund of the VNSNY
Dates: 09/01/2020 – 08/31/2021
P.I: Byon, Ha Do
VNS Health P.I: Topaz, Maxim, PhD, RN, MA

**PREVENT: Improving patient prioritization during hospital-homecare transition: A mixed methods study of a clinical decision support tool**

This study is a rigorous effectiveness trial evaluating an innovative clinical decision support system (CDSS) called PREVENT, PREVENT assists home care agency schedulers and nurses in prioritizing patients in need of immediate first homecare nursing visits.

Sponsor: National Institute of Nursing Research (NINR)

Dates: 09/25/2019 – 07/31/2022
P.I. : Topaz, Maxim, PhD, RN, MA
VNS Health P.I.: McDonald, Margaret, MSW

**Making health care safer for older adults receiving skilled home health care services after hospital discharge.**

This study seeks to address critical gaps in the understanding of safety issues during the high-risk hospital to home health care transition. This project will analyze threats, refine and then pilot test a bundle of interventions

Sponsor: Agency for Healthcare Research and Quality (AHRQ)
Dates: 08/01/2019 – 05/31/2022
P.I.: Arbaje, Alicia, MD, MPH, PhD
VNS Health P.I.: Bowles, Kathryn, RN, PhD, FACMI, FAAN

***Doyle:* Perspectives of Patient, Caregiver and Healthcare Provider on Care Management and Shared Decision Making among Home Hospice Patients with Heart Failure**

Building on findings from on earlier Doyle Fund sponsored pilot study, this project explores the perspectives of patients, caregivers and healthcare providers who are caring for HF patients enrolled in the Cardiac Home Hospice care program.

Sponsor: Eugenie and Joseph Doyle Research Partnership Fund of the VNSNY
Dates: 09/01/2018 – 08/31/2019
P.I.: Masterson Creber, Ruth, PhD, MSc, RN & Baik, Dawon, PhD
VNSNY: Russell, David, PhD

**Center for Improving Palliative Care for Vulnerable Adults with MCC (CIPC)**

The Center for Improving Palliative Care in Vulnerable Adults with MCC (CIPC) aims to provide expert guidance to nurse scientists in becoming leaders of interdisciplinary research teams that generate knowledge to inform how best to provide vulnerable adults with multiple chronic conditions with palliative that care is consistent with their personal preferences and reduces burdensome treatments and transitions.

Sponsor: National Institute on Nursing Research (Subcontract w/ Columbia University)
Dates: 08/08/18 – 05/31/23
P.I.: Stone, Patricia, PhD & Shang, Jingjing, PhD
VNS Health P.I.: Topaz, Max, PhD

***Doyle:* Provider insight on identification and management of urinary incontinence in home hospice**

This project involves utilizing structured interviews with nurses to learn how hospice nurses identify and manage urinary incontinence in home hospice patients.

Sponsor: Eugenie and Joseph Doyle Research Partnership Fund of the VNSNY
Dates: 07/15/2018 – 07/14/2020

P.I.: Chughtai, Bilal, M.D.
VNS Health P.I.: Russell, David, PhD

### *Doyle:* Examining the Relationships between Dementia, Race, Ethnicity, Socioeconomic status and Late Referral to and Live discharge from Hospice

This pilot study uses secondary data analysis to examine the associations and moderating effects of Alzheimer's Disease and related dementias and socioeconomic status on risk of late referrals and live discharge from hospice.

Sponsor: Eugenie and Joseph Doyle Research Partnership Fund of the VNSNY
Dates: 07/15/2018 – 07/14/2019
P.I.: Luth, Elizabeth, PhD
VNS Health P.I.: Russell, David, PhD

### *Doyle:* Informal Caregivers' Experiences Managing Complex Care for Older Post-Acute Home Health Care Patients

The pilot study aims to describe informal caregivers' experiences providing medical/nursing care for an older adult who transitioned from hospital to home; along with exploring caregivers' perspective on their training and support.

Sponsor: Eugenie and Joseph Doyle Research Partnership Fund of the VNSNY
Dates: 07/01/2018 – 08/31/2019
P.I.: Chase, Jo-Ana, PhD, APRN-BC
VNS Health P.I.: Russell, David, PhD

### WIO Ladders to Value: HHA Core Curriculum and Health Coach Training Initiatives- Year 1 Evaluation Plan

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: 07/01/2018 – 04/30/2020
P.I.: Ryvicker, Miriam, PhD

### Home-based Primary Care for Homebound Seniors: a Randomized Controlled Trial

Evaluate the impact of home-based primary care on utilization of healthcare, health outcomes, satisfaction, and healthcare spending among homebound older adults and their caregivers. VNSNY is responsible for identifying the target population and soliciting permission to release contact information to Mount Sinai study staff.

Sponsor: National Institute on Aging (NIA)
Dates: 10/01/2017 – 08/31/2019
P.I.: Federman, Alex, MD, MPH
VNS Health P.I.: Shah, Shivani, MPH

### A Longitudinal Network Study of Alzheimer's and Dementia Care in Relation to Disparities in Access and Outcomes

The study will use innovative network analytics to capture complex patterns in care trajectories that may contribute to adverse outcomes in a racially and socioeconomically diverse sample of individuals with Alzheimer's disease or dementia.

Sponsor: National Institute on Aging (NIA)
Dates: 09/30/2017 – 08/31/2018
P.I.: Ryvicker, Miriam, Ph.D

### SHARP: Assessing a Stroke Homehealth Aide Recovery Program as a Potential High Impact Strategy for improving in Functional mobility after Stroke

This initiative is pilot testing an innovative, culturally tailored Stroke Homehealth Aide Recovery Program (SHARP) that expands the care team to include a corps of advanced home health aides specially trained as stroke "coaches," and will assess the viability of this avenue of research to improve functional outcomes following stroke.

Sponsor: National Institute of Child Health and Human Development (NICHHD)
Dates: 09/11/2017 – 08/31/2019
P.I.: Feldman, Penny, Ph.D

### CAPABLE: Reducing disability following hospital discharge in vulnerable older adults: the CAPABLE intervention

This study is testing the effectiveness of the CAPABLE program, which combines evidence-based nursing, occupational therapy, and handyman components to help diverse older adults function at home and save our nation costly nursing home care.

Sponsor: National Institute of Aging (NIA)
Dates: 09/01/2017 – 04/30/2022
P.I.: Szanton, Sarah L., PhD, RN
VNS Health P.I.: Melissa, Trachtenberg

### *Doyle:* Exploring Medication Management with LEP patients in HHC

The purpose of this pilot study was to explore the role of language concordance on the medication management of limited English proficient population in home health care using both qualitative and quantitative data.

Sponsor: Eugenie and Joseph Doyle Research Partnership Fund of the VNSNY
Dates: 07/15/2017 – 08/15/2018
P.I.: Miner, Sarah, PhD, RN
VNS Health P.I.: McDonald, Margaret, MSW

### *Doyle:* Survival Analysis of Urban Home Care Patients with HF Entering Hospice Using the Palliative Performance Scale as a Predictor of Mortality

This pilot study seeks to identify prognostic cut-points of the Palliative Performance Scale for predicting survival and predictors of discharge from hospice in a cohort of racially and ethnically diverse, urban sample of heart failure patients receiving hospice care.

Sponsor: Eugenie and Joseph Doyle Research Partnership Fund of the VNSNY
Dates: 07/01/2017 – 06/30/2017
P.I.: Masterson Creber, Ruth, PhD, MSc, RN
VNS Health P.I.: Russell, David, PhD

### Health Coaching Initiative

Health coaches trained by VNSNY Partners in Care are imbedded NORC programs (currently the Stanley M. Isaacs and Elliott-Chelsea NORCs) to help vulnerable older adults age in place.

Sponsor: New York Foundation for Eldercare; Fan Fox & Leslie R. Samuels Foundation
Dates: 06/01/2017 – 01/31/2020
P.I.: Oberlink, Mia, MA

### Data Preparation Pilot to Identify Fall Risk Characteristics and Fall Prevention Interventions among Home Care Recipients

The ultimate purpose of this body of research is to advance the science of falls prevention. This pilot study will provide the study team with experience in using several home health care data sources and provide preliminary results that will support a larger National Institutes of Health grant submission.

Sponsor: UPenn Challenge Grant
Dates: 03/23/2017 – 03/22/2018
P.I.: Bowles, Kathryn, RN, PhD, FACMI, FAAN

### Population Care Coordination Program (PCCP) Evaluation

The Population Care Coordination Program (PCCP) is a retraining program designed to provide VNSNY nursing staff with opportunities to increase both competence in ability to perform in a care coordination role. Through this program, VNSNY nursing staff complete the Duke Population Care Coordination course.

Sponsor: New York State Department of Health
Dates: 01/01/2017 – 12/31/2018
P.I.: Russell, David, PhD

### Health Coach Training Program Evaluation

The health coach training program provides intensive classroom training in health coaching principles and practice to home health aides employed by Partners in Care.

Sponsor: New York State Department of Health
Dates: 01/01/2017 – 12/31/2018
P.I.: Russell, David, PhD

### Comparative Effectiveness of Home Health Therapies after Joint Replacement

There is almost no evidence about whether more intensive home health therapy results in better functional outcomes, reduces hospital readmissions and emergency department visits, or lowers overall Medicare spending in the months after a total hip or knee replacement surgery. Through analyzing Medicare data, this project will address these issues and ultimately seeks to identify post-acute-care practices that help older adults who have total hip or knee replacements to remain mobile and live independently in the community.

Sponsor: National Institute on Aging (NIA)
Dates: 09/15/2016 – 09/14/2017
P.I.: Murtaugh, Christopher, Ph.D.
Co-P.I.: Siu, Albert L., MD

### Fatigue in Elderly Latino Home Health Care Patients with Chronic Disease

This is a pilot study investigating issues of fatigue in home care patients. This is a non-interventional study linking patient Outcome and Assessment Information Set (OASIS), survey, Actigraphy (human rest/activity cycles), and biomarkers (saliva) data. VNSNY is responsible for identifying the target population and soliciting permission to release contact information to CUSON study staff.

Sponsor: National Institute of Nursing research (NINR)
Dates: 08/16/2016 – 05/31/2017
P.I: Dowding, Dawn, Ph.D, RN

### Infection Control in Home Care and Predictive Risk Modeling

The objectives of this research are to address the knowledge gap of current infection control practices in HHC, and test and explore the use of predictive risk modeling techniques to identify patients with high risk for infection.

Sponsor: Agency for Healthcare Research and Quality (AHRQ)
Dates: 07/01/2016 – 04/30/2020
P.I. : Shang, JingJing, PhD, RN
VNS Health P.I.: Dowding, Dawn, Ph.D, RN

### IPCOA-HC: Interprofessional Primary Care of Older Adults in Home Care

VNSNY will work with the NYU Hartford Institute for Geriatric Nursing team to: Transform practice for at least 50 key healthcare professionals by engaging them in a geriatric specific community-based, interprofessional team educational program.

Sponsor: Hearst Foundation; subcontract with NYU College of Nursing
Dates: 06/28/2016 --- 06/27/2018
P.I.: Greenberg, Sherry, PhD, RN, GNP-BC
VNS Health P.I.: McDonald, Margaret, MSW

### reCAPABLE Program Pilot Study

The objective of this pilot project is to identify eligible VNSNY CHOICE members following hospitalization and receipt of home care to assess need for home modifications.

Sponsor: Silvian Foundation
Dates: 01/01/2016 – 01/30/2017
P.I.: Szanton, Sarah L., PhD, ANP, FAAN
VNS Health P.I.: Russell, David, Ph.D

### Physical Functioning Trajectories among Racially and Ethnically Diverse Older Adult Home Health Care Recipients: A Pilot Study

This study will identify and describe racial and ethnic differences in physical functioning and discharge outcomes among older home health care recipients

Sponsor: Frank Morgan Jones Fund (University of Pennsylvania)
Dates: 11/28/2015 – 11/27/2016
P.I.: David Russell, Ph.D

### Development of Dashboards to Provide Feedback to Home Care Nurses

This study objectives are to develop and test the usefulness of a type of technology, known as dashboards, for nurses in home care settings to use to know how well they are delivering patient care. Dashboards provide information to users as graphs, and are thought to help people understand information more effectively. In this study we will be developing the dashboards with the help of nurses, to see if they can be used as a way of helping improve quality of care.

Sponsor: Agency for Healthcare Research and Quality (AHRQ)
Dates: 09/30/2015 – 03/31/2017
P.I.: Dowding, Dawn, Ph.D, RN

### Sepsis Survivors' Post-Accute Outcomes: Impact of Early Home Health and MD Visits

This study is using a national Medicare data to examine the impact of commonly available, home health and physician interventions on the hospital readmission rate of over 250,000 sepsis survivors discharged to home health care, and to produce a longitudinal, comprehensive view of patient, hospital, home care agency and physician services and their relationship with other patient outcomes. Study results have the potential to fill a critical void in clinical guidelines and substantially improve the quality of life of the large and growing number of sepsis survivors.

Sponsor: National Institute of Nursing Research (NINR)
Dates: 09/25/2015 – 07/31/2018
P.I.: Murtaugh, Christopher, Ph.D
Co-P.I.: Bowles, Kathryn, RN, PhD, FACMI, FAAN

### Language Concordance and Post-Acute Patient Outcomes in Home Health Care

The objective of this study is to help improve healthcare providers' understanding of how language barriers impact 30-day readmission rates from home care and home health care resource utilization

among limited English proficiency (LEP) patients recently discharged from the hospital, with a secondary aim of understanding their impact on functional status.

Sponsor: Agency for Healthcare Research (AHRQ)
Dates: 07/15/2015 – 04/30/2018
P.I.: Squires, Allison P, PhD
VNS Health P.I.: Feldman, Penny, Ph.D.

### Health Workforce Retraining Initiative Analytics and Reporting

This is an evaluation of the health coach training sessions being conducted by Partners in Care.

Sponsor: New York State
Dates: 05/01/2015 – 06/30/2016
P.I.: Russell, David, Ph.D.

### Colorectal Cancer Outcomes

VNSNY is providing the following services: planning and identification of specifications for the data, assistance with preparing an IRB proposal for VNSNY, collation the different sources of data from the patient data warehouse, assistance with data analysis and interpreting results from the study, and reviewing manuscripts for publication. VNSNY will also provide MSKCC with demographic, outcome, cost, and episodic data points.

Sponsor: Memorial Sloan Kettering
Dates: 02/01/2015 – 02/01/2016
P.I.: Russell, David, PhD.

### Pepper Center Pilot Study: The Use of Implantable Cardiac Devices in Home Care Patients with Advanced Heart Failure

The goal of this pilot study is to describe the population of home care patients with advanced heart failure who do and do not receive implantable cardiac devices and to examine the relationship between implantation of a device and outcomes such as hospice use, hospital readmission, nursing home admission, and mortality.

Sponsor: National Institute on Aging (Subaward from the Claude D. Pepper OAIC Icahn School of Medicine at Mt. Sinai)
Dates: 01/01/2015 – 12/31/2015
PI: Siu, Albert, MD
VNS Health P.I.: Murtaugh, Christopher, PhD

### Dementia Symptom Management at Home (DSMH) Program

VNSNY is responsible for developing an algorithm for participant recognition, for purchasing data, and for implementing changes in the electronic medical record.

Sponsor: Cambria Foundation(Funder) | NYU(Prime Awardee)
Dates: 10/15/2014 – 10/14/2016

P.I.: Russell, David, Ph.D

### Partners in Care Health Coach Training Pilot

Evaluation of health coach training program being implemented by Partners in Care.

Sponsor: Deutsche Bank Americas Foundation
Dates: 01/01/2014 – 12/31/2015
P.I.: Russell, David, PhD

### WICER 4 U

This initiative is applying principles of stakeholder engagement and a variety of methods to understand the needs of diverse stakeholders (CER/PCOR investigators, clinical transformation leaders, WHI community members, and WHI community-based organizations) and use this understanding to enhance the existing WICER data infrastructure.

Sponsor: Agency for Healthcare Research and Quality (AHRQ),
Dates: 09/30/2013 – 03/31/2015
P.I.: Bakken, Suzanne, R.N., Ph.D., Columbia University College of Nursing
VNS Health P.I.: Feldman, Penny H., Ph.D.

### Nurse education, practice, quality and retention program (NEPQR): Interprofessional collaborative practice

The purpose of this project is to implement and evaluate the effectiveness of an innovative interprofessional education-practice model of collaborative, coordinated care that reflects the right communication across the health care system.

Sponsor: Health Resources and Service Administration (HRSA)
Dates: 07/01/2013 – 06/30/2016
P.I.: Cortes, Tara, R.N., Ph.D., New York University College of Nursing
VNS Health P.I.: Feldman, Penny H., Ph.D.

### Rehabilitation HHA Grant: Evaluation

Evaluation of a pilot on a home health aide training program.

Sponsor: New York Community Trust
Dates: 02/12/2013 – 02/11/2014
P.I.: Russell, David, Ph.D.

### Center for Stroke Disparities Solutions (CSDS): Community Transitions Intervention

The overall goal of this study is to address health disparities and reduce patient risk of experiencing another stroke by providing transitional care support after an acute care episode and helping patients manage their hypertension more effectively.

Sponsor: National Institute of Neurological Disorders and Stroke (NINDS)
Dates: 09/30/2012 – 08/31/2018
P.I.: Ogedegbe, Olugbenga, M.D., New York University School of Medicine
VNSNY PI: Feldman, Penny H., Ph.D.

### Adaptation of the CARE Tool for Settings Providing Community-Based Long Term Services and Supports

The purpose of this Task Order contract is to develop the Continuity Assessment Record and Evaluation (CARE) Functional Assessment Tool for use with individuals using long-term services and supports (LTSS). This task is expected to be completed by identifying gaps and modifying key measures (as necessary) in the current CARE Tool and then advising and providing assistance to the TEFT Technical Assistance Contractor on 2 rounds of field testing of a subset of data elements from the CARE Tool in selected states.

Sponsor: Centers for Medicare and Medicaid Services (CMS).
Dates: 9/26/2012 – 9/25/2014
P.I.: Mon, Donald, Ph.D., RTI International
VNSNY PI: Murtaugh, Christopher M., PhD.

### New Workers Training Evaluation

This project is evaluating the quality of training of the home care aides among the United Jewish Appeal-Federation of Jewish Philanthropies of New York, Inc. agencies (UJA).

Sponsor: The Harry and Jeanette Weinberg Foundation, Inc.
Dates: 07/01/2012 – 12/31/2014
P.I.: Feldman, Penny H., PhD.

### Treating Pain to Reduce Disability among Older Home Health Patients

The goal of this research study is to reduce disability among older home health patients by treating their pain more effectively. The study will compare the effectiveness of usual care provided to older home health patients with activity-limiting pain, to usual care plus instruction by physical therapists in a cognitive–behavioral pain self-management (CBPSM) program. The study will include sizeable numbers of Hispanic, non-Hispanic African Americans and non-Hispanic white patients and will examine the heterogeneity of CBPSM treatment effects among patients with different pain conditions and minority group status.

Sponsor: Agency for Healthcare Research and Quality (AHRQ)
Dates: 03/01/2012 – 12/31/2014
P.I.: Murtaugh, Christopher M., Ph.D.

### Communication between Home Health Nurses and Physicians: Quantity, Quality, and the Impact on Hospital Readmission

The aim of this study was to determine how often home health nurses have difficulty in reaching patient physicians and how this might be associated with hospitalization.

Sponsor: Aetna Foundation, subcontract from Weill-Cornell
Dates: 01/15/2012– 07/15/2013
P.I.: Press, Matthew, M.D., Cornell University
VNSNY PI: Peng, Timothy, Ph.D.

### Comparative Effectiveness of Intensive Home Health and MD Visits in Heart Failure

The overall goal of the project is to improve heart failure patient outcomes by identifying the most effective combination of home health nursing visits and physician follow-up in reducing rehospitalization, and to determine whether some patients benefit more than others.

Sponsor: Agency for Healthcare Research and Quality (AHRQ)
Dates: 09/30/2011– 03/31/2014
P.I.: Murtaugh, Christopher M., Ph.D.

### Built Environment and Health Care Use: Disparities among Chronically Ill Elders

This study is examining the relationships between neighborhood built environment (e.g. walk-ability, access to public transit), use of physician services, and preventable hospitalizations and emergency department visits among elderly, chronically ill Medicare beneficiaries who live in New York City.

Sponsor: National Institute on Aging (NIA)
Dates: 09/30/2011 – 08/31/2016
P.I.: Ryvicker, Miriam, Ph.D.

### RIBN Regional Expansion

The original RIBN project: “Multi-Regional Model to Increase the Proportion of Baccalaureate Nurses in New York City and North Carolina” was expanded in this iteration to include additional New York City and North Carolina nursing schools. The purpose of the project is to create a seamless progression for nursing students from associate degree nursing programs (in community colleges) to baccalaureate degree nursing programs (in 4-year colleges). The schools develop partnerships to allow students to enroll in both programs at the same time thereby encouraging and facilitating higher education for nursing students.

Sponsor: Jonas Center for Nursing Excellence & Partners Investing in Nursing's Future, Northwest Health Foundation (RWJF)
Dates: 09/01/2011 – 08/31/2014
P.I.: Oberlink, Mia, M.A.

### Washington Heights Initiative Community-based Comparative Effectiveness Research (WICER)

The aim of the Washington Heights/Inwood Informatics Infrastructure for Community-Centered Comparative Effectiveness Research (WICER) project was to build on an existing institution-focused data infrastructure to create a robust community-focused data infrastructure that will support the kinds of innovative comparative effectiveness research studies needed to effectively tackle seemingly intractable public health problems. VNSNY staff collaborated on two main activities of this grant:
1. Participated as a data source for a research data warehouse.
2. Designed and implemented an informatics-support Hypertension (HTN) Care Management Pilot Study in collaboration with New York Presbyterian clinicians and investigators.

| | |
|---|---|
| Sponsor: | Agency for Healthcare Research & Quality |
| Dates: | 09/30/2010 – 08/31/2013 |
| P.I.: | Wilcox, Adam, Ph.D., Columbia University Medical Center |
| VNS Health P.I. | Feldman, Penny H., Ph.D. |

### Capturing the Quality of Community Care Transitions with the CTM-3 (Care Transitions Study)

This study investigated the potential of the 3-item Care Transitions Measure (CTM-3, developed by Eric Coleman and colleagues) to improve transitional care in the post-acute home health setting. We did so by analyzing the tool's capacity to help home health providers: 1) distinguish among high and low performing hospitals whose transitional care successes or deficiencies affect the preparation of the patient and the chronic care coordination challenges of the home care team, 2) identify inadequately prepared patients who are thus at heightened risk of transition-related rehospitalization early in the post-acute care episode, 3) predict post-acute care resource use attributable to inadequate hospital to home preparation, and 4) measure home care's "value added"(or not added) to the transitional care process.

| | |
|---|---|
| Sponsor: | Commonwealth Fund |
| Dates: | 06/01/2010 – 11/30/2011 |
| P.I.: | Feldman, Penny H., Ph.D. |

### Measuring the Impact of Home-Based Primary Care on Healthcare Utilization, Health-related Quality of Life, Caregiver Burden, and Patient Satisfaction

The study will evaluated whether Home Based Primary Care (HBPC) is associated with decreased healthcare utilization; improved quality of life and satisfaction with care; and lower caregiver burden for homebound community dwelling seniors as compared to homebound seniors who do not receive HBPC. The HBPC model brings primary care physicians to the homebound. The model has the potential to improve the health of vulnerable elders; however, HBPC has not yet been widely adopted. The specific objectives of this research project were to: 1) examine the impact of physician home visits on hospitalization of homebound adults; 2) examine the impact of physician home visits on health related quality of life and satisfaction with care among homebound adults; and 3) assess the impact of physician home visits on caregiver burden among caregivers (e.g., family and friends) of homebound adults. These

objectives were accomplished through a prospective, observational study comparing patients in the Mount Sinai Visiting Doctors (MSVD) program to a group of patients who are similar in their demographic and health status characteristics in the VNSNY Long Term Home Health Care Program (LTHHCP).

| | |
|---|---|
| Sponsor: | Research Retirement Foundation |
| Dates: | 04/01/2010 – 03/31/2012 |
| P.I.: | Federman, Alex, M.D., M.P.H., Mount Sinai School of Medicine |
| VNS Health P.I. | Rosati, Robert, Ph.D. |

### Prevent Return of Stroke

The purpose of the study was to evaluate a community-based recurrent stroke intervention, versus usual care, at reducing primary risk factors for recurrent strokes while providing an effective, low-cost, sustainable recurrent stroke prevention program in neighborhoods like Harlem, whose residents bear a disproportionate burden of suffering from strokes.

| | |
|---|---|
| Sponsor: | National Institutes of Health (NIH) |
| Dates: | 02/01/2010 – 01/31/2012 |
| P.I.: | Horowitz, Carol R, M.D., M.P.H., Mount Sinai School of Medicine |
| VNS Health P.I. | Rosenfeld, Peri., Ph.D. |

### Improving Medication Management Practices and Care Transitions through Technology (IMPACT) – Focus on the Cognitively Impaired

This study extended the medication optimization intervention developed through the AHRQ-funded IMPACT initiative to the cognitively impaired patient population and their caregivers. Specifically, it 1) implemented the IT intervention to improve management for cognitively impaired patients in home health care with complex medication regimens; 2) examined the effects of the intervention on medication management practices of intervention home health care nurses serving cognitively impaired patients compared to usual care; and 3) examined the effects of the intervention on patient/caregiver outcomes and service use.

| | |
|---|---|
| Sponsor: | The Center for Technology and Aging, SCAN Foundation |
| Dates: | 01/01/2010 - 12/31/2010 |
| P.I.: | Feldman, Penny H., Ph.D. |

### Develop a Patient-Centric Geriatric Homecare Management Model

The Center for Home Care Policy & Research evaluated the outcomes of the Patient Centered Care Model (PCCM) developed and piloted by the VNSNY Long-term Care Home Health Care Program (also known as Lombardi) in three teams in Queens. The evaluation sought to demonstrate whether the PCCM interventions, which include elements of two Transitional Care Models (Coleman and Naylor), result in increased patient readiness in self-management, increased patient knowledge of medications, reduced hospitalizations, reduced ER visits and stabilized functional status, among others. The evaluation used a multi-methods approach including both qualitative and quantitative analyses, including secondary analysis of OASIS data, as well as data compiled through surveys and other tools.

| | |
|---|---|
| Sponsor: | Atlantic Philanthropies |
| Sponsor: | United Hospital Fund |
| Dates: | 01/01/2010 – 09/30/2011 |
| P.I.: | Sarli, Gail, RN, NP |
| P.I.: | Rosati, Robert J., Ph.D. |
| P.I.: | Rosenfeld, Peri, Ph.D. |

### Cornell-Columbia Translational Research Institute on Pain in Later Life (an Edward R. Roybal Center)

This center grant translated the findings of basic behavioral, medical, public health, and social science research into treatments, intervention programs, and policies that improve the health and well-being of older adults who suffer from or are at increased risk for pain. A second and related goal of the center is to promote translation of evidence-based practices, treatments, and interventions across diverse venues to improve management of pain in later life.

| | |
|---|---|
| Sponsor: | National Institute of Aging (NIA) |
| Dates: | 10/01/2009 – 09/30/2014 |
| P.I.: | Reid, Cary, M.D., Weill-Cornell Medical College |
| VNS Health P.I.: | Murtaugh, Christopher M., Ph.D. |

### Self-Management of Urine Flow in Long-Term Urinary Catheter Users

This study used a two-arm randomized clinical trial design to test the effectiveness of a urinary catheter self-management intervention developed by the PI based on previous work. The study was conducted at two sites: the University of Rochester and the Visiting Nurse Service of New York (VNSNY). The experimental intervention was designed to enhance self-management of urine flow in individuals with long-term urinary catheters, with the goal of decreasing catheter related complications and enhancing quality of life.

| | |
|---|---|
| Sponsor: | National Institute of Nursing Research (NINR) |
| Dates: | 09/24/2008 – 06/30/2012 |
| P.I.: | Wilde, Mary, RN, Ph.D., University of Rochester School of Nursing |
| VNSNY PI: | Feldman, Penny H., Ph.D. |

### Improving Medication Management Practices and Care Transitions through Technology (IMPACT)

The goal of this study was to conduct a randomized trial to examine the effectiveness of a comprehensive information technology (IT) strategy to improve management for home health patients at risk of a potentially serious medication problem due to the complexity of their medication regimen. The intervention combined clinical information systems, clinician alerts and a clinical decision support (CDS) tool – complemented by patient education materials. Primary analyses were completed on 3 samples: full intent-to-treat, a survey subsample, and the intervention group, where we examined the effect of nurses CDS use on patient outcomes.

Sponsor: Agency for Healthcare Research and Quality (AHRQ)
Dates: 09/30/2008 - 09/29/2011
P.I.: Feldman, Penny H., Ph.D.

### Promoting Readiness and Interest in Self-Management (PRISM)

The purpose of the project was to promote patient-centered care by identifying and providing recommendations to overcome barriers and to cultivate facilitators of clinician involvement in promoting patient self-management. Specifically, this research : (1) evaluated psycho-social and clinical/ functional determinants that influence a change in patients' activation levels over time; (2) examined patients' perspectives on their involvement in their care; (3) investigated factors that may help or hinder home care nurses promotion of self-management and patient engagement; (4) provided recommendations to improve clinician education and patient interventions. This descriptive effort used data and a patient population recruited for the Home-Based Blood Pressure Interventions for African Americans study (funded by the National Heart Lung & Blood Institute) and targeted home care nurses employed by the study organization. Findings from the PRISM study provide important information to inform the future development of more effective patient engagement and self-management promotion strategies.

Sponsor: Robert Wood Johnson Foundation
Dates: 07/01/2008 – 03/31/2010
P.I.: Feldman, Penny H., Ph.D.
Co-P.I.: Gerber, Linda, Ph.D., Weill-Cornell Medical College

### The Geriatric CHAMP Program as an Expansion of a Framework for Geriatric Home Care Excellence

To guide the improvement of quality in geriatric home care, the Research Center created a multifaceted home care practice change effort by leveraging the National Framework for Geriatric Excellence ("Framework") and CHAMP projects and expanding the scale of the overall effort. We built on CHAMP's reputation, "brand" and implementation expertise to promote awareness and support implementation of the evidence-based Framework findings. We also capitalized on the prestigious names of CHAMP's major funders – the Atlantic Philanthropies and the John A. Hartford Foundation – both of which are closely associated with improving the lives of older adults.

Specifically, the expanded Geriatric CHAMP Program sought to achieve three broad aims: 1) Build geriatric capacity in a significant number of home care agencies nationally; 2) Establish an active, ongoing Community of Practice to motivate and support quality improvement in geriatric home care; and 3) Achieve significant, measurable improvement in home care for older persons.

Over the project period, the Center:

- Maximized spread of existing CHAMP courses and develop new courses for nurse managers.
- Developed a national Geriatric Community of Practice for excellence in care of older persons at home and a robust web-based resource of evidence-based tools and materials to support the Community
- Undertook branding and marketing activities.
- Developed and marketed products for front-line nurses.
- Assessed the Geriatric CHAMP Program on an ongoing basis.

Sponsor: The John A. Hartford Foundation
Sponsor: The Atlantic Philanthropies
Sponsor: California Health Care Foundation
Sponsor: New York State Health Foundation (NYSHF)
Dates: 10/01/2008 – 09/30/2011
P.I. : Feldman, Penny H., Ph.D.

### Establishing a National Framework for Geriatric Home Care Practice

This project developed a national consensus on a framework to improve geriatric home care practice. The goal of the project was to influence the future of geriatric home care by making the framework available to accrediting agencies, public and private purchasers and home care organizations to guide and assess the delivery of home health services to older persons. The project aims were:

- Achieve national consensus on industry wide geriatric goals, guidelines and priority improvement areas
- Recommend evidence-based strategies for improving geriatric practice
- Raise national awareness about the importance of a framework for improving home care for older persons

To achieve its aims, the project conducted a series of information gathering activities including: 1) an environmental scan of existing resources, 2) an open solicitation of best geriatric practices, 3) a series of focus groups, 4) in-depth interviews with key informants, and 5) commissioned white papers. A comprehensive consensus development process was guided by a National Advisory Council. A national home care stakeholder conference was convened to discuss and assimilate the new national geriatric framework and to stimulate subsequent dissemination and implementation activities. Outcomes included: 1) the first national geriatric special interest group in the home care field, formed to keep geriatric home care excellence front and center in the future development of home care programs “on the ground”; 2) endorsement of the project’s national framework by key groups; and 3) input into the development of homecare standards. The project included a conference of national stakeholders, with experts from nursing, medicine, social work, pharmacy and paraprofessional groups, as well as representatives from consumer and family care giving organizations, and national homecare organizations.

Sponsor: John A. Hartford Foundation
Dates: 05/01/2007 – 02/28/2009
P.I.: Feldman, Penny H., Ph.D.

### First 30 Days: An Exploratory Study

The primary objective of this study was to describe the home care experiences of home care patients, their informal caregivers, and formal caregivers during the first 30 days following a patient's discharge home from the hospital. This ethnographic study used in-depth, in-home interviews and observation in patients' and/or caregivers' homes. In addition, telephone or in-person interviews with home care providers were conducted. Qualitative analysis to identified major themes in the way activities, interactions or experiences were described. It is hoped that themes can be used to inform the design of future interventions, provide better support to patients and care givers, facilitate smoother, safer transitions and lead to better outcomes.

Sponsor: Intel Corporation
Dates: 07/11/2007 – 05/10/2008
P.I.: Foust, Janice RN, Ph.D.

### Chinatown NNORC

Mia Oberlink asked to assist VNSNY Home Care Business Development in implementing quality improvement efforts at the VNSNY Chinatown NNORC.

Sponsor: DFTA, SOFA, Dreyfus Foundation
Dates: 04/01/2007 – 12/31/2017
P.I.: Oberlink, Mia, MA

### AIM: Testing an Advanced Illness Management Model

Numerous national and local initiatives have tried to increase awareness and use of hospice and palliative care by patients with advanced illness, who account for a large share of Medicare/Medicaid costs and often receive costly, hospital-based poorly managed care. As New York State seeks to downsize hospital capacity, new cost-effective models of non-hospital based advanced illness management are needed that can succeed within current regulatory and financial structures. In 2008-2009, VNSNY developed, implemented and evaluated an Advanced Illness Management (AIM) model of care. The goals of AIM were to improve the quality of care, increase use of hospice services and reduce hospitalization by improving advanced illness management for severely ill homecare patients. The AIM model included the following components: 1) an electronic algorithm to target the intervention to the most appropriate patients; 2) palliative care training and mentoring for generalist homecare nurses; and 3) integration of AIM expertise into homecare teams, instead of primary reliance on outside palliative care specialists. The evaluation used a randomized design to assess AIM's impact on hospice use, re-hospitalization and emergency department use as well as patient reports of quality of care and nurses' perceptions of advancement opportunity.

The AIM program yielded a statistically significant, positive impact on patient-reported pain control and involvement in advance care planning discussions with clinicians. Moreover, the program resulted in an increase in referrals to hospice. However, the program did not significantly increase hospice utilization or reduce the number of hospitalizations or emergency department visits.

Sponsor: New York State Health Foundation
Dates: 02/01/2007 - 01/31/2009
P.I.: Feldman, Penny H., Ph.D.

### Telemedicine Integration Project

This demonstration enhanced the adoption of Telemedicine as an adjunct and resource to home health care delivery by physicians, nurses and patients by making clinical data more accessible and easier to use. The project focused on integration of Telemedicine (TM) data into the VNSNY clinical data system to support transmission of graphical, tabular and trended Telemedicine data to nurses via their mobile patient record system. The program enrolled 300 patients annually for a total of 600 patients over the two

years of the demonstration. Episodes of care are projected to total 578 in each year for participating patients. The project benefited homecare patients in all five boroughs of New York City, Westchester and Nassau Counties, who represented a multi-cultural cross section of the patient population throughout the region. The proposed TM homecare demonstration, although not disease specific, was expected to demonstrate clinical, financial and humanistic outcomes for specific disease states. VNSNY demonstrated that making Telemedicine data available for integrated clinical operations would enhance nurse, physician and patient communication and support knowledge and decision-making at the point of care; promote prompt interventions in an earlier point in care thereby reducing emergency room visits and hospitalizations; preserve and improve the health status of the patient and provided improved access to care as well as produce clinical efficiencies. In addition, providing the nurse access to Telemedicine data, which could be shared with the patient during home visits, provided a visual reinforcement, which had the potential to promote adherence to the plan of care. Finally, the demonstration identified a number of factors influencing nurses, physicians and patients to promote or not promote the use of telehealth.

| | |
|---|---|
| Sponsor: | New York State Dept. of Health |
| Dates: | 01/01/2007 - 12/31/2008 |
| P.I.: | Rosati, Robert J., Ph.D. |

### Interdisciplinary Geriatric Research Center in NYC (IGRC) (Rand Hartford)

An interdisciplinary research approach is needed to address pressing problems associated with aging (e.g., chronic pain, functional disability, social isolation) given the complex nature of social, behavioral, and biological factors that frequently interact to precipitate these disorders as well as mediate associated outcomes. Partnering with community members and key agencies serving older adults, in addition, has immense potential to advance the science of geriatric care by generating better-informed hypotheses, developing more effective interventions, and enhancing translation of research to practice. The purpose of the New York City Interdisciplinary Geriatric Research Center (NYC-IGRC) was to promote Community-Based Participatory Research (CBPR) as a means of translating basic research into practice to improve the health and healthcare of older adults in NYC. Major activities included formation of an interdisciplinary Working Group composed of the IGRC's core investigators from VNSNY, Weill-Cornell Medical College and Cornell-Ithaca, to develop and promote interdisciplinary geriatric research among the three institutions, and implementation of a newly developed seminar series that provided specific training in CBPR for pre- and post-doctoral fellows and faculty, as well as master's level trained nursing and public health staff at VNSNY interested in research career development. Products from the project activities include an educational environment that fosters interdisciplinary geriatric research and productive community-based research partnerships, a cadre of researchers trained in CBPR, and pilot data for use in subsequent NIH proposals.

| | |
|---|---|
| Sponsor: | John A. Hartford Foundation |
| Dates: | 01/01/2007 - 12/31/2008 |
| P.I.: | Reid, Cary, M.D., Weill-Cornell Medical College |
| VNS Health P.I.: | Murtaugh, Christopher M., Ph.D. |

### Health Related Quality of Life: Elders in Long Term Care (HRQoL)

The Health Related Quality of Life (HRQoL) study was funded by the National Institute on Aging and the National Institute of Nursing Research and was led by the University of Pennsylvania School of Nursing.

This five-year project took place in several long-term care sites. The purpose of this project was to examine at the HRQoL of chronically ill elders who recently started to receiving long term care (LTC) services. The goal of the project was to examine the changing needs of older adults and if these needs differ among LTC settings (community/home, nursing homes and assisted living facilities). The study enrolled 125 patients with the intent of following them over a multi-year period. The patient's home health aide (HHA) were also interviewed to gather information on the patient's functional health and on selected observed behaviors.

| | |
|---|---|
| Sponsor: | National Institute on Aging (NIA) |
| Dates: | 09/01/2006 – 05/11/2011 |
| P.I.: | Naylor, Mary, Ph.D., University of Pennsylvania School of Nursing |
| VNS Health P.I.: | Foust, Janice, RN, Ph.D.<br>Murtaugh, Christopher M., Ph.D. |

### Pforzheimer Planning Grant: "Patients First"

This project conducted a scan of VNSNY's internal and external environments to better understand chronic care issues among home care patients and to identify promising opportunities for enhancing patient-centered care at VNSNY and in the wider home care sector. It also undertook several spin-off activities, including: 1) a large-scale survey of VNSNY patients to assess the range of patient readiness for self-care management, 2) patient interviews to assess the potential for building on VNSNY's information technology to enhance patient-centered support, and 3) a collaborative field study with the Intel Corporation to gain direct, "on the ground" knowledge of the home care experience from the vantage point of patients and families.

| | |
|---|---|
| Sponsor: | Carl & Lily Pforzheimer Foundation |
| Dates: | 12/01/2005 - 05/01/2009 |
| P.I.: | Feldman, Penny H., Ph.D. |

### Effect of the Patient Activation Measure on Chronic Care (PAM)

The purpose of this project was to test the effectiveness of an intervention -- in a chronically ill managed long term care population -- that provided nurse Care Managers and their interdisciplinary teams with a change package of evidence-based hypertension management strategies. The package contained a range of interventions that could be individualized and geared to each patient's Patient Activation Measure (PAM) score. The Care Teams randomized into the intervention group used the change package in conjunction with a patient's PAM score to design an individualized management plan for their active HTN patients. The four PAM stages included: (1) Believes Active Role Important, (2) Confidence and Knowledge to Take Action, (3) Taking Action, and (4) Staying the Course Under Stress. The quantitative analysis estimated the impact of the intervention on patient knowledge and self-management skills and blood pressure outcomes In addition to the quantitative analysis, a qualitative analysis was conducted on the implementation of the intervention, and the perceived usefulness of the Visual Scan Assessment as a tool to increase feedback to Care Managers.

| | |
|---|---|
| Sponsor: | Agency for Healthcare Research & Quality (AHRQ) |
| Dates: | 09/15/2005 - 09/30/2007 |
| P.I.: | Gerber, Linda, Ph.D., Cornell University Medical Center |

VNS Health P.I.: Feldman, Penny H., Ph.D.

### Promoting Healing Through Falls Prevention Among Older Adults: Linking Family And Formal Home Health Caregivers

Relatively little attention has been given to preventing falls among convalescing older adults in a home health setting. Moreover, among published studies, interventions have not taken into account the impact of the patients' social environment (i.e., family support care) on falls prevention. Since family caregivers are an integral part of the patient care system and play an important role in the recovery process, the primary goal of the proposed project was to enhance family caregivers' involvement in the recovery process of homebound older adults at risk for falls. The key objective of the project was to demonstrate that involving family caregivers in the recovery process of older homebound adults at risk for falls will enhance such patients' healing trajectory, resulting in improved physical functioning, shortened recovery periods, and a reduction in the incidence of adverse events including recurrent falls, unanticipated hospitalization, and emergent care use. The project tested an intervention that provided training to family caregivers and family caregivers in the intervention group with information on the risk of falls and fall-preventive techniques during home health visits and/or telephone consultations from home health staff. The intervention was designed to: (1) build family caregivers' ability to enhance the patients' healing process; (2) improve home health patients' physical functioning; and (3) enhance the recovery period by reducing the recurrent incidence of falls that impede the healing process.

Sponsor: Jacob and Valeria Langeloth Foundation
Dates: 07/01/2005 - 06/30/2007
P.I.: Murtaugh, Christopher M., Ph.D.

### Enhancing Palliative and Home Hospice Care Services to Minority Patients

The specific aims of this study were: (1) to examine the barriers to home hospice referrals within the Visiting Nurse Service of New York (VNSNY), with a particular emphasis on minority populations; and (2) to create and test a pilot intervention with a sample of VNSNY acute care nurse coordinators of care and patients that would (a) enhance the quality of palliative and end-of-life care for minority patients; (b) increase hospice referral rates of eligible patients, with an emphasis on minority patients; and (c) increase the length of time in the hospice program through earlier referral of eligible patients from VNS Acute Care program to its Hospice Program.

Sponsor: Aetna Foundation
Grant No: 854216
Dates: 12/01/2004 – 06/30/2005
P.I.: Fleischman, Alan, M.D., NY Academy of Medicine
VNSNY Co-P.I.: Dennis, Jeanne
VNSNY Co-P.I.: Navaie-Waliser, Maryam, Dr.P.H.
Dates: 07/01/2005 – 05/31/2006
VNSNY Co-P.I.: Murtaugh, Christopher

### A Home Health Setting Collaborative Change Package to Enhance Quality of Care for Patients with Chronic Conditions and Avoid Unnecessary Hospitalization Admissions

The primary objective of this project was to develop and test a comprehensive Change Package that can be used by Quality Improvement Organizations as they help their Home Health Agencies (HHAs) implement improvement initiatives to improve patient outcomes and to reduce avoidable hospitalization for their patients with chronic conditions. In partnership with the Visiting Nurse Service of New York's Center for Home Care Policy and Research, the Delmarva Quality Improvement Organization (QIO) developed an Acute Care Hospitalization Change Binder (the Change Binder). The Change Binder was pilot-tested with participating HHAs and QIOs. The project team then tracked the HHA/QIOs progress in using the Change Binder, analyzed the results, and made recommended changes to the materials in the Change Binder as appropriate. These suggested changes were identified via interviews and surveys with the participating QIOs and HHAs. CMS introduced the main product from this study, the Change Binder, for use at the national level by QIOs and HHAs in the 8th Scope Of Work beginning in August 2005.

Sponsor: Centers for Medicare and Medicaid Services (CMS)
Dates: 10/18/2004 - 08/12/2005
P.I.: Feldman, Penny H., Ph.D.

### Home Health Aide Partnering Collaborative: Evaluation

Recent years have seen a growing interest in strategies to develop the capacity of the Home Health Aide workforce and better integrate these paraprofessionals into care delivery. However, little research has been conducted to rigorously evaluate such strategies or assess the linkages between aide integration and job satisfaction, on the one hand, and patient outcomes, on the other. To address this knowledge gap, we evaluated the "Home Health Aide (HHA) Partnering Collaborative" which the Visiting Nurse Service of New York (VNSNY) launched in 2003. The HHA Collaborative was designed to better integrate professional and paraprofessional services and employ established principles of quality improvement to achieve two main goals: (1) improving the quality of work life of home care paraprofessionals, and (2) increasing nurses' and aides' support for patients' improvement in key activities of daily living.
The specific aim of the Collaborative was "to optimize the role of the HHA as part of a care team, resulting in patient services matching need, better [patient] self-care management, continuity of care, and improved satisfaction (HHA, patient and staff)." The major impact of the Collaborative was on patients' functional outcomes. During the randomized trial, patients in the intervention group showed greater levels of improvement in the ability to walk and get in and out of bed than patients in the control group. These improvements were achieved without additional home care visits and were sustained during the agency-wide spread period. However, the improvements were modest and were not seen in the original control group after joining the agency-wide spread. The initiative did not show an impact on home health aide job perceptions or retention. Rather, the number of hours an aide worked was the strongest predictor of whether or not he/she stayed on the job; this suggests that increasing access to a full workload may improve job retention for home health aides.

Sponsor: Office of the Assistant Secretary for Planning and Evaluation (ASPE)
Dates: 10/01/2004 - 09/30/2007
P.I.: Feldman, Penny H., Ph.D.

### Development of E-Transitions Tools for Home Health Care

The transition from hospital to home care is an area that requires significant attention. Poor communication between providers, a lack of physician involvement in designing the care plan, and the use of handwritten and verbal orders all can lead to errors and adverse events. This project, conducted jointly with Weill Medical College of Cornell University, evaluated the impact of a redesigned and automated CMS 485 (i.e., the Centers for Medicare and Medicaid Services' Home Health Certification and Plan of Care form). The redesign of the CMS 485, completed in Phase 1 of the project, was intended to promote physician involvement in discharge planning, increase the amount and accuracy of information available to providers at the time of patient transitions, and promote the adoption of evidence-based practices. The project also further developed and pilot tested e-transitions, a web-based hospital-home care transitions intervention intended to improve care and outcomes for heart failure and other patients. To evaluate the impact of the redesigned CMS 485, the process of care and outcomes of patients one year before and one-year after implementation were compared. In the final months of the project, the web-based system of communication (e-transitions) was pilot tested. Subsequently, focus groups with physicians and home health nurses participating in the pilot test were conducted as well as telephone interviews with patients of participating physicians. The purpose of the focus groups and telephone interviews was to collect information in the areas of user-computer application interface, content of electronic messages, and clinical value of electronic communication.

| | |
|---|---|
| Sponsor: | Agency for Healthcare Research & Quality (AHRQ) |
| Dates: | 10/01/2004 - 09/30/2006 |
| P.I. : | Callahan, Mark, M.D., Weill-Cornell Medical College |
| VNS Health P.I.: | Murtaugh, Christopher., Ph.D. |
| VNSNY Co-P.I.: | Rosati, Robert J., Ph.D. |

### Curricula for Homecare Advances in Management and Practice (CHAMP)

This program addressed a series of interrelated problems that had led to suboptimal geriatric care for many home health care patients and took advantage of a changing environment that had created stronger incentives for home health agencies to put quality of care for this patient population at the top of their strategic goals and priorities. The problems were that: 1) home care nurses are inadequately prepared in geriatric care; 2) continuing education for home health nurses is variable and outmoded; 3) home health care managers lack the management and teaching skills necessary to help them supervise and support nurses in achieving improved outcomes for geriatric patients; and 4) inadequate training and staff development opportunities for home healthcare managers and nurses detract from job satisfaction and quality of care. The purpose of the initiative was to improve care for older patients served by home health agencies and to embed in those agencies the capacity for continuous practice improvement. The specific aim was to develop and test a sustainable training model for frontline nurse managers, who are trained to use quality improvement techniques to help the nurses they manage employ "best geriatric practices" in the care of their older patients. Successful implementation of the training program, which was conducted twice over a four-year project period, reached approximately 300 frontline managers, 3,000 nurses under their supervision, and 150,000 to 200,000 older patients in the short run.

Specifically the project:

A. Developed two geriatric best practice content modules focused on significant clinical or functional problems of older home healthcare patients – pain and medication management.
B. Developed a curriculum for frontline managers in HHAs focused on "managing and teaching for improvement."

C. Designed, tested and refined a multimode training model for the home healthcare managers combining, Face-to-face workshops; Group coaching calls; E-learning modules combining instruction in geriatric content with problem solving tools and exercises to be applied by managers with frontline nurses under their supervision; and An "E-measurement" system designed so that program participants can enter the data from simple record reviews into the program's web-based database and obtain repeat measurements of their progress toward reaching practice improvement goals
D. Conducted two iterations of training during the project period.
E. Evaluated the model to a) provide "formative" information for refining its individual components and overall design, and b) assess its impact on the participating organizations and the geriatric practices selected for improvement.
F. Established a firm structure for spread and sustainability.

Sponsor: The Atlantic Philanthropies through Visiting Nurse Association of America (VNAA)
Dates: 10/01/2004 – 12/31/2008
P.I.: Feldman, Penny H., Ph.D.

### Home-Based Blood Pressure Interventions for African Americans (HTN Study)

The goal of the study was to conduct a randomized trial to examine the effectiveness and cost-effectiveness of two organizational interventions aimed at improving BP control among an especially high-risk population, African Americans receiving home care. The two interventions being tested were (i) a "basic" intervention delivering key "just-in-time" information to nurses, physicians and patients while the patient is receiving traditional post-acute home health care; and (ii) an "augmented" intervention transitioning patients to a Home-Based HTN Support Program that extended the information, monitoring and feedback available to patients and primary care physicians for an 12-month period beyond an index home care admission.

Sponsor: National Heart, Lung, & Blood Institute (NHLBI)
Dates: 09/30/2004 – 11/30/2011
P.I.: Feldman, Penny H., Ph.D.

### Palliative Care and Hospice Consultation

The "PCC" project was designed to provide non-hospice patients in VNS Acute Care with the social, emotional and physical support necessary to manage pain and confront the realities of their illnesses. The core of the project, the Palliative Care Consultation (PCC) Team, consulted with patients, their VNS home care nurses and other health care providers to coordinate services and communication as well as to assist with the transition to hospice. Originally consisting of a hospice nurse practitioner and medical director, in the second year of the program, the team was expanded to include an additional nurse practitioner to enable the team to serve more patients and families, and funding was secured to add a part time social worker.

Through a collaborative process, the interdisciplinary PCC team implemented a four-pronged effort to: (1) increase palliative care and hospice awareness and information among VNS acute care staff, (2) identify patients who might benefit from palliative care, (3) assess the scope of their physical, emotional and spiritual needs, with particular focus on relief of pain, and (4) intervene with

recommendations to address ways to relieve symptom burden in all realms. The project was found to significantly increase hospice admissions among those patients who received a PCC consultation.

| | |
|---|---|
| Sponsor: | Starr Foundation |
| Dates: | 04/01/2004 - 06/30/2006 |
| P.I.: | Navaie-Waliser, Maryam, Ph.D. |
| Co-P.I.: | Feldman, Penny H., Ph.D. |
| Co-P.I.: | Dennis, Jeanne, Director, Hospice |

### Early Head Start Fatherhood Initiative

The project's objectives were to (1) assist in the reduction of infant mortality throughout the Far Rockaway Community, (2) increase paternal participation in childrearing, (3) empower fathers and mothers as caretakers of their children and families by helping them obtain necessary knowledge and skills, and (4) link children and their families through referrals to needed services to enhance health and well-being.

| | |
|---|---|
| Sponsor: | New York City Department of Health |
| Dates: | 12/02/2003 - 06/30/2004 |
| P.I. : | Navaie-Waliser, Maryam, Ph.D. |

### Beatrice Renfield Nursing Research Program

The aim of the Renfield Nursing Research Program is to support work the development and dissemination of new models of home health nursing practice and education that can significantly enhance patient care, increase professional satisfaction and influence the nursing arena both internally and nationwide.
Specifically, the Program aims to:

- Support and promote the practice of evidence-based home nursing care that optimizes service quality and patient outcomes
- Maximize the professionalism, satisfaction and impact of home health nurses
- Heighten the visibility and importance of home health nurses in the health care work force
- Influence nursing school curricula and the training of future home health/community nurses
- Demonstrate the value of investing in work force development and practice changes
- Attract outside philanthropic and government resources to support the development of innovative models, materials and educational technology

Major activities under this program include:

**The Beatrice Renfield Evidence-Based Practice Improvement Fellow Program**

The primary purpose of the Renfield EBPI Fellows Program is to provide clinical staff with the knowledge, skills and opportunities to evaluate and apply relevant evidence to improve practice that addresses VNSNY quality initiatives and strategic priorities. The clinical manager is in a pivotal position to create and support a professional climate that integrates evidence-based practice improvement into daily practice in a way that is relevant and sustainable. In its formative stage the Fellows program trained 15 Fellows who applied their new knowledge and skills to

implement practice improvement projects in the areas of pain and medication management. In 2011 the Fellows program adopted a "train the trainer" model so that Quality Improvement Specialists in every region can train others to incorporate EBPI principles into practice improvement initiatives across the organization.

**The VNSNY Clinical Lecture Series for Frontline Managers**

This lecture series, started in the fall of 2004, provides a program of four lectures each year. The goal of the series is to expose VNSNY staff to the best academic nursing science by inviting experts to speak on topics relevant to their work. Through first-rate lectures and lively post-lecture discussions, VNSNY staff learn how the best, most recent research can be used to inform care in people's homes.

**Sponsorship of the Home Healthcare Nurse Research Brief Column**

Quarterly columns describing published research articles relevant to home healthcare are produced by VNSNY nurses and other staff. This effort engages clinicians in reviewing evidence from a variety of different service settings which they then translate to implications for home health service delivery.

| | |
|---|---|
| Sponsor: | Beatrice Renfield Foundation |
| Dates: | 06/01/2003 – ongoing |
| P.I.: | Bowles, Kathryn, RN, PhD, FACMI, FAAN |
| Co-P.I.: | McDonald, Margaret, M.S.W. |

### Partnership for Achieving Quality Homecare (PAQH)

This project launched a national partnership among home health care providers to improve care for a priority population--elderly home care recipients. It created a model and established an infrastructure through which collaborating organizations could 1) identify and prioritize aims for improvement, and 2) gain access to methods, tools, and materials that enabled them to conduct more sophisticated evidence-based quality improvement activities than they could individually. The partnership initially comprised six home health agencies from across the United States and ultimately expanded to include more than 150 agencies across the U.S. A learning collaborative model, adapted from the successful breakthrough series approach developed by the Institute for Healthcare Improvement (IHI), was created to serve as a central mechanism of the partnership. The two main topics that were addressed were improving the quality of home care for patients with diabetes and reducing avoidable hospitalizations. The development of "tool kits" of materials and techniques provided partnership members, as well as other home health care organizations interested in quality improvement, with easily accessible resources for translating research findings into daily practice.

| | |
|---|---|
| Sponsor: | Agency for Healthcare Research & Quality (AHRQ) |
| Dates: | 09/30/2002 - 09/29/2006 |
| P.I. : | Feldman, Penny H., Ph.D. |

### Improving Transitions and Outcomes for Heart Failure Patients through a Hospital-Home Care Information Exchange

This project designed and pilot tested an information-based hospital-home care transition intervention intended to improve care and outcomes for heart failure patients. The intervention was designed to improve communication among members of the transition team at discharge and at readmission to:

- Increase "on-time," safe, appropriate hospital discharge

- Reduce medical errors associated with hand-offs
- Reduce unnecessary re-hospitalizations, and improve patient outcomes

The first phase of the project pilot tested the electronic exchange of clinical information on heart failure patients during transition from hospital to home care. The information exchange included post-acute care instructions and rapid feedback of selected home health agency intake data to patients' physicians for review and revision. The intervention built on existing hospital and home health agency data, tools and platforms. These included hospital generated assessment and discharge information; the CMS 485/486 which is used by the physician to certify and recertify an individual's need for home care; automated home health agency assessment data (OASIS), and records of communications with physicians and other coordination of care notes; and electronic devices or mechanisms to transmit the information and trigger appropriate actions.

| | |
|---|---|
| Sponsor: | Agency for Healthcare Research & Quality (AHRQ) |
| Dates: | 08/01/2002 - 05/31/2004 |
| P.I.: | Callahan, Mark, M.D., Weill-Cornell Medical College |
| VNS Health P.I.: | Murtaugh, Christopher M., Ph.D. |
| VNSNY Co-P.I.: | Feldman, Penny H., Ph.D. |
| VNSNY Co-P.I.: | Rosati, Robert J., Ph.D. |

### Working Conditions & Adverse Events in Home Health Care

The goal of the project was to describe the relationships between and among key features of the organizational work place, the nursing work force and adverse events due to preventable errors in the home health care setting. The project focused on four specific aims: 1) to estimate the effects of variations in the nursing team environment on rates of adverse patient events; 2) to estimate the relationship between adverse patient events and measurable variations in the characteristics of individual nurses such as training, experience and skills, as well as nurses' physical and mental health, morale and job satisfaction; 3) to examine how a nurse's productivity, measured by home health visits per day or week, affects or is affected by an adverse patient event; 4) to review medical records to better understand the relationship between adverse events and specific types of patient care errors, defined as deficiencies in the execution or planning of care by front line nurses.

| | |
|---|---|
| Sponsor: | Agency for Healthcare Research & Quality (AHRQ) |
| Dates: | 10/01/2001 - 09/29/2005 |
| P.I.: | Feldman, Penny H., Ph.D. |

### Patient Safety in Home Care: Developmental Center for Evaluation and Research in Patient Safety

The project involved a partnership between the Division of Nursing (DON), School of Education at New York University (NYU), and the Center for Home Care Policy and Research at the Visiting Nurse of New York (VNSNY). The goal of the partnership was to enhance the intellectual resources, disciplinary skills, measurement tools and organizational techniques for understanding and teaching about medical errors in home health care and designing and evaluating mechanisms for learning from such errors and reducing them. The project: 1) developed a multi-disciplinary team to conduct research on patient safety, 2) strengthened the ties between NYU-DON and VNSNY, 3) developed educational programs on the importance of patient safety and evidence-based approaches to improving it, and 4) conducted pilot

research studies, including a descriptive study of nurse medication teaching and administration errors and an exploration of the role of automated drug utilization review in reducing potential adverse events.

| | |
|---|---|
| Sponsor: | Agency for Healthcare Research & Quality (AHRQ) |
| Dates: | 10/01/2001 - 09/30/2004 |
| P.I.: | Kovner, Christine, Ph.D., New York University |
| VNS Health P.I.: | Feldman, Penny H., Ph.D. |

### Early Head Start

The VNSNY Early Head Start Program is a comprehensive child health and development program serving 75 pregnant and parenting teens and their infants and toddlers in Rockaway. A broad range of services are provided including prenatal and postpartum nursing care, childbirth preparation, education and support groups for mothers and fathers, home visits to enhance child health and development, and center-based child care services. In collaboration with the Research Center, a comprehensive program evaluation was begun in the Fall of 2001. The evaluation used both qualitative and quantitative methodologies to examine: (a) process measures focusing on operational, programmatic, and staff-related activities; and (b) outcome measures related to family outcomes (e.g., parent-child bonding and quality of life), parental health and development outcomes (e.g., physical and emotional health, knowledge and skills development), child health and development outcomes (e.g., birth outcomes, immunizations, preventive care, and physical and emotional growth development); (c) staff development outcomes (e.g., skills and knowledge advancement), and (d) community outcomes (e.g., collaborative arrangements, linkages to community networks, parent participation in community activities, and satisfaction with program services in targeted communities).

| | |
|---|---|
| Sponsor: | Department of Health and Human Services |
| Dates: | 09/01/2001 - 09/30/2006 |
| P.I.: | Navaie-Waliser, Maryam, Ph.D. |

### Effort for Quality Improvement and Performance in Home Health Care (EQUIP)

This initiative had two main objectives. First, it assessed the current knowledge base for supporting home health care quality improvement to identify ways to improve its relevance and accessibility. Second, it developed a model for collaboration among home health care providers and researchers to improve quality performance. To accomplish these ends, it conducted a set of three interrelated activities with knowledge synthesis, knowledge sharing and model building at their core. The three sets of activities were 1) the preparation and dissemination of synthesis papers, 2) the convening of meetings informed by those papers, and 3) the design and initial development of a model practice consortium involving collaboration among home health care providers and researchers.

| | |
|---|---|
| Sponsor: | Robert Wood Johnson Foundation |
| Dates: | 08/01/2001 - 07/31/2007 |
| P.I.: | Feldman, Penny H., Ph.D. |

### The Road to Recovery: The Effects of Informal and Formal Home Health Care Services on Older Adults

The purpose of this study was to determine: (1) how informal and formal care affect the physical and psychological recovery of adult home care recipients with several common home health admission conditions, (2) whether there is a relationship between the use of informal and formal care, and (3) how the various components of informal and formal care interact with each other. The study was conducted in three phases over a three-year period. Phase I focused on prospectively identifying and recruiting adult home health recipients with two of three tracer conditions (congestive heart failure, joint replacements, or surgical wounds). Additional activities included survey design, instrument reliability and validity testing, and pilot testing. Phase II involved primary data collection from four main sources including VNSNY's clinical and administrative databases, in-home and telephone interviews with home health recipients, and electronic mail surveys administered to formal caregivers (nurses or therapists). Phase III concentrated on the application of various statistical methodologies to conduct data analysis and interpretation.

Sponsor: Jacob and Valeria Langeloth Foundation
Dates: 01/01/2000 - 06/30/2003
P.I.: Navaie-Waliser, Maryam, Ph.D.

### Black Elders in Home Care: Contributors to Successful Recovery

The purpose of this study was to understand how and why recovery rates differ between black and white elderly patients at VNSNY, so that the information gained can be used to improve the provision of care and patients' outcomes. The project examined the dimensions and extent of differences in the recovery of black and white elders who receive formal home care, and the contributions of key psychosocial and situational factors to their recovery. The focus of the project was on black elderly patients who entered care after a fracture requiring surgery and internal fixation, or who had been diagnosed with diabetes secondary to decubitus ulcer. The project included an analysis of the VNSNY administrative and OASIS databases to determine differences in outcomes of home health care recipients after adjusting for health-related case mix. In-home interviews of patients with the tracer conditions were conducted to understand how psychosocial factors, along with readily available measures of clinical illness, demographics, and access to care, affected outcomes. The findings of the research were designed to help guide efforts to develop and promote policies that ensure equitable provision of care for vulnerable populations in need of home health services.

Sponsor: Jacob and Valeria Langeloth Foundation
Dates: 01/01/2000 - 06/30/2002
P.I.: Peng, Timothy, Ph.D.

### Evidence-Based E-Mail "Reminders" in Home Health Care

This project tested the relative effectiveness and cost-effectiveness of alternative information-based strategies designed to improve provider performance and promote adherence to evidence-based practice guidelines among home health care nurses. The study employed a randomized design that assigned nurses to treatment or control groups. The treatment groups consisted of nurses receiving either “basic” or “enhanced” email reminders with evidence-based practices for patients diagnosed with heart failure or cancer pain The analysis estimated the impact of the interventions on nursing practices and processes of care, patient outcomes, and costs. It found that the just in time reminders significantly improved nursing practices and patient outcomes for heart failure patients and that the basic reminder intervention was

more cost effective than an enhanced intervention that offered more guidelines and additional consulting by advanced practice nurses.

Sponsor: Agency for Healthcare Research & Quality (AHRQ)
Dates: 10/01/1999 - 03/31/2004
P.I.: Feldman, Penny H., Ph.D.
Co-P.I.: Murtaugh, Christopher M., Ph.D.

### Home Health Outcomes Assessment Initiative

This project was designed to support additional data collection, analytic work and preparation of informational materials under VNSNY's Home Health Outcomes Initiative. Activities were designed to transform VNSNY's internal data initiative into useful information for developing home health standards, improving service delivery, and addressing broader resource allocation questions that are important to the research community, as well as to local, state and national policymakers. Specific activities of the project were: preparation of practice- and policy-relevant user friendly information that can be disseminated to key decision-makers within VNSNY and in the broader health care community, and expansion of our data collection and analysis activities to include patient assessments at a fixed point post-admission. The aim of this supplemental assessment activity was to help disentangle the relative effects of length of stay, service intensity (i.e., number of visits or hours per day or week) and natural progression of patient change in health and functional status. This allowed us to address a potential problem posed by using disparate lengths of stay to estimate appropriate home care service use and to examine outcomes.

Sponsor: New York Community Trust
Dates: 10/01/1998 - 01/31/2000
P.I.: Feldman, Penny H., Ph.D.

### Transitions among Post-Acute & Long-Term Care Settings

In the last two decades, the number of people aged 65 and older who receive formal health care services after discharge from an acute care hospital has grown substantially, and will continue to expand as the population ages. Despite this growth, very little is known about seniors' transitions to or from post-acute and long-term care settings and how such transitions affect their health. This study sought to identify the frequency and patterns of transitions to or from post-acute and long-term care settings (rehabilitation facilities, nursing homes, care settings such as psychiatric facilities, and formal home health care), for a nationally representative group of seniors. The study also aimed to identify events that might indicate problems with transitions and the frequency with which these events occurred. Based on analysis of data from the 1994 National Long Term Care Survey and Medicare claims linked to the survey, the study found that almost 18 percent of seniors, or 4.9 million persons, were admitted to or discharged from a post-acute or long-term care setting between 1992 and 1994. A sizeable number of these elders (22.4 percent) subsequently used health care services within 30 days, suggesting possible transition problems. Discharges from hospitals to formal home care represented 20.8 percent of all transitions and tended to be followed by the greatest number of potential problems.

Sponsor: National Institute on Aging (NIA)
Dates: 09/01/1998 - 11/30/1999
P.I.: Murtaugh, Christopher M., Ph.D.

### Implementation and Evaluation of Health Outcomes Management and Evaluation (HOME© Plans) for Home Health Patients with Diabetes

The New York State Health Services Quality Improvement (HSQI) Grants Program provided funding for continued assessment of a multi-faceted improvement strategy centered on home health protocols of Health Outcomes Management and Evaluation (HOME©) Plans (PHASE 2) designed for specific high-cost, high frequency chronic conditions. Building on the study design and achievements of the congestive heart failure study funded in 1996, this project assessed a HOME© Plan-based intervention for patients with diabetes. Specifically, the aim of the Diabetes Mellitus HOME© Plan study was to determine if a nurse-coordinated intervention--consisting of a specialized care plan, a medication adherence tool, and a telephone support component--would lead to improved medication adherence and glycemic control in older patients with diabetes mellitus. Outcomes of interest were patient perceptions of the care process, and changes in service use, health status, functioning, and health-related quality of life. The intervention was found to have a significant but modest impact on glycemic control – patients in the intervention group achieved better control than those in the comparison group.

| | |
|---|---|
| Sponsor: | New York State Department of Health |
| Dates: | 09/01/1998 - 12/31/1999 |
| P.I.: | Feldman, Penny H., Ph.D. |

### Preferences for Everyday Living Inventory (PELI) Project

Frail elders with disabilities often require a variety of care services, yet current approaches to care generally fail to incorporate elders' preferences for how they wish to live their daily lives. Incorporating such preferences can greatly improve quality of life, but no scientifically tested instrument exists to capture these preferences and translate them into care practices. This study sought to pilot-test a questionnaire that would capture elders' preferences for everyday living. Such an inventory of preferences could be used to tailor services to individuals receiving long-term care and could serve as an "advance directive" should seniors become cognitively impaired. Researchers administered the pilot questionnaire through interviews with 604 clients of the Visiting Nurse Service of New York. Patients and adult family members, most often the patient's child, were also interviewed to assess the ability of family members to act as proxies for their elders. In addition to researcher-administered interviews, the study also tested administration by three subsets of interviewers: nurses, family members, and patients who self-administered the questionnaire. Following the pilot tests, health care professionals were asked for their views on the usefulness of the pilot instrument.

| | |
|---|---|
| Sponsor: | Fan Fox and Leslie R. Samuels Foundation, Inc. |
| Dates: | 05/01/1998 - 03/31/2000 |
| P.I.: | VanHaitsma, Kimberly, Ph.D., Polisher Research Institute (formerly Philadelphia Geriatric Center) |
| VNS Health P.I.: | Feldman, Penny H., Ph.D. |

### The Bridge Program: Effecting a Successful Transition from Hospital Emergency Department to Treatment at Home

This was a planning grant for a pilot project to test the feasibility of a collaborative home care/hospital project to avert unnecessary inpatient hospitalizations among elderly patients presenting at a hospital

emergency room. Through collaboration between the VNSNY Research Center and the Office of Clinical Effectiveness at Columbia Presbyterian Medical Center (CPMC), the project analyzed multiple emergency department visits and subsequent hospitalizations. This analysis identified elderly patients with community acquired pneumonia as a potential target group for an intervention to reduce avoidable hospitalizations. Due to numerous technical and institutional barriers, however, the two organizations decided that the timing was not ripe to pursue a full-blown intervention project.

Sponsor: Fan Fox and Leslie R. Samuels Foundation, Inc.
Dates: 02/01/1998 - 07/31/1998
VNS Health P.I.: Feldman, Penny H., Ph.D.

### Review of Assessment Instruments for Individuals Receiving Home-Based Long-Term Care

In order to deliver care that maximizes positive health and functional outcomes for enrollees in long-term managed care plans, providers are seeking more sophisticated systems to assess consumers' needs and preferences. The Center convened an Expert Panel to explore how consumer and family preferences could be incorporated into the care planning process. The Center also convened a group of clinical experts to examine the apparent benefits and limitations of a standard assessment instrument and related outcome indicators developed by Inter-RAI, an international consortium of health and social service providers. The instrument--the Minimum Data Set for Home Care (MDS-HC)--is an adaptation of the nursing-home-based Minimum Data Set that is mandated for use in nursing homes across the U.S. The project developed recommendations about how the MDS-HC might be refined and adapted for use by New York City providers for use with a community-based long-term care population.

Sponsor: United Hospital Fund
Dates: 08/01/1997 - 01/01/2000
VNS Health P.I.: Feldman, Penny H., Ph.D.

### Improving Pharmacotherapy in Home Health Patients

Cooperative study with Vanderbilt University, VNSNY and the Visiting Nurse Association of Los Angeles. The objective of the study was to develop guidelines for improving medication use in home health care and to test the efficacy of an intervention using these guidelines in a randomized controlled trial. The project took advantage of computerized information systems to identify potential medication problems among long-stay patients and to feed back such information to nurses and physicians in order to reduce the use of inappropriate medication. The project intervention, which relied on an expert pharmacy consultant to support nurses in discussing potential medication problems with patients' physicians, yielded significant reductions in inappropriate medications among patients in the intervention group.

Sponsor: John A. Hartford Foundation
Dates: 12/01/1995 - 09/01/1998
P.I.: Ray, Wayne, Ph.D., Vanderbilt University
VNS Health P.I.: Feldman, Penny H., Ph.D.

### Implementation and Evaluation of Health Outcomes Management and Evaluation (HOME© Plans) for Home Health Patients with Congestive Heart Failure

The objective of this study was to test the effects of the Health Outcomes Management and Evaluation (HOME) Plan, a quality improvement tool developed by the Visiting Nurse Service of New York (VNSNY), to determine its benefits for home care patients with congestive heart failure. The tool consisted of standardized, clinically proven guidelines for nursing care and a patient self-care guide. The study hypothesized that use of the tool would allow nurses to deliver quality care in fewer visits, decrease variation in the number of visits they provided, and improve patients' health outcomes and satisfaction with care. The study found that the HOME Plan reduced the number of skilled nursing visits to patients with congestive heart failure and the variation in the number of visits provided across patients without significantly increasing physician or emergency department (ED) use or patient mortality. The results also suggest that, among patients entering home care from a hospital setting, the HOME Plan reduced the risk of ED use and lowered the likelihood of re-hospitalization. No differences in patient health outcomes or satisfaction with care were found between groups, suggesting that improvement in patient outcomes may require a more coordinated effort among the many providers throughout the health care system that deliver care to these patients.

| | |
|---|---|
| Sponsor: | New York State Department of Health |
| Dates: | 01/01/1995 - 12/31/1998 |
| VNS Health P.I.: | Feldman, Penny H., Ph.D. |
| Co-P.I.: | Kelleher, Catherine, Sc.D. |

### Developing a Survey of Consumer-Centered Community Care

The objective of this joint project with the Picker Institute of Boston was to develop a survey instrument that could be used to measure the key dimensions of high quality community care from the consumer's perspective. The instrument incorporated those dimensions that consumers can evaluate and that consumers, providers, and purchasers of care identify as important indicators of quality. The survey instrument was designed for use across community-based long-term care settings, including home-health agencies, assisted living facilities and continuing care retirement communities to support quality monitoring and evaluation by providers and purchasers of care.

| | |
|---|---|
| Sponsor: | The Commonwealth Fund |
| Dates: | 01/01/1995 - 12/31/1996 |
| P.I.: | Walker, Janice, Picker Institute |
| VNS Health P.I.: | Feldman, Penny H., Ph.D. |

### Assessing the Use of Televideo Technology to Enhance Medication Compliance Among Elders with Congestive Heart Disease

Cooperative study with Dr. Terry Fulmer, New York University School of Nursing. The objective of this study was to assess the feasibility and efficacy of using videophone reminders to increase medication compliance among elderly CHF patients. Patients were randomly assigned to videophone, telephone, and control groups. Medication compliance was measured with the use of electronic medication caps.

| | |
|---|---|
| Sponsor: | Merck & Company, Inc. |
| Dates: | 1/1/1995 - 12/31/1996 |
| P.I.: | Fulmer, Terry, R.N., Ph.D., FAAN, New York University |
| VNS Health P.I.: | Feldman, Penny H., Ph.D. |

## II. Projects on analyzing and informing public policies that affect home-based care:

### 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
VNS Health 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
VNS Health 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
VNS Health 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

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 (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 collected 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) |
| VNS Health P.I.: | Murtaugh, Christopher M., Ph.D. |

### Study of LTC Utilization Patterns among New Yorkers who Frail 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
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?
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

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
VNS Health P.I.: Murtaugh, Christopher M., Ph.D.

### Trends in Medicare Home Health Care Use: 1997-2001

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
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

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.

## III. Projects on supporting communities that promote successful aging in place:

### VNSNY Veterans Outreach Project

The Research Center's role in this project is to provide data collection support and conduct an evaluation of the Veteran Liaison Program, which strives to expand healthcare access to veterans and their families; assist veterans in accessing benefits and community resources to ensure they are receiving the care and services to which they are entitled; help bridge the transition into the community from in-patient facility settings; and provide educational sessions for nurses, social workers, and home health aides to sensitize them to the special needs of veteran patients.

Sponsor: Mother Cabrini Health Foundation
Date: 01/01/20-12/31/22
P.I: Soberman, Rhonda, MSSW & Oberlink, Mia, MPH

### Gender Affirmation, Quality of Life, and Access to Care: A Mixed-Method Longitudinal Investigation

Gender minorities experience disparities in physical and mental health. Gender-affirming healthcare has the potential to mitigate these disparities, yet this population faces multiple barriers to accessing competent care. This mixed-method, longitudinal cohort study examines changes in psychosocial adjustment and health-related quality of life after gender-affirming surgery, informing the development of future home- and community-based healthcare interventions to promote their health and wellbeing.

Sponsor: National Institute of Nursing Research
Date: 07/01/2021-04/30/2026
P.I: Ryvicker, Miriam, PhD

### Young Men's and Young Women's Hebrew Association

The purpose of this project is to expand healthcare access to veterans and their families; assist veterans in accessing benefits and community resources to ensure they are receiving the care and services to which they are entitled; help bridge the transition into the community from in-patient facility settings; and provide educational sessions for nurses, social workers, and home health aides to sensitize them to the special needs of veteran patients.

Sponsor: Mother Cabrini Health Foundation
Dates: 01/01/2020 – 04/30/2021
P.I: Oberlink, Mia, MA

### Developing a Research-Based Road Map for the Provision of Effective Services that Enhance Senior Housing: JASA Evelyn & Louis Green Housing @ Cooper Square.

This project has two related goals: 1) To research and identify best practices in providing effective services to older adults in senior housing that enhance their lives and enable them to age in place; and 2) To evaluate nursing and other services provided to the mostly Cantonese-speaking residents of JASA's Cooper Square housing site and report on how well the services engage residents as active participants in their own health self-management.

Sponsor: JASA

Dates: 06/17/2019 – 06/30/2020
P.I. : Oberlink, Mia, MA

### East Harlem Falls Intervention Project

This project involves providing technical assistance to staff at the Carter Burden Center on Aging as they develop and implement a comprehensive falls prevention initiative for older adults who attend the Covello Senior Center and the Lehman Village Senior Center in East Harlem.

Sponsor: The Fan Fox and Leslie R. Samuels Foundation
Dates: 09/06/2016 – 02/05/2018
P.I. Oberlink, Mia, M.A.

### Health Indicators Project

The purpose of the Health Indicators project is to provide technical assistance to three NORC programs in Queens as they collect data from their clients, input the data into a database developed by the NYC Dept. for the Aging, interpret the data, and use the information to develop programs for their clients.

Sponsor: UJA Federation
Dates: 01/01/2015 – 06/30/2016
P.I.: Oberlink, Mia, M.A

### Rockaway Wellness Partnership

This project involves “wellness coaches” (nurses & social workers) & “community wellness workers” (think: “navigators”) in helping connect at-risk Rockaway residents to health care and providing support to participants who are trying to make lifestyle changes for better health.

Sponsor: New York State Sandy Social Services Block Grant
Dates: 01/01/2014 – 03/31/2016
P.I.: Oberlink, Mia, M.A

### Technical Assistance Provider and Evaluator for the Community Innovations in Aging in Place (CIAIP) Grantees

**Community Innovations for Aging in Place.** The Center for Home Care Policy & Research was selected by AoA to be the technical assistance provider for this national 3-year program, which awarded grants to 14 communities to implement innovative strategies to help older people "age in place." As the technical assistance grantee (TAG), CHCPR and its consultants are providing group and individual support to the grantees as they implement their initiatives, such as help with evaluation plans, communications strategies, partnership development, and other topics of interest to the grantees. The TAG organized a National Advisory Committee consisting of experts from a variety of different fields, who are lending their expertise to the grantees as well as the TAG. In the second year of the program, the TAG convened a meeting of grantees in Washington, D.C. to share information about their initiatives and lessons learned. The TAG developed a public and password protected website to share information about the CIAIP program with the public and to serve as a forum for the grantees to share best practices,

access resources, and keep abreast of their fellow grantees' accomplishments. Information about the grantees and the TAG can be found on http://www.ciaip.org.

Sponsor: Administration on Aging (AOA)
Dates: 09/30/2009 – 08/31/2013
P.I.: Oberlink, Mia, M.A.

### Time Bank Research Project

The purpose of this project was to: 1) measure the extent of older members' involvement in the VNSNY Community Connects Time Bank, the types of services provided and used most often, and changes in perceived mental health status, social contacts, access to services, and financial savings pre and post involvement in the Time Bank; and 2) provide findings to the VNSNY Time Bank team to market the Time Bank and inform future expansion of the Time Bank to other neighborhoods

Sponsor: Fan Fox & Leslie R. Samuels Foundation
Dates: 12/01/2008 – 11/30/2009
P.I.: Oberlink, Mia, M.A.

### Naturally Occurring Retirement Community Supportive Services Program (NORC-SSP): Full Implementation of the Health Status Indicators in 54 New York City-Funded and New York State-funded NORCs (Part III)

In Part III of the project, the Center for Home Care Policy and Research is building a database and system for administering the aforementioned survey questionnaire in all 54 NORC programs in New York State. In this multi-year project, the NORC programs will collect health information from all clients they serve and enter the data into the database. The Center will analyze the data and provide the findings to the NORC-SSPs in a user-friendly format. Health risks will be identified and prioritized and then evidence-based interventions will be selected and implemented to diminish these risks. Towards the end of the project, the indicators survey will be re-administered to measure any changes from the baseline findings.

Sponsor: United Hospital Fund
Dates: 07/01/2007 – 12/31/2011
P.I.: Oberlink, Mia, M.A.

### Naturally Occurring Retirement Community Supportive Services Program (NORC-SSP): Blueprint and Development of Health Status Indicators (Part I)

### Naturally Occurring Retirement Community Supportive Services Program (NORC-SSP): Health Status Indicators Project (Part II)

In the NORC-SSP Blueprint project the Center for Home Care Policy and Research developed a chapter on "Understanding the Community" for United Hospital Fund's (UHF) NORC Blueprint, which was published on the worldwide web in 2007. This "Blueprint" is a guide to help communities throughout the country identify naturally occurring retirement communities and develop supportive services programs for residents 60 and older. Related to the Blueprint project, the Center collaborated with the Aging in Place Initiative of UHF to develop a set of indicators that can be used by NORC-SSPs to identify health risks

among seniors 60 and older who live in the community. In Part II of this project, we developed a survey questionnaire to administer to people aged 60 and older being served by NORC-SSPs in the New York City area to identify health risks. In this part of the project, the questionnaire was tested in several NYC NORCs to determine whether it collected the desired information and whether it could be easily administered by NORC-SSP personnel.

Sponsor: United Hospital Fund
Dates: 10/01/2006 - 06/30/2007
P.I.: Oberlink, Mia, M.A.

### Community Partnerships for Older Adults: Technical Assistance Project

In this project, the Center for Home Care Policy and Research served as a technical consultant to the Robert Wood Johnson Foundation's Community Partnerships for Older Adults National Program Office (NPO) at the University of Southern Maine. This included assisting the NPO in developing: 1) a strategic plan for the remaining years of the program; 2) a communications plan; and 3) strategies to disseminate the work of the NPO and individual grantees to national audiences.

Sponsor: Robert Wood Johnson Foundation
Dates: 04/01/2006 – 01/31/2010
VNS Health P.I.: Oberlink, Mia, M.A.
P.I.: Community Partnerships for Older Adults, University of Southern Maine

### Policy Barriers to Creating a Livable Community

Building on years of experience in developing measures of livable communities and working with diverse communities to plan and implement positive change, the Center for Home Care Policy and Research was commissioned to research and report on major policy barriers to creating livable communities and successful methods jurisdictions have used to overcome them. The final report was published in 2008 by AARP.

Sponsor: AARP - American Association of Retired Persons
Dates: 12/01/2005 - 07/01/2006
P.I.: Oberlink, Mia, M.A.

### Livable Communities for All Ages: Identifying Leading Models and Best Practices

Building on five years of experience in developing measures of livable communities and working with diverse communities to plan and implement positive change, the Center for Home Care Policy and Research worked with the Administration on Aging to identify leading models of "livable communities for all ages" and to disseminate information designed to help communities replicate promising models and practices. Specifically, with input from the AoA, the Center worked with two principal partners—the American Planning Association and the International City/County Management Association—and others to: 1) implement a competitive process to identify the top eight models of "livable communities for all ages;" 2) develop a written manual with descriptions of the models, related technical assistance materials, and an action plan that AoA can use as a framework for discussion at the 2005 White House Conference

on Aging; and 3) recommend a dissemination strategy to make these materials widely available to "change agents" in communities around the country. The ultimate purpose of this initiative was to raise awareness and motivate action among stakeholders to improve the livability of their communities for people of all ages and abilities.

Sponsor: Administration on Aging (AoA)
Dates: 09/29/2004 - 12/31/2005
P.I.: Oberlink, Mia, M.A.

### Livable Communities for Adults with Disabilities—Part II

The Center for Home Care Policy and Research collaborated with the National Cooperative Bank Development Corporation to conduct research and create a report that: 1) identifies policy levers or strategies to build and sustain key elements of livable communities, including affordable housing, accessible transportation, consumer responsive health care, and individual choices and integration for the benefit of people with disabilities; 2) identifies model programs that exemplify successful multiple federal agency coordination and collaboration to support the development of livable communities; 3) and identifies state or local programs that either build on or are supported by this federal coordination and collaboration. A summary of common challenges and facilitators as well as recommendations to promote collaboration and livable communities was included.

Sponsor: National Council on Disability
Dates: 09/01/2004 - 08/30/2005
P.I.: Oberlink, Mia, M.A.

### National Council on Disability Livable Communities—Part 1

The purpose of this project was to identify: 1) the *key elements* of communities that promote the health, well being and independence of adults with disabilities, or those at risk of developing disabilities, across the age spectrum; 2) *communities* that have incorporated one or more of these elements into their physical, social and service systems and the *strategies/interventions* they have employed to do so; 3) the major *challenges and barriers* that communities face in moving toward greater livability for persons with disabilities, as well as factors that *facilitate* positive change, and 4) promising *policy levers and policy changes* that if adopted would facilitate communities' capacity to enhance their livability for their disabled residents. The Center conducted research in this area and produced a final report containing a status update on livable community initiatives as well as strategies, policies, and recommendations for long-term government planning and funding.

Sponsor: National Council on Disability
Dates: 09/25/2003 - 08/30/2004
P.I.: Feldman, Penny H., Ph.D.
Co-P.I.: Oberlink, Mia, M.A.

### AdvantAge Strategic Plan

With the help of consultants, the AdvantAge Initiative project team of the Center for Home Care Policy and Research undertook a strategic planning process to transform the AdvantAge Initiative into a national program capable of helping many more communities across the country prepare for a rapidly aging population. The strategic planning process involved: 1) conducting an environmental scan, or in-depth analysis of the needs and opportunities present in the current external environment in which the expanded project would be launched; and 2) drafting a plan to lay out the vision for the new, expanded AdvantAge Initiative that details the resources, skills, and relationships that the Initiative currently has and those that it must develop to grow successfully.

Sponsor: Atlantic Philanthropies, Inc.
Dates: 05/01/2002 - 12/31/2002
P.I.: Feldman, Penny H., Ph.D.
Co-P.I.: Oberlink, Mia, M.A.

### Best Practices--Models of Community Success in Supporting the Health, Well-Being, and Independence of Older People

The Best Practices project inventoried and profiled a set of successful strategies and models that communities can use to support the health and well-being of older residents. Funded by the Robert Wood Johnson Foundation, the project focused on multidimensional efforts aimed at transforming communities to make them better places for older people to live. Rather than being an academic exercise, the project sought to provide local community leaders and stakeholders with strategies and tools for change.

Sponsor: Robert Wood Johnson Foundation
Dates: 02/01/2000 - 01/31/2001
P.I.: Feldman, Penny H., Ph.D.
Co-P.I.: Oberlink, Mia, M.A.

### Promoting Elders' Health & Well-Being: Benchmarks for Supportive Communities

AdvantAge Initiative

The original goal of this project was to develop a set of benchmarks or indicators that will allow communities to rate themselves (or be rated) on how well prepared they are to promote successful aging among healthy older people living in their communities, sustain independence among those at increased risk of disease or disability, and care for the frail, the sick, and the disabled. In the first few years of the project, a framework for understanding the components of “elder-friendly” communities, a set of 33 indicators, and a survey instrument to solicit information from older people about their experiences in and impressions of their communities were developed and tested in 10 pilot communities. Since then, the AdvantAge Initiative has conducted a national survey and worked with more than 30 communities to help them measure their elder-friendliness using the AdvantAge Initiative framework and tools, build public awareness about aging issues, and plan action steps to make their communities more livable for older people and their families. In 2010 the AdvantAge Initiative embarked on a new phase to convert its exclusive survey into an online tool that will make it possible for many more communities to avail themselves of our tools and methods.

**Related Grants 1999 to date**

1999
Robert Wood Johnson

Fan Fox & Leslie R. Samuels Foundation, Inc.
Archstone Foundation
Retirement Research Foundation
Hartford Foundation

2001
Robert Wood Johnson Foundation
Helen Andrus Benedict Foundation
Fan Fox & Leslie R. Samuels Foundation, Inc.
Archstone Foundation
Retirement Research Foundation
CICOA
Mather Lifeways

2002
Helen Andrus Benedict Foundation
Atlantic Philanthropies
Virginia C. Piper Charitable Trust
Winter Park Foundation

2003
Mather Lifeways Supplement

2004
Grand Rapids Community Foundation
John Muir/Mt. Diablo Community Health Fund - Contra Costa
The Archstone Foundation

2005
United Jewish Communities – Parsippany, NJ
Freemont Area Community Foundation - Newaygo County, MI
Elkhart, Kosciusko, LaPorte, Marshall Counties, IN, AAA/Real Services
El Paso - AARP
Community Foundation of St. Joseph County - St. Joseph County, IN

2006
NYS Office for the Aging - Chinatown

2007
Fan Fox & Leslie R. Samuels Foundation, Inc. – Lincoln Square Follow-up
Fan Fox & Leslie R. Samuels Foundation, Inc. – Brownsville
Indiana (Indiana Area Agencies on Aging, Indiana State Unit on Aging, University of Indianapolis, Daniels Fund, Lilly Foundation)

2008
Fan Fox & Leslie R. Samuels Foundation, Inc. – Harlem
Daniels Fund

2010

Fan Fox & Leslie R. Samuels Foundation, Inc. – AdvantAge Online

2013
Plough Foundation - Memphis, TN
Family Eldercare - Austin, TX
University Settlement - New York, NY
Vincennes University – Indiana
Pathfinder Services – Indiana
Actors Fund - New York

2014
Shelby Senior Services – Shelbyville, IN

2015
Community Foundation of Greater Birmingham - Blount, Shelby, St. Clair, Walker, Jefferson Counties, AL
Middle Alabama Area Agency on Aging – Chilton County, AL

2016
New York City Council – Bay Ridge, NY
United Way of Greater Union County - Plainfield, NJ
Fan Fox and Leslie R. Samuels Foundation – Spring Creek Towers, NY
New York City Council – Staten Island, NY
Fan Fox and Leslie R. Samuels Foundation – Far Rockaway, NY

2017
Fan Fox and Leslie R. Samuels Foundation – East Harlem, NY
Forsyth County Senior Services – Forsyth County, NC

2018
Fan Fox and Leslie R. Samuels Foundation – Coney Island, NY
Fan Fox and Leslie R. Samuels Foundation – Lower East Side, NY
Fan Fox and Leslie R. Samuels Foundation – Roosevelt Island, NY
Rochdale Village Board of Directors – Rochdale Village, NY

2019
Fan Fox and Leslie R. Samuels Foundation – New York City, NY