CAPABLE

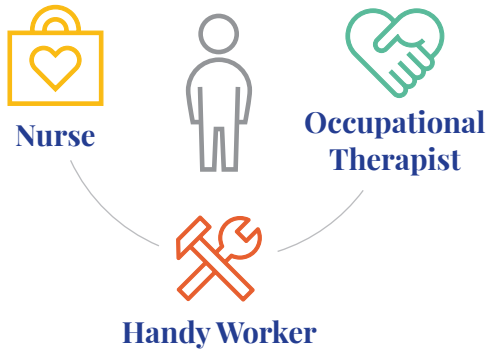
CAPABLE promotes older adults' ability to age in their homes & communities

HOW CAN IT IMPROVE WHAT WE ARE ALREADY DOING?

CAPABLE consists of **time-limited services** from an occupational therapist, a nurse, and a handy worker collaborating with the older adult as an interprofessional team. The older person **drives the goal setting** and brainstorming strategies supported by the team toward reaching goals.

Each visit builds on the one before, **increasing the participants' capacity to function at home**. Studies showed reduced hospitalization and nursing home stays by improving medication management, problem-solving ability, strength, balance, mobility, nutrition, and home safety, while decreasing disability, isolation, depression, and fall risk.

Your organization is already providing programs and services for older adults.



CAPABLE can **help fill any gaps** and support certain sub-populations. CAPABLE **can be integrated into other existing care approaches**–such as with expanded primary care, extended care coordination, home based care and support services, housing modification, and other models.

WHAT IS THE NEED?

For **older adults** with functional limitations, environmental challenges are often as pressing as their health challenges.

Broken stair railings, uneven floors, poor lighting, no grab bars–can lead to disability, falls, isolation, lack of mobility. Coupled with the belief that "there is nothing I can do" to improve their status, these individuals often experience unwanted ER visits, hospital stays, and condition decline.

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Key Elements of Success

HOW IS THIS DIFFERENT WHEN WE ALREADY PROVIDE EXCELLENT CARE?

- **Person/participant** directs the goal setting—not clinicians
- **Home-based** series of visits
- Unique Interprofessional team—**OT, RN, Handy worker**
- The team works in partnership around **the person's goals**.
- The team is guided by the **Participant's** Action Plan. They select up to 3 goals with the RN and 3 goals with the OT
- Plans are created using the participant's **own words**
- Participants usually complete the program within **four/five months**
- **Home modifications and supplies related to their goals** are key elements of success; they are visual markers for their own goals and cues to new behaviors.
- **Motivational interviewing** applied by both the OT and RN

WHAT DO WE EXPECT TO SEE AS OUTCOMES?

- Reduced use of both inpatient and outpatient healthcare services
- Improvement in function
- Reduced symptoms of depression
- Improved self-confidence
- Better quality of life
- Greater participant engagement in health and condition management

How do we identify those who can benefit the most?

Organizations can choose to offer CAPABLE based on their own services and needs.

The people for whom there is proven benefit:

- **Are over 65**
- **Cognitively intact, and**
- **Have "some" or "a lot" of difficulty in performing at least one activity of daily living.**

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Case Study

COLORADO VISITING NURSE ASSOCIATION, DENVER, CO

Home health care agency—Colorado VNA was the first community-based home health care agency to implement CAPABLE.

Program Implementation

A 24-month pilot was funded by the Colorado Health Foundation, The Denver Foundation, income generated from ReStore revenues, and an anonymous donor. A second two-year phase was funded through the Harry and Jeanette Weinberg Foundation to Habitat for Humanity International and Habitat for Humanity Metro Denver affiliate.

CVNA and Habitat for Humanity Denver have:

- ☑ Served 150+ older adult clients with a waiting list
- ☑ Demonstrated impact to key social workers, care managers from Kaiser Permanente and local clinics who now regularly refer older adults to the program
- ☑ Identified past and current patients who would benefit from the program
- ☑ Increased their capacity to provide CAPABLE with three RNs and three OTs trained
- ☑ Collected pre and post CAPABLE data using CAPABLE forms as well as healthcare utilization and claims data to inform outcome evaluation
- ☑ Incorporated CAPABLE forms into the electronic medical record

Lessons To Date

- ☑ Expect to work extensively to **build understanding** of the program **among potential referral sources**—this takes time
- ☑ Once a social worker, care manager, or other referring clinician has a few clients with a good experience, they will be a **loyal and regular source of referrals**
- ☑ Consider targeting a regional Medicare Advantage plan as a source of referrals and to **build toward sustainability**—as the program demonstrates positive functional outcomes and data analysis shows reduction of unnecessary healthcare utilization compared to prior use or a comparison non-intervention group
- ☑ Working with a healthcare provider or insurer that already provides CAPABLE provides faster way to **track results**, connect with care coordinators and smooth health information exchange
- ☑ Once your referrals to the program are built to the point you have a waiting list, consider how to **build capacity**, such as training additional OTs and RNs. This capacity will be important to payers and delivery system partners