Improving Life for Elders—At Home

Sarah Szanton's CAPABLE program helps older adults 'age in place' and cuts health care costs.

Sarah L. Szanton, PhD, ANP, FAAN. Photo by Will Kirk / homewoodphoto.jhu.edu.

"We all have different paths as nurses, and mine is not your typical one—but I've often found there aren't typical ones," says Sarah L. Szanton, professor at Johns Hopkins University's School of Nursing in Baltimore, Maryland, and creator of CAPABLE (Community Aging in Place, Advancing Better Living for Elders), a program funded by the National Institutes of Health (NIH) and the Centers for Medicare and Medicaid Services (CMS) that helps low-income seniors live more safely in their homes.

As an undergraduate at Harvard University, Szanton majored in African American studies and envisioned working on health care policy, thinking it would be "a good way to change the world." She went on to work as a lobbyist for reproductive issues—a job that partly entailed bringing nurses to meet with their representatives on Capitol Hill.

"That was my first exposure to nurses," Szanton recalls. "What they did sounded much more fun than what I was doing, so I started volunteering at a free clinic. I really fell in love with that one-on-one therapeutic rapport you get with people when they come to you in need."

Szanton enrolled at Johns Hopkins University and earned a nursing degree, later becoming an NP. Looking back, she says her subsequent nursing jobs shared a common theme: assisting people for whom "housing was an issue." She worked with migrant farmworkers and the homeless, and made house calls to homebound low-income older adults. The experience of these home visits made Szanton think about how to help patients live better—and laid the foundation for CAPABLE.

"Being in someone's home gives you the opportunity to see what matters to them. You see their pictures, their hobbies, and more evidence of their culture and values," Szanton says. "You automatically see a patient as a whole person for whom managing illnesses has a lot more to do with function and being able to do what they would like to do than just medications and exercise."

THE PROGRAM

Szanton says she initially performed her house calls in what she calls "a 'medical model' kind of way"—an approach that primarily focused on her patients' medications and diets. But as she spent more time at patients' homes, noticing "the holes in people's floors, or the shaky banisters, or steps that they couldn't get down," she began to feel that model was inadequate.

"In geriatrics and gerontology we talk about person–environment fit—it's not just what the person can do, but also what the environment requires of them. If their bedroom is on the third floor, that's going to be a different fit than if it's on the ground floor," she explains. "But when I looked at what we were doing for older adults, it tended to be just about the person."

In 2008, the NIH called for grant proposals for projects to help people who had lost their jobs in the recession. Szanton realized that many people with jobs in the housing industry, such as carpenters or mechanics, would likely need work and could potentially make a positive impact on her patients' lives. "I started to think, what if we had a program that combined nurse house calls with fixing the home environment?"

After hearing about the work of Laura Gitlin, a researcher who developed a model that provided

older adults with home-based occupational and physical therapy as well as home modifications, Szanton proposed building on that model to create CAPABLE. Her plan was to provide homebound seniors with visits from a team comprising a nurse, an occupational therapist, and a handyman who could make repairs. Addressing both health and environmental needs, Szanton believed, would improve seniors' quality of life and help them maintain their independence longer.

SUCCESSES

Szanton secured funding for a CAPABLE pilot study in 2009, and the program was later studied in an NIH randomized controlled trial and a CMS demonstration project, both of which began in 2012. Over several years of study, the program has shown it can improve patient outcomes. For example, among the 234 participants in the demonstration project who were enrolled in CAPABLE—which provided up to 10 visits with the care team over five months—75% improved their ability to perform activities of daily living, 65% reported decreased difficulty with instrumental activities of daily living, and more than half experienced an improvement in depressive symptoms.

In 2015, CAPABLE underwent its first expansion: it became part of a Michigan Medicaid pilot to keep nursing home–eligible adults in the community. Now, CAPABLE has been implemented in various iterations in 13 cities in eight states, including some rural areas. It continues to expand.

The "secret sauce" behind CAPABLE's success, says Szanton, is that it's tailored to patients' specific functional goals, which they identify with the help of their nurse and occupational therapist. "One person's goal may be 'I want to be able to walk to the bathroom instead of sitting on this commode chair.' For someone else, it might be 'I want to be able to stand long enough to prepare a meal,' or 'I want to be able to get down my front steps and get into my daughter's car.' We're not prescriptive about what the goals are."

CAPABLE's other key strength, she believes, is that simultaneously addressing patients' needs and their environments is a motivating factor for patients. Improving the lighting in one patient's home, for example, was all she needed to restart working on projects she once enjoyed, and to be able to go to her basement, which she had been avoiding because the poor lighting made her afraid she would fall.

In addition to improving quality of life, CAPABLE is cost-effective. According to a recent CMS evaluation of the demonstration project, the program costs, on average, $2,765 per participant per quarter; it yields a six-to-one return on investment of nearly $20,000 over two years in Medicare costs due to associated reductions in both inpatient and outpatient expenditures. Specifically, CAPABLE was associated with reduced readmissions and observation stays.

"Even though we're doing something that's explicitly not medical, we're finding results that are very medical in terms of cost savings," Szanton says. "Although people think of chronic conditions as the driver of health care utilization, it's really when people with chronic conditions start to have functional difficulty—when it's hard to get dressed, bathe, or walk across a small room. That's when people become what economists call 'high-cost users.' So attacking that functional dependence and difficulty makes a lot of sense for decreasing utilization."

And Szanton has found that improving patients' functionality often requires small, relatively inexpensive changes. She recalls one patient who was in pain, had difficulty hearing, and had asthma that caused shortness of breath. She found pain relief by soaking in her bathtub, but couldn't easily get in and out of it. Through CAPABLE, the patient's team helped her obtain a more effective inhaler, altered her tub for accessibility, and purchased her a SuperEar personal amplifier. "She went from not being able to walk around because she was so breathless, in pain, and unable to hear, to none of those being true," Szanton says. "And a $35 SuperEar, grab bars in her bathtub, and the right medications are just tiny things. We listened to what was important to her and then we attacked those things. You can see why CAPABLE is so inexpensive—it's really just tiny things working together."

LOOKING AHEAD

CAPABLE will soon be tested in another NIH randomized controlled trial among a population of patients who lost physical functioning after recent hospitalizations; it will also be tested by the Visiting Nurse Service of New York.

And Szanton is pushing for CAPABLE's expansion. In light of an Affordable Care Act provision stipulating that programs tested by the CMS Innovation Center and shown to improve health and save costs can be implemented more widely, she's written to the CMS to urge the expansion of CAPABLE into a Medicare benefit. She also says that, this year, several Medicare Advantage plans have inquired about the possibility of including CAPABLE as a service.

Szanton's "ultimate vision" is for Medicare's annual wellness visit to periodically occur at the patient's home, so that the home environment could be observed in relation to tasks like bathing, dressing, and grooming. Ideally, such home visits could "trigger a full CAPABLE package or just one or two visits, depending on what the patient needs," she says.—*Diane Szulecki, editor* ▼