

<p>Center for Home Care Policy & Research at</p> 	<p>MASTER PROJECT LIST</p> <p>1995-PRESENT</p>
<p>Projects on improving the quality, cost-effectiveness, and outcomes of home care services</p>	

Supporting Dementia Caregivers During Medicare Home Health: Developing the DECLARE Needs Assessment Intervention

Family caregivers often act as an extension of the care team during home health care for older adults, yet their capacity and needs are not systematically assessed which limits their access to necessary support. This project will develop, refine, and pilot test a self-assessment intervention for the home health setting to improve communication and support between the care team and family caregivers to patients with Alzheimer's Disease and Related Dementias.

Sponsor: National Institute on Aging (NIA)
Date: 06/01/23-02/29/28
P.I: Burgdorf, Julia, PhD

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

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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

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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

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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

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

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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, Lizzyka,

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

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Development and Testing of the Palliative Care related, Knowledge, Attitudes, & Confidence in the Home Health Care (PC-KAK 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

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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 undiagnosed 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)

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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)

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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 an 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

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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

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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 (NICHD)
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

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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

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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

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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-Acute 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

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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, PhD.

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, PhD.

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.

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Sponsor: Cambria Foundation(Funder) | NYU(Prime Awardee)
Dates: 10/15/2014 – 10/14/2016
P.I.: Russell, David, PhD

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

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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

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P.I.: Murtaugh, Christopher M., PhD.

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.

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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 evaluate 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

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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

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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)

<p>Center for Home Care Policy & Research at</p> 	<p>MASTER PROJECT LIST</p> <p>1995-PRESENT</p>
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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.

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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.

<p>Center for Home Care Policy & Research at</p> 	<p>MASTER PROJECT LIST 1995-PRESENT</p>
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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: 04/01/2017 – 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

<p>Center for Home Care Policy & Research at</p> 	<p>MASTER PROJECT LIST 1995-PRESENT</p>
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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

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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.
 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)

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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)

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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.

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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)

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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

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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.

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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)

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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.

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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-

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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.

<p>Center for Home Care Policy & Research at</p>  <p>VNS Health</p>	<p>MASTER PROJECT LIST</p> <p>1995-PRESENT</p>
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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

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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

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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

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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
 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
 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),

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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.

