

WHAT TO DO ABOUT THE PATIENT YOU WORRY ABOUT AFTER DISCHARGE?

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Do you worry about some patients after they leave the hospital? You might wonder how they will navigate stair climbing and showers. Maybe they live alone and are unable to stand long enough to prepare food. These are just some of the challenges facing older patients when they transition from hospital to home. Although loss of function is often a result of an illness, disease or injury, it does not have to be a normal part of aging.

When patients are in the hospital, we learn a lot about them but learn little about their overall life goals and how they achieve them in the context of daily life. A full 25 percent of all healthcare costs in the U.S. are spent on people with functional limitations, yet the medical system rarely addresses function in a systematic way.

Together, we are working to implement a program called CAPABLE for patients who have recently been discharged from the hospital or the emergency department. CAPABLE stands for Community Aging in Place, Advancing Better Living for Elders. The program is focused on building the capability of the older adult — as well as modifying the home environment to maximize their abilities rather than accept continuing decline.

CAPABLE is strength-based. In other words, rather than conducting a comprehensive assessment of the older adult, focusing on the clinician's determination of the person's key areas of weakness, CAPABLE assesses the person for key areas of strength and determination. These drive goal setting and care plan development. CAPABLE is a client-directed, home-based intervention to increase mobility, functionality and capacity to "age in place" for older adults. CAPABLE consists of time-limited services from an occupational therapist, a nurse, and a handyman working in tandem with the older adult.

A key component of this approach is having the client drive the goal-setting and brainstorming strategies with the team. Each monthly visit and each service builds on the others by increasing the participant's capacity to function at home. The client, family caregiver (if there is one), and three "professional" team members work collaboratively to achieve shared goals.

The client works with the occupational therapist and nurse to identify three achievable goals per discipline. These professional team members use motivational interviewing techniques (active listening, follow-up responses, and using the person's own words in describing issues presented). This conversational approach is in contrast to having the clinician assess the problem and determine a solution. Thus, the client can tap into the team member's knowledge and expertise and explore ideas for overcoming barriers to independent living.

Building skills and self-efficacy (belief and confidence in one's own abilities) are core components of this approach. The client learns new skills, exercises and how to work with additional tools/equipment — practicing in-between visits in the actual home environment. In the case of safe bathing, for example, barriers could include a slippery tub, muscle weakness and lack of handrails that impact how to get safely into and out of the tub. In this example, the handyman makes structural improvements needed to overcome these barriers, and

the client learns tips for safe transfer. The real world of the person's home and his/her awareness of structural or other anomalies in the home makes this approach superior to practicing in a "home-like" unit located within a facility or another setting.

The CAPABLE program has been tested in research trials and has shown it can decrease hospitalization and nursing home stays by improving medication management, problem-solving ability, strength, balance, nutrition and home safety, while decreasing isolation, depression, pain and fall risk. Johns Hopkins Hospital has transitioned this research into a successful practice model and is using it to advance self-care management across the care continuum. This service is being offered to clients living in Baltimore City who are discharged from the hospital and have identified loss of function. A coordinated effort between care management in the acute care setting and CAPABLE trained clinicians in home-based services drives program referrals.

The "special sauce" of CAPABLE really is the client-directed focus. The beauty of this program is in its simplicity and real-world positive impact on the health of our community. Case managers can be a force for making CAPABLE more available to all.

BEFORE

Mrs. G., age 85, spent most of her days alone and moved around her home by grabbing onto backs of chairs and other pieces of furniture. She could not use her front steps due to a broken railing. Her bathroom and kitchen were not set up to accommodate her weaknesses and limited mobility. Mrs. G. increasingly felt like a prisoner in her own home. She was admitted to the hospital after a fall and is worried about coming home and being more isolated and falling again.

AFTER

The CAPABLE program, with a team of nurse, occupational therapist and handyman offered the chance for improvement within a structure approach. Since it was interactive and focused on Mrs. G.'s personal and actionable goals, it was different from most "assessment and care planning" activities in which Mrs. G. had participated. As a former teacher, Mrs. G. welcomed the opportunity to learn more about how to build her physical stamina, improve her balance and move with less fear of falling. She looked forward to the monthly visits to demonstrate progress and achieve her goals.

After the 4-month program, Mrs. G. now uses her new, solidly built front railing to get to the mailbox and reconnect with neighbors. She safely gets into and out of bed and her shower due to assistive devices and training. She gets into and out of cars to go on excursions due to strength and balance training — exercises she safely did at home and has continued. Her mood is improved, and she is adherent to her newly streamlined medication regimen.

To learn more about the CAPABLE Program, visit the website at https://nursing.jhu.edu/faculty_research/research/projects/capable/index.html. ■



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