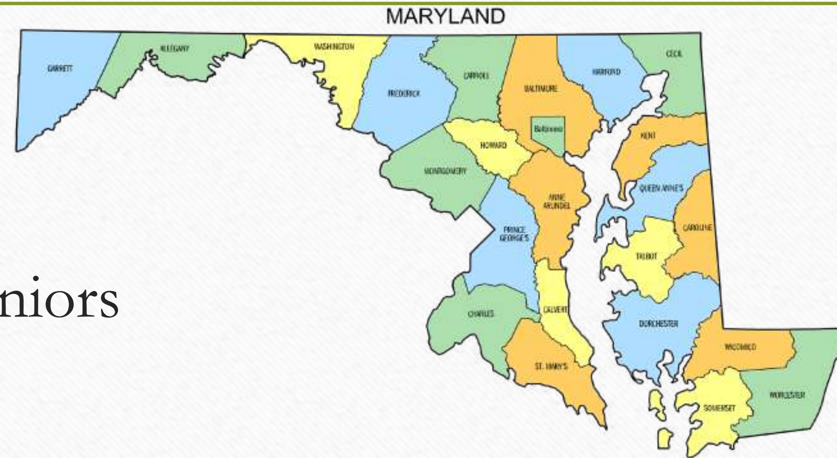
2023 Rural Summit - Aging in Place

The CAPABLE Model in Garrett County, MD

Shanna Humphrey, B.S., M.S. - Director of Garrett County Area Agency on Aging

Garrett County, Maryland

- Location – Western most county in MD



- Population – just under 29,000, 24% are seniors

- Garrett County Community Action Committee, Inc (GCCAC) serves around 2,000 seniors a year across all services.

Identifying the Need

- Low-income Seniors who own their own home
- Seniors who lacked resources on maintaining accessibility as they age due to fixed income or lack of resources available in their service area
- Decreased ability to engage in Activities of Daily Living (ADL's)
  - Bathing, toileting, dressing, eating, bed mobility, sit-to-stand mobility
- Decreased ability to engage in Instrumental Activities of Daily Living (IADL's)
  - Telephone use, meal prep, medication management, access to transportation

CAPABLE Program Overview

What is CAPABLE?

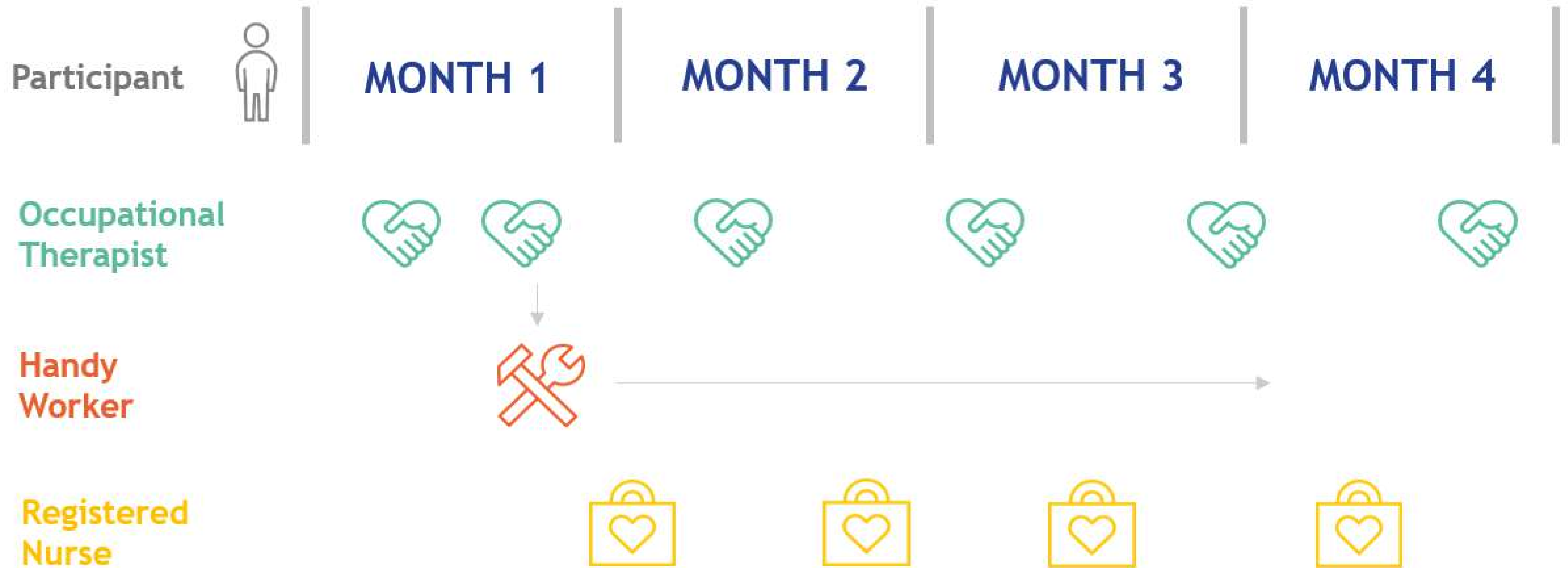
CAPABLE is a person-directed, home-based program that addresses both function and healthcare expenses.

The four- to five-month program integrates services from an interdisciplinary team who work together with the senior to set goals and direct-action plans that change behaviors to improve health, independence, and safety.

Participants learn new skills, exercises, and how to work with additional tools/equipment/home modifications to improve function and safety.

CAPABLE Program

An in-home program targeting older adults with functional limitations to achieve functional goals



Benefits of CAPABLE

More than a decade of research shows that CAPABLE reduces the impact of functional impairment and disability, enhances motivation and self-efficacy, reduces health disparities, improves emotional health, and reduces hospitalizations and nursing home days.

- IMPROVES INDEPENDENCE, SAFETY, AND HEALTH
  CAPABLE has been shown to decrease hospitalization and nursing home stays by improving medication management, problem-solving ability, strength, balance, mobility, nutrition, and home safety.
- LOWERS HEALTHCARE COSTS
  Research has shown that CAPABLE has provided more than six times the return on investment. Roughly $3,000 in program costs per participant yielded more than $30,000 in savings in medical costs driven by reductions in both inpatient and outpatient expenditures.
- ENHANCES MOTIVATION AND SELF-EFFICACY
  Through the client-driven brainstorming process, clients are given the opportunity to work as a team with their clinicians. This process improves the clients' self-efficacy and builds self-confidence to address challenges once the CAPABLE program is completed.
- REDUCES HEALTH DISPARITIES
  In a population of low-income older adults on Medicaid and Medicare who participated in CAPABLE, 75% of participants improved their self-care over the course of 5 months.
- REDUCES SYMPTOMS OF DEPRESSION
  Symptoms of depression, as well as the ability to grocery shop and manage medications, also improved.

Program Structure

- Each participant receives visits over a 4–5-month period.
- OT completes 6 visits.
  - Environmental screening completed on visit 2, work order then submitted
  - Last 2 visits are scheduled after work order is complete
- RN completes 4 visits.
  - Most participants to receive 10 total visits with a min of 4 from the OT.
  - The minimum is 8 visits for participant as the exception

Team Players

- **Program Coordinator/Case Worker**
- **Occupational Therapist**
- **Registered Nurse**
- **Handy person/people**

Getting Started with CAPABLE

Finding Participants

- Who Qualifies? – CAPABLE Standards
  - Self identify difficulty with 1 ADL or 2 IADLs
  - Cognitively intact
  - Not on End-Of-Life services
- Additional Criteria by GCCAC
  - 60+ in age
  - Homeowner
  - Low income (MEAP guidelines)

Screening & Data Collection

- Utilized internal software (empowOR) and presumptive eligibility to identify seniors who would qualify who are already engaged in services
- Identified additional participants through the Level 1 Screening Process through our Maryland Access Point (MAP)
- Screening is completed by the program manager to ensure participants meet the ADL, IADL, cognitive levels to demonstrate the need and ability to participate in the program.
- Data collected for ADL, IADL and PHQ8 Depression screening
    - ADL and IADL data is self-reported pre and post program participation
    - PHQ8 data is collected by the RN at the first and final visit

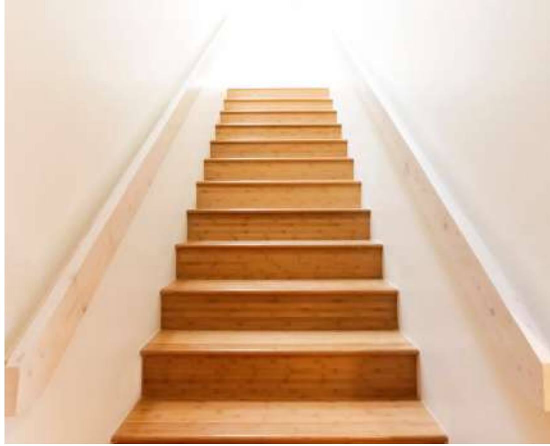
Timeline 2023

Client Launch Timeline			
Identify & Pre-Screen 11 clients - Round #1	Joni/Katie	Done	10/13/2022
OT & RN Training	Robin/Beckie	Done	11/17/2022
OT Start Clients - Round #1	Robin - OT	Done	12/19/2022
RN Start Clients - Round #1	Becky - RN	Done	1/9/2023
Identify & Pre-Screen 12 Clients - Round #2	Joni/Katie	Done	3/1/2023
Wrap Round #1 Clients	Robin/Beckie	Done	4/15/2023
OT Start Clients - Round #2	Robin - OT	Done	4/15/2023
RN Start Clients - Round #2	Becky - RN	Done	5/1/2023
Identify & Pre-Screen 11 Clients - Round #3	Joni/Katie	Done	8/1/2023
Wrap Round #2 Clients	Robin/Beckie		8/31/2023
OT Start Clients - Round #3	Robin/Beckie	Done	9/1/2023
RN Start Clients - Round #3	Robin - OT	Done	9/1/2023
Wrap Round #3 Clients	Becky - RN		12/31/2023
Spring	11 actual		
Summer	13 actual		
Fall	11 actual		
	35 Total		

What can be provided?

Durable Medical Equipment (DME)

- Bedside commode
- Hospital bed
- Elevated toilet seat
- Walker
- Cane



Home Modifications

- Lever door handles
- Railings – stairways inside & outside
- Grab bars
  - Bathroom
  - Kitchen
  - External doorways

Medical Concerns

- Pill planners
- Medication schedules
- Assistance with making appointments
- Assistance getting referrals for specialists
- Assisting with transportation

What Does the Data Say?

Current Data Trends - Quantitative

- Pre & Post Data has been collected for the 21 completed participants.

- ADL – overall positive trends across 8 ADL areas tracked
- IADL – overall positive trends across 8 IADL areas tracked
- PHQ8 – overall positive trends across depression symptoms

- Post-program survey will be sent out a year after program completion

Cost Savings

- Average Home Modification cost per participant is approx. $1,400
  - National Average for Program is $3,400 per participant
- On average, for every $3k-to $4k spent through the CAPABLE program on participants, there is a savings of over $22,000 in savings in medical costs driven by reductions in both inpatient and outpatient expenditures.*
  - Reduced ER visits, hospitalizations, rehabilitation in long term care settings.

**Documented by CMS evaluators, Ruiz et al, 2016*

Qualitative Data

Case Studies

Case Study 1

- M.R. is a 61-year-old man who suffered a stroke resulting in left sided weakness.
- He was unable to shower and was sponge bathing for 2 years with assistance from his family.
- CAPABLE set him up with a shower chair and techniques taught by the OT to be safe in the bathroom.

Case Study 2

- N.T. is a 67-year-old-woman with obesity and a history of leukemia. She utilizes an electric wheelchair for mobility and lives alone.
- She had been confined to her electric wheelchair for years, 24 hours a day due to lack of mobility regarding transfers.
- CAPABLE allowed us to provide her with a hospital bed, bariatric trapeze, and modified side table. She was able to sleep in a bed for the first time in years.

Case Study 2

Bariatric Hospital bed with Trapeze

One of the angels who delivered the hospital bed & table asked me to email them how it worked, and I promised I would. Internet demons returned her email. Probably because of my bad eyesight. Could you forward this to her?

The bed is wonderful. After you left, I decided to play with it and got into it to test it out. I woke up around 11pm. It felt wonderful to stretch out after being in the chair for so long. I am having fun organizing what I want on the bed table now.

N.T.

Unintended Outcomes

- Weekly Interdisciplinary Meetings
- Increased Level 1 Screenings
- Internal and External Referrals for participant
  - Referrals for other family or household members
  - Energy Assistance, Denture Assistance, Transportation Assistance
- Identified additional resources to fulfill participant goals before utilizing CAPABLE funding sources
  - Insurance, Medicare, Medicaid, local resources, etc.

Program Challenges

- Difficulty locating clinicians – OT and RN
- Difficulty with consistent handy person services during summer months, competing with more profitable jobs
- Funding did not include monies for a dedicated program coordinator
- ADL & IADL data is self-reported, may not reflect what a clinician observes
- Rigid fidelity structure for minimum number of visits
- Inclusion of the RN for all participants
- Fiscal Sustainability, more on next slide.

Fiscal Program Sustainability

- Community Development Block Grant (CDBG) for CAPABLE
    - not approved FY24
- Identify a community partner to provide clinical staff (RN & OT) to fulfill the CAPABLE Programs clinical needs (GCHD)
    - GCCAC to provide: Program Administration, Grant Application & Facilitation, Funding & Coordination for Home Modifications
- Older Adults Home Modification Grant FY24-27, alternative Home Modification program
- Thome Aging Well – Possible funding source for CAPABLE

Questions?

Source Information

- https://nursing.jhu.edu/faculty-research/research/projects/capable/
- For individual inquiries,
  please contact: CAPABLEinfo@capablenationalcenter.org.