



January 13<sup>th</sup>, 2020

To the California Department of Aging Leadership Team:

We are pleased to provide information on the CAPABLE program related to the California Master Plan on Aging and Medi-Cal's Healthier California for All (formerly CalAIM), a Transition Plan to a Mandatory MLTSS and D-SNP Model.

Thank you very much for the opportunity to submit feedback.

Best Regards,

A handwritten signature in black ink, appearing to read "Sarah L. Szanton".

Sarah L. Szanton, PhD, ANP, FAAN  
Health Equity and Social Justice Endowed Professor  
Director, Center on Innovative Care in Aging  
Johns Hopkins School of Nursing  
Joint Appointment with the Department of Health Policy and Management,  
Johns Hopkins Bloomberg School of Public Health  
525 North Wolfe Street #424  
Baltimore, MD 21205  
(410) 502-2605  
[sarah.szanton@jhu.edu](mailto:sarah.szanton@jhu.edu)

A handwritten signature in black ink, appearing to read "Alice Bonner".

Alice Bonner, PhD, RN  
Director of Strategic Partnerships for CAPABLE and Adjunct Faculty  
Johns Hopkins University School of Nursing  
525 North Wolfe Street  
Baltimore, MD 21205  
[abonner9@jhu.edu](mailto:abonner9@jhu.edu)  
Mobile 508-269-3879

## Recommendations for CAPABLE<sup>1</sup> Integration into the next California Master Plan on Aging and Medi-Cal's Transition Plan to a Mandatory MLTSS and D-SNP Model (CalAIM)

- California will include access to CAPABLE for eligible participants as part of California Department of Aging's (CDA's) Master Plan on Aging (currently in development) and the Division of Health Care Services (DHCS) Medi-Cal Healthier California for All (formerly CalAIM) initiative (target is statewide MLTSS coverage for eligible Medi-Cal and dual eligible members by 2026).
- DHCS/CalAIM, its stakeholders and partners will plan and sequence scale and spread of CAPABLE within mandatory, integrated MLTSS over the next six years. The new Master Plan on Aging will include Medi-Cal members and all older adults, care partners and communities as well.
- Initially, California will implement CAPABLE for eligible duals and non-duals (Medi-Cal recipients) in 3-5 counties over Year 1. This option will enable the state to study, scale and spread CAPABLE as the state moves toward universal coverage and access in all 58 counties by 2026.
  - California could add 10-12 sites/counties annually after Year 1, until all 58 counties are covered.
- California will track quality measurement of clinical outcomes and social determinants of health, behavioral health services and outcomes, as well as utilization outcomes such as total cost of care, hospitalizations, emergency department visits, readmissions, skilled nursing facility (SNF) costs, and hospital and SNF lengths of stay.
- CDA, DHCS, Medi-Cal and their stakeholders will work with the Johns Hopkins University (JHU) CAPABLE team on building local partnerships and working through start-up logistics, including JHU technical assistance with each additional CAPABLE site.

### CAPABLE Improves Lives while Reducing Costs

- CAPABLE is an evidence-based, five-month program that improves lives and saves money.
  - **CAPABLE IMPROVES HEALTH OUTCOMES AT LOWER COSTS: 7x RETURN ON INVESTMENT.** Roughly, \$3,000 in program costs yielded approximately \$22,000 in medical cost savings (Ruiz et al, 2017).
  - **HALVES DIFFICULTIES IN FUNCTION.** Participants had difficulty with an average of 4.0 out of 8.0 Activities of Daily Living (ADLs) at baseline, compared to 1.6 after five months.
  - **REDUCES SYMPTOMS OF DEPRESSION.** Symptoms of depression, as well as the ability to grocery shop and manage medications also improved.
  - **IMPROVES ENGAGEMENT AND SELF-CONFIDENCE.** The change in physical environment further motivates participants. Addressing both the person and the environment in which they live allows the person to thrive.

---

<sup>1</sup> CAPABLE=Community Aging in Place: Advancing Better Living for Elders

- CAPABLE develops and supports older adult self-efficacy, teaches problem-solving and brainstorming skills to address current and future functional issues, including physical and behavioral health.
- CAPABLE clinicians use open-ended questions and motivational interviewing, to exploring *what matters most* to the participants. What would they like to be able to *do* to age at home? CAPABLE is a useful complement to primary care.
- CAPABLE promotes person-directed goals, longer tenure in community, enhanced quality of life and improved function (Szanton & Gitlin, 2016; Ruiz et al, 2017; Szanton et al, 2017) while providing 7x return on investment. There are 28 active CAPABLE sites in 15 states.
- There are 10 total visits per participant in CAPABLE. After local clinicians complete the CAPABLE online training program (10-14 hours plus technical assistance as needed), an occupational therapist (OT) makes six home visits and a registered nurse (RN) makes four home visits to each participant.
- A handy worker spends about one day in the home completing modifications as requested on the OT's work order.
- Total cost per CAPABLE participant has ranged from \$3,000 to \$3,500, depending on the hourly wages for clinicians, travel time and other factors in each region.

## Evidence base

- For the past ten years, CAPABLE research has demonstrated significant older adult satisfaction, improved activities of daily living (ADLs) and instrumental activities of daily living (IADLs), as well as a 7:1 return on investment (ROI) across several payer types.
- In a 2017 *Health Affairs* paper, Ruiz and colleagues reported a \$22,256 per participant traditional Medicare savings over 2 years, or \$2,765 per quarter per person for 8 quarters (Ruiz et al, 2017).
- In addition to traditional Medicare, studies have examined savings to Medicaid programs (Szanton et al, 2017) and to accountable care organizations (ACOs).
- In a 2017 *JAGS* paper, Dr. Szanton and colleagues reported a total average Medicaid savings of \$867 per month (~\$10,000/year) per CAPABLE participant compared to a matched comparison group.
  - The CAPABLE group had lower probability of every service type except for a modest increase in home health (which was expected).
  - They also had a statistically lower probability of using inpatient, outpatient and specialist services (Szanton et al, 2017).
- In a June 2019 Academy Health Annual Research Meeting presentation, inpatient rates were reported to be reduced from 23% pre-CAPABLE to 9% post-CAPABLE.
  - Ninety percent of CAPABLE participants reported feeling safer and more independent at home, and those readmitted to the hospital in less than 90 days cost \$6,920 less on average than prior to CAPABLE.

- CAPABLE participants also reported a reduction in difficulty in seven daily activities (Szanton et al, 2019).
- Research to date from around the United States indicates that Total Cost of Care (TCOC) for older adults on Medicaid, Medicare or both (dual eligible) is lower after the CAPABLE intervention.
- In addition to providing education and skills training to participants, CAPABLE clinicians work with primary care and specialty providers to develop and enhance geriatric skills and knowledge. We anticipate that this translates to improved comprehensive care of non-CAPABLE older adults in those practices as well.

**CAPABLE’s mission and vision strongly align with CDA’s work with stakeholders on the Master Plan on Aging and with *DHCS’ transition plan “to improve the quality of life and health outcomes of dual eligibles by implementing broad delivery system, program and payment reform across the Medi-Cal program” (DHCS, 2019). CAPABLE will fill a service gap for a targeted sub-population of older adult Californians, will promote quality of life and greater older adult engagement in their communities.***

Please see Appendix for additional details and references. We would be happy to answer any questions.

## **APPENDIX**

### **CAPABLE Program Eligibility and Targeting**

- There are currently 28 CAPABLE sites in 15 states. The SCAN Health Plan is a D-SNP with a CAPABLE site in Cypress and Riverside, California.
- While most sites have followed JHU eligibility guidelines, some have adapted those guidelines to best meet the needs of their community.
- CAPABLE targets a sub-population of community-dwelling people (living in their own homes or in rental units) over age 65 who are relatively cognitively intact and report difficulty with at least one ADL (bathing, dressing, using the toilet, eating, ambulating/transferring).
- CAPABLE is program.
- The size of each local program can be managed through eligibility criteria (i.e., starting at age 70 or 75 instead of at 65 years old, and/or requiring assistance with at least two or three ADLs instead of just one).

### **CAPABLE Implementation, Comprehensive Assessment, and Measures**

- Standard measures and an initial comprehensive assessment enable the team, including the older adult, to compare valuable functional and utilization measures before and after CAPABLE.
- Each site has some flexibility in determining which measures they would find most helpful for their continuous quality assurance performance improvement (QAPI) and related programs. There is a team to support CAPABLE implementation that is based at Johns Hopkins University. This team provides sample templates and measure sets.
- We connect new sites with existing sites that have implemented CAPABLE and have months or years of experience to share with colleagues.
- The JHU CAPABLE team also provides regularly scheduled office hours each month for RNs, OTs and program administrators. These sessions reflect effective peer-to-peer learning, coaching and sharing across sites and geography, creating a core group of dedicated and collaborative CAPABLE clinicians and administrators.
- A website for active implementers also provides the opportunity for CAPABLE teams to share their experiences and what they have learned over time.

### **Workflow, Goal Setting, Coordination and Communication**

- Referrals to CAPABLE often come from the health system, such as hospitals (discharge planners, case managers, social workers), primary care or specialty office practices, home health agencies, or home care providers.

- Community-based organizations may also make referrals, as do local businesses, faith-based organizations, municipal leaders and others.
- The RN and OT take their cues from the older adult, in terms of which six goals (three with the RN and three with the OT) the participant would like to address.
- Discussion topics may include pain, depression/mood, function, mobility/exercise, medications, nutrition, continence with the RN; and physical environment, mobility, function, activities with the OT.
- The RN and OT work closely together, since selected goals may overlap or align with one another, and effective communication is critical to achieving successful outcomes.
- The CAPABLE team also communicates with primary care providers. CAPABLE is an enhancement of (not a replacement for) primary care, and CAPABLE professionals coordinate with primary care to fully support older adults in the community.
- CAPABLE participants often become more engaged in primary care visits after CAPABLE due to higher self-efficacy, decreased depression and pain

### **Handy Worker Role**

- The initial comprehensive assessment also enables the OT to draft a work order for a handy worker, leading to basic modifications that promote safety and independence at home.
- For example, home modifications may include LED lights, grab bars, additional railings or bannisters, fixing floors or stairs that are in poor repair, lowering kitchen cabinets, providing a heating pad or sturdy step stool.
- These changes are discussed with the older adult, who is given an opportunity to agree or disagree with the recommendations before the work order is processed.
- Generally, the handy worker is at the home for one to one-and-a-half days.
- The average cost of the home repairs (including handy worker time, materials/supplies and equipment) is between \$1,000-\$1,300.
  - Examples of acceptable handy worker modifications are detailed in written documents and described in teaching videos.
  - We encourage sites to contract or partner with local, reputable handy worker organizations that have experience working with older adults and ideally with [CAPS \(Certified Aging in Place Specialist\)](#) or similar certifications.

### **CAPABLE Program Costs**

In addition to the \$1300 per participant cost associated with home modifications, other costs include:

- Training and technical assistance costs per clinician;
- Hourly wages and benefits of the OT and the RN (plus travel and documentation time);
- Dedicated time from a program administrator to assist with start-up logistics, data collection, scheduling, preparing participant materials.

Total cost per participant has ranged from \$3,000 to \$3,500, depending on the hourly wages for clinicians, travel time and other factors in each region.

### **Approach to including CAPABLE as a targeted benefit or service in CDA's Master Plan on Aging and/or for older adults in CalAIM program redesign**

- CMS memo (SMDL #18-012) to State Medicaid Directors outlined ten opportunities to better serve individuals dually eligible for Medicaid and Medicare through new developments in managed care and a coordinated, integrated approach (Verma, 2018).
- The memo indicated that dually eligible individuals have a disproportionately high share of health expenditures compared to non-duals.
- CAPABLE implementation supports **expanding access to integrated care for California dual eligibles**.
- It might be possible to integrate CAPABLE into Medi-Cal waiver programs such as Multipurpose Senior Services Program (MSSP), or other Medicaid programs/authorities. These options should be explored further.
- California seeks a broader, statewide transformation to support older adults' quality of life, independence and longer tenure in community. The CAPABLE philosophy, fundamental principles and demonstrated benefits support the drive toward universal MLTSS coverage in all 58 California counties (urban, suburban and rural regions).
- Furthermore, CAPABLE will promote improved outcomes during community care transitions (e.g., older adults going from hospital to skilled nursing and rehabilitation facilities or SNFs, from hospital or SNF to home health, from hospital or SNF to assisted living residence, etc.).
  - Incidents of adverse events and medical errors are higher during care transitions (Donovan et al, 2016; Kapoor et al, 2019); CAPABLE's assessment, medication reconciliation and home environmental supports could play a key role in improving quality of life, reducing unnecessary expenditures and preventing poor outcomes related to transitions in care.
- California has identified a major opportunity to get more consumers (dual eligibles) and their care partners to be *more knowledgeable and engaged* in designing the Master Plan on Aging and expanding Medi-Cal access to integrated care through MLTSS. These goals align with the CAPABLE focus on older adult independence and engagement.
- If dual eligible older adults are not aware that they may be eligible for Medicaid or Medicare programs that could help to meet their needs, they may continue to struggle on their own and often end up in the emergency department or admitted to the hospital with an injury or illness that could have been prevented.
  - In at least one CAPABLE program that targeted older people prior to elective surgery (a "pre-hab" model), participants experienced better clinical outcomes and higher satisfaction scores compared to those who did not go through CAPABLE prior to surgery (Personal Communication by Judith Kell, PI with Dr. Sarah Szanton, 2018).

- CAPABLE may be most effective as a preventive model in enhancing quality of life, preventing adverse events and reducing unnecessary acute care utilization.

### Case Study – the Value of CAPABLE

***Mrs. K was an 85-year old former housekeeper with severe degenerative arthritis of her hands, knees and hips who lived alone. She became unable to go up and down the stairs inside or outside her home due to arthritis pain; she ate poorly, had difficulty doing laundry and became lonely and depressed. She did not want to live in a nursing home.***

***Mrs. K’s primary nurse practitioner referred her to CAPABLE, and Mrs. K was eager to see what the program could do for her arthritis pain and limited function. After five months of CAPABLE, Mrs. K now does basic exercises every day, which has enabled her to slowly walk up and down the stairs again – even with a small laundry bag or basket. She has resumed using her upstairs clothing closets. Thanks to the handy worker adding grab bars outside of her front door, she can negotiate the front steps safely and can get in and out of a taxi or a neighbor’s car to visit her friends. Her mood is improved, and her pain is much less than prior to CAPABLE. Mrs. K has recommended CAPABLE to friends and neighbors.***

### Summary

- CAPABLE will provide important health and functional benefits, increase safety, support older adult tenure in community and strengthen municipal and state efforts to engage everyone in the age-friendly movement.
- Critical outcomes are older adults’ improved function, mood, self-efficacy, problem-solving skills, knowledge, resilience and independence.
- By treating older people with respect, dignity and an open mind, adults are better able to address issues, live their lives as they would like – and to achieve their own goals.
- In addition to achieving person-directed goals, there would likely be significant cost savings to Medi-Cal, as there have been to Medicare, ACOs, health systems and health plans.
- By reducing total cost of care for these individuals and populations, savings and resources may be redistributed to programs for people in greatest need living in those communities.
- CAPABLE will fill a service gap for a targeted sub-population of older adult Californians and will promote quality of life and greater older adult engagement in their communities.

We would be pleased to answer any questions. Thank you very much.

### Selected References

Aliberti, M. J. R., Covinsky, K.E. (2019). Home Modifications to Reduce Disability in Older Adults with Functional Disability. *JAMA Internal Medicine* January 7<sup>th</sup> 2019; E1-E2.

California Department of Health Care Services Memo (December 6<sup>th</sup>, 2019). Expanding Access to Integrated Care for Dual Eligible Californians: 1-9. [calduals.org/wp-](http://calduals.org/wp-)



content/uploads/2019/12/Expanding-Access-to-Integrated-Care-for-Dual-Eligible-Californians-FINAL.pdf.

Donovan, J.L., Kanaan, A.O., Gurwitz, J.H., Tjia, J., Cutrona, S.L., Garber, L., Preusse, P., Field, T.S. (2016). A Pilot Health Information Technology-Based Effort to Increase the Quality of Transitions from Skilled Nursing Facility to Home: Compelling Evidence of High Rate of Adverse Outcomes. *JAMDA*: 312-317.  
<http://dx.doi.org/10.1016/j.jamda.2015.11.008>.

Kapoor, A., Field, T., Handler, S., Fisher, K., Saphirak, C., Crawford, S., Fouayzi, H., Johnson, F., Spenard, A., Zhang, N., Gurwitz, J.H. (2019). Adverse Events in Long-Term Care Residents Transitioning from Hospital Back to Nursing Home. *JAMA Internal Medicine*; 179(9):1254-1261. doi:10.1001/jamainternmed.2019.2005.

Ruiz, S., Page Snyder, L., Rotondo, C., Cross-Barnet, C., Murphy Colligan, E., Giuriceo, K. (2017). Innovative Home Visit Models Associated with Reductions in Costs, Hospitalizations, and Emergency Department Use. *Health Affairs* 36: (3): 425-432. doi: 10.1377/hlthaff.2016.1305.

Szanton, S., Alfonso, Y.N., Leff, B., Guralnik, J., Wolff, J. L., Stockwell, I., Gitlin, L. N., Bishai, D. (2017). Medicaid Cost Savings of a Preventive Home Visit Program for Disabled Older Adults. *JAGS* 2017: 1-7. DOI: 10.1111/jgs.15143.

Szanton, S. L., Gitlin, L. N. (2016). Meeting the Health Care Financing Imperative Through Focusing on Function: The CAPABLE Studies. *Public Policy and Aging Report*, 00, Vol. 00, No. 00, 1-5. Doi:10.1093ppar/prw014.

Szanton, S.L., Kell, J., Bourdon, T., Purvis, J., Zhang, X., Gitlin, L. N. (June 4<sup>th</sup>, 2019). An Aging in Place model in the innovation pipeline: testing an evidence-based program in an Accountable Care Organization. Academy Health Annual Research Meeting, Washington D.C.

Szanton, S., Leff, B., Wolff, J. L., Roberts, L., Gitlin, L. N. (2016). Home-Based Care Program Reduces Disability and Promotes Aging In Place. *Health Affairs*: September 2016; (35:9): 1558-1563.

Szanton, S., Xue, Q., Leff, B., Guralnik, J., Wolff, J.L., Tanner, E.K., Boyd, C., Thorpe, R. J. Jr., Bishai, D., Gitlin, L. N. (2019). Effect of a Biobehavioral Environmental Approach on Disability Among Low-Income Older Adults A Randomized Clinical Trial. *JAMA Internal Medicine* January 7<sup>th</sup> 2019; E1-E8.

Verma, S. (2018). Ten Opportunities to Better Serve Individuals Dually Eligible for Medicaid and Medicare. CMS Memo SMDL #18-012: 2-13.