AGING WELL AT HOME THROUGH THE CAPABLE PROGRAM

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Imagine that after sustaining a few falls without serious injuries in the past year, one evening you slip on some ice on the pavement and break your right hip. After surgery and a short period in a rehabilitation and skilled nursing facility, the clinical team tells you that you are not safe to go home alone. Despite this recommendation, you are determined to return to your apartment and your pet cat.

After a psychiatric evaluation determines that you have capacity to make this decision, you are ready to return home. As part of the discharge process, the discharge planner makes a referral to the CAPABLE program.

CAPABLE combines the skills and resources of an occupational therapist, a registered nurse and a handyperson or similar worker to support older adults to age in the place that they call home. Developed by Sarah Szanton, PhD, Laura Gitlin, PhD, and colleagues at the Johns Hopkins School of Nursing about 10 years ago, the program is built on the principles that older adults often have capacity to improve functional status (ability to bathe, dress, use the toilet, transfer from a chair or walk by themselves) — but they may not recognize how to adapt basic approaches or resolve symptoms to engage in those activities more independently.

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CAPABLE promotes autonomy and independence, using motivational interviewing and open-ended questions to build rapport with older adults from the first encounter. (Motivational interviewing is a specific method of communication to empower a person toward making decisions and reaching their own goals.) Health care settings can sometimes feel rushed and impersonal, especially for older adults with impaired hearing and/or vision. By coming into someone's home, the nurse and occupational therapist learn about environmental challenges that the participant faces each day. After thorough assessments, the nurse and occupational therapist are able to target areas of concern raised by the participant and can coach her or him through action steps to take before the next visit.

During the 2020 COVID-19 pandemic, a number of CAPABLE programs were on "pause" for a few months due to older adults not wanting health care professionals or others visiting inside their homes. Some programs continued with existing clients, following state and federal guidelines for the use of masks, hand hygiene and personal protective equipment (PPE) as indicated. Now, most CAPABLE programs are back to their usual schedules and routines.

The occupational therapist may focus on promoting mobility, identifying needs for common household items such as a sturdy step stool or banister for stairs, and building the participant's self-confidence. The registered nurse spends time on pain management, depressive symptoms, exercise for strengthening lower extremities and core muscles. The nurse reviews the person's medication regimen, looking for particular high-risk medications or multiple medications that may have interactions and side effects.

Based on the participant's goals, the occupational therapist and the person develop a work order for the handyworker that includes simple

home repair and modification as well as useful household items such as LED light bulbs or grab bars in the shower. The occupational therapist reviews that work order with the participant and handyperson and ensures that the participant is clear on the home modification to be done. There is a CAPABLE training manual for the nurse and occupational therapist, and a guideline for the handyperson that they share with each other.

WHY DOES IT WORK?

People often ask why CAPABLE has been so successful. Data from multiple research studies demonstrate improved activities of daily living, better depression scores, and lower acute care costs such as hospitalizations and emergency department visits.[1, 2] While functional status (being able to move around independently or with adaptive equipment) is sometimes discussed during medical or hospital visits, it often is not specifically addressed until after an event, such as a fall or medication interaction. CAPABLE may intervene earlier in the process, before serious events or accidents have occurred, and works to build self-confidence and strengthen the person's skills in order to avoid consequences.

FINDING SOLUTIONS

On her second visit with one CAPABLE program participant, an occupational therapist noticed the participant seemed rather depressed. The man explained that the one thing he used to love doing was mowing his own lawn. Because his outdoor shed was falling apart, it was no longer safe for him to retrieve his lawn mower, so he hadn't been able to mow his lawn in years. The occupational therapist conferred with the registered nurse, and the occupational therapist wrote a work order for a laborer to fix the floor of the shed.

A few months later, the man couldn't believe his eyes. The shed was rebuilt safely, and he was able to take out the lawn mower and mow his own lawn again. That put a real smile on his face.

Therefore, it is considered a preventive model, relying on and building the strengths and skills of older adults.

We strongly encourage close collaboration between the participant, CAPABLE team and the participant's primary care provider/team. We believe this is another strength of the CAPABLE model — integration and interdisciplinary coordination with the primary care team.

While the primary mission of CAPABLE is to support older adults in the place they call home and where they would like to age independently, there are significant cost savings to the health system, taxpayers and government programs.

The CAPABLE program takes place over about four to five months. During that time, typically the occupational therapist makes six visits, the nurse makes four visits and the handyworker spends a day or so in the home. While health professionals see themselves as coaches or mentors, the older adult sets his/her own goals, works to develop the care plan and practices activities between each visit.

CAPABLE is now being implemented in over 33 sites in 17 states. CAPABLE is funded through a variety of financial supports, including local philanthropy or foundations, state and/or federal grants, housing grants and other vehicles. Medicare Advantage plans may add CAPABLE (goal attainment) language to their suite of services under the Chronic Care Act or other recent legislative or regulatory updates. While traditional fee-for-service Medicare does not cover the cost of the CAPABLE program yet, the Physician Payment Technical Advisory Committee (PPTAC) unanimously recommended that Medicare consider covering CAPABLE during the annual wellness visit or similar encounter.

COST IMPLICATIONS

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and where they would like to age independently, there are significant cost savings to the health system, taxpayers and government programs. In a *Health Affairs* paper describing several research studies, Dr. Sarah Ruiz and colleagues reported that CAPABLE saved Medicare about $22,000 per participant over two years.[3] In a 2017 paper in the *Journal of the American Geriatrics Society*, Szanton and colleagues reported that CAPABLE also saved Medicaid about $10,000 per participant per year.[4] Thus, the total savings to both state and federal government programs far exceeds the annual costs of the program (by about 3-7 times CAPABLE's cost).

CONCLUSION

Given the national shift to value-based purchasing, newer alternative payment models and accountable care organizations within health systems, the time seems right for exploring CAPABLE as a Home and Community Based Services model designed to promote healthy, positive aging in community. If we can deliver programs and services that enable older adults to design and manage their own goals and care plans, and extend their tenure in community, results such as better quality of life, enhanced well-being and mobility, and enabling older people to contribute to their communities are likely outcomes.

For more information about CAPABLE, please contact us at: CAPABLEinfo@jhu.edu, or email Alice Bonner at abonner9@jh.edu.

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NOTES

1. Sarah Ruiz et al., "Innovative Home Visit Models Associated with Reductions in Costs, Hospitalizations, and Emergency Department Use," *Health Affairs* 36, no. 3 (2017): 425-32, doi: 10.1377/hlthaff.2016.1305.
2. Sarah L. Szanton et al., "Medicaid Cost Savings of a Preventive Home Visit Program for Disabled Older Adults," *Journal of the American Geriatrics Society* (2017): 1-7, doi: 10.1111/jgs.15143.
3. Ruiz et al., "Innovative Home Visit."
4. Szanton et al., "Medicaid Cost Savings."

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