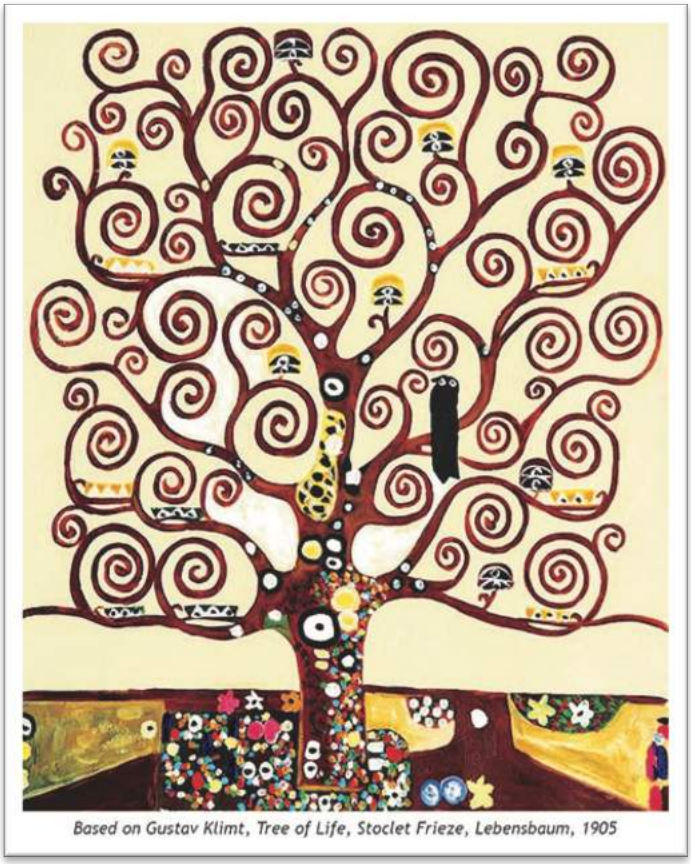
Community Aging in Place—Advancing Better Living for Elders

Interview with Sarah Szanton



By Jean Galiana

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CAPABLE

"*As a nurse making house calls in Baltimore, I have seen patients who had to crawl to the front door to let me in. Others had to throw me the keys from the upper window because they could not come down to the first floor to open the door.*"[1]

Sarah Szanton

Background

Providers in the United States are historically poised to design better care and support models that meet the needs of the older population and shorten the gap between life expectancy and healthy life expectancy.[2] Merging social support, housing, and healthcare, as demonstrated by Community Aging in Place—Advancing Better Living for Elders (CAPABLE), is one such model.

CAPABLE combines nursing care, occupational therapy, and home improvements to support the needs of older adults who wish to remain in their home. The goal of the program is to enable a better quality of life for their participants by using the multidisciplinary team to support improved physical function. CAPABLE breaks away from the existing requirement that a person must have recently experienced an acute illness or recently been hospitalized to qualify for home care.

CAPABLE has proven that it is possible to delay or reduce the level of chronic disease related disability in frail older adults. CAPABLE is driven by the belief that the overall wellbeing of a person reaches beyond basic health measures and disease management into the livability of the home. The CAPABLE team makes modifications or repairs that enable the participant to move about their home freely and safely. Safety changes can be as inexpensive and practical as securing railings, improving lighting, removing throw rugs, widening doorways for wheelchair access, or providing a baby type sling to carry pets up and down the stairs. The goal of the CAPABLE program is to improve overall function as measured by the ability of participants to perform the basic activities of daily living[3] and instrumental activities of daily living.[4]

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[1] http://nursing.jhu.edu/faculty_research/research/projects/capable/capable-news.html

[2] Healthy life expectancy is defined as the period of life without physical barriers to normal life functioning.

[3] Activities of daily living are used as a measure for functional status. They include, personal care such as bathing, dressing, grooming, feeding oneself, and toileting.

[4] Instrumental activities of daily living are not those that contribute to the physical functioning of a person but enable people to live independently. They include: preparing meals, house cleaning, managing finances, shopping, using the phone or possibly the computer, medication adherence, and pet care.

In this interview, Sarah Szanton describes the CAPABLE program.

Biography

Sarah Szanton, PhD, ANP, FAAN, is the Associate Director of policy for the Center on Innovative Care in Aging and Professor at the Johns Hopkins School of Nursing. She studies health disparities in older adults and works to eliminate health and quality of life differences for seniors across socioeconomic and racial lines. A goal of Dr. Szanton's research is to help seniors age in place.
Szanton completed her undergraduate work in African American Studies at Harvard University. She holds a M.S.N. from the University of Maryland and a Ph.D. from Johns Hopkins University.

Interview

JG: What inspired you to build the CAPABLE program?

SS: I was a nurse practitioner providing house calls that were medically oriented because I was trained to focus mostly on medical conditions. House calls are not the same as treating someone in an office setting. I came face to face with what mattered to people when I was in their home. I saw a clear picture of the environment they were living in. I found holes in floors and shaky bannisters.

During the recession, the National Institute of Health called for applications for programs that emphasized hiring people who had lost their jobs. It occurred to me that there were carpenters and people who build homes who were likely in need of work. I thought it would be a novel idea to combine improvements to the home with nursing. As I started to consider the idea, colleagues here at John Hopkins told me about Laura Gitlin's work in Philadelphia. She developed the ABLE program that combined occupational therapy, and physical therapy with home modifications. We added the nursing component and home repair to her model. We created a new role for nurses. Nurses have traditionally not been focused on function to the degree that CAPABLE does. Additionally, no one has been reimbursing for home repairs such as fixing a hole in the roof, widening doorways, putting in grab bars, or raising toilet seats.

JG: Please explain your statement, "Social workers can move patients into better housing which can result in the need for fewer medications and better health outcomes."

SS: Before CAPABLE, I had a one hundred and one year old patient who lived in a housing development that was rife with crime. She lived with a high level of fear that intensified as she became less mobile. She was unable to leave her home to run errands and had to hire neighbors to help her pay her bills and take out her trash. She experienced increasing loneliness and social isolation with her loss of mobility. She was taking four blood pressure medications and four diabetes drugs that barely controlled the diseases. She was eventually forced to move because her housing development was going to be demolished. The social workers were able to move her into a repurposed school building that had the large long windows and hardwood floors reminiscent of older schools. Even though the building was designated for seniors, she was still much older than many of the other residents. The new home gave her an instant network of supportive neighbors and she felt safe. Not long after the move, I was able to take her off some of her diabetes and blood pressure medications. That was one of my 'ah ha' moments. My patient was the same person. She had lived the same one hundred and one years. She had the same physiology and biology, yet she needed less medication because of the physical environment. The difference was striking.

JG: Did she change her diet or move around more?

SS: Her diet might have changed a little bit, but I think the change occurred because her stress reaction was reduced substantially. Stress mitigation can have a surprisingly powerful effect. There is a large body of literature about how chronic stress exposure affects diabetes, high blood pressure, and other diseases.

JG: What are the demographics of the CAPABLE participants?

SS: The CAPABLE participants are low income adults, age sixty five and older, with one or more basic activity of daily living limitation or two or more independent activity of daily living limitations. They are mostly African American and duel eligible, meaning they are insured by both Medicare and Medicaid.

JG: Please describe the CAPABLE program.

SS: The CAPABLE program spans a period of four months. The nurse, the occupational therapist, and the home improvement team member meet individually in the home with the patient to learn their functional goals and medical priorities. Goals might be something like the desire to have friends over for a meal, or have better access to the items in a closet or the refrigerator, or to shower safely. After the assessment period, the occupational therapist writes a work order.

Work orders are informed by the priorities of the patient not the care team. Repairs might include a second railing on a staircase for improved support and stability and brighter lighting. This would support the goal of a participant who wants to sleep

upstairs in bed rather than on the couch downstairs. From this goal the occupational therapist might create a program to strengthen the arms and improve the balance of the patient.

JG: How many home repairs do you typically make?

SS: Home repair work orders have, on average, sixteen to seventeen small repairs that are individualized to the home and the priorities of the patient. Repairs might include bed risers that make it more easily to get into and out of bed or a simple three dollar pull chain so the patient does not have to climb up onto the table to turn the light on and off. Our most common repair is to add a second bannister on the main staircase.

JG: Please describe the importance of participant engagement.

SS: The program has proven effective only when the team honors the priorities and goals of the participant over their own ideas. People do not want someone coming in and telling them what to get rid of and what to change. For fall prevention it is common to take away all throw rugs, but we have learned that we cannot go in and suggest that. People have things in their home because they want them there. We might suggest that, in our professional fall risk opinion, we would like to tape down the throw rugs or replace them with some nonskid backing. We have learned that the program is most successful when we build motivation for people to do what *they* want to do. It does not motivate people when we tell them what we want them to do and how to do it.

JG: How much of the care plan is designed by the participant?

SS: We use our clinical judgment to mix input from the team with the goals of the patient. We add our ideas if the patient agrees. When other organizations implement CAPABLE, it is important that the team use the old fashioned paper and carbon method to document, by hand, the goals and ideas of the patient in duplicate. A couple of our partners have not embraced the idea of using that method and tell us, “We can print the plan out for our patients at the office if they want.” That is a different process for the patient. It is more empowering for them to see their ideas being written down by a professional and then given back to them. We tell them, “Here are the things you said you would like to try.” When we return, we ask them if they have attempted to meet their goals. The response is often a glass half full kind of answer such as, “I was going to do the exercises three times per week but I did them only once per week.” We respond, “It is wonderful that you did them once.” We do not say, “What about the other two times you did not do them?” Our focus is always on building their motivation.

JG: What health outcomes have CAPABLE participants experienced? (Appendix A)

SS: On average, the program has resulted in cutting the disability of the participants in half. Seventy five percent of the CAPABLE participants experienced improvement in their ability to perform activities of daily living. The average improvement reduced limitations, such as bathing, dressing, grooming, or walking from four to two. As impressive as those results are, they are probably conservative because if the patient has even minor difficulty at all with any activity, we do not mark it as improved. For example, a person may have extreme difficulty getting into and out of the bathtub before they work with our team and have only minor difficulty after our program, and it will not count as an improvement. The results of the improvement in the independent activities of daily living were also substantial. Sixty five percent of CAPABLE participants experienced improvement in their ability to perform the independent activities of daily living. This is especially impressive because the patient population we serve is expected to experience a decline in those abilities--even over a four month period. Other trials have not seen anywhere close to those results.

The depressive symptoms of CAPABLE participants were reduced, on average, from moderate to mild. This improvement in depression level may seem minor, but is not. It can mean the difference between needing to take antidepressant medication or not.

JG: Were you surprised by the initial results?

SS: Yes. We have been analyzing the results of a recent randomized control trial and we had to change to a different statistical model than we usually use because there were so many zeroes in terms of people having no difficulty with any activities of daily living. At first, we thought, “Oh no, this is not working!” In actuality, it was working better than we had hoped.

JG: Has the program reduced hospitalizations for the participants?

SS: The Centers for Medicare & Medicaid Innovation project matched each of the two hundred and fifty patients in the CAPABLE program to ten people with the same age, race, gender, zip code, number of chronic conditions, and amount of healthcare usage as a comparison group. Capable participants saw dramatically lower rates of hospitalization as compared the control group.

JG: Did you track nursing home placement rates?

SS: The comparison group entered nursing homes at approximately a five percent rate as compared to the two percent rate of the patients in the CAPABLE program. That means the program reduced their likelihood of nursing home placement by more than fifty percent.

JG: What cost savings does the CAPABLE program generate?

SS: The cost savings per CAPABLE patient is estimated at ten thousand dollars each year for two years amounting to twenty thousand dollars. The program cost is three thousand dollars, representing a six times return on investment.

JG: Do you measure wellbeing or patient satisfaction?

SS: The physical health and cost savings are substantial but one cannot overlook the improvements in mental health and overall wellbeing that the participants experienced. A number of the participants are foster parents. When they can stay in their homes safely and actively, they are also able to care for their foster children. These relationships are a great benefit to both the children and the older adults.

JG: Has CAPABLE resulted in fewer falls for participants?

SS: We are not statistically powered to measure falls well but, based on the fact that safely accomplishing activities of daily living prevents falls, CAPABLE was recently named a leading falls prevention program by the National Council on Aging.

JG: Where are the CAPABLE sites?

SS: The CAPABLE projects that have been completed in Baltimore have served approximately four hundred and fifty people. Today there are CAPABLE programs operating in sixteen cities or rural areas in eight states. There is a national accountable care organization that has a CAPABLE site in Michigan. We also have projects in California, North Carolina, Pennsylvania, Vermont, Colorado, four locations in Maine, and two in Maryland.

Because CAPABLE has yielded such positive results, an increasing number of providers have adopted the program. CAPABLE more than pays for itself, so providers who receive value based reimbursements are willing to absorb the cost. That is really exciting because one does not need grant funding or insurance reimbursement to offer the CAPABLE model to patients.

JG: Do you have another case study that you would like to share?

SS: The two most common case studies represent different but important points. The first is the one I referenced before about moving a patient to a safe location and the effects it had on her physical and mental health. Another story I tell is about a participant who was highly overmedicated but her family did not realize it. Her husband would pull her up off the bed and sit her on a commode chair all day. That was all he was able to do because he was frail himself. When reviewing the medications, the nurse found that the patient was taking twenty six medications. Too many of them were for pain, which was why she was dazed and unable to move around and use the toilet as

needed. After medication adjustments, the nurse helped the family make a medication chart that was clear. It explained when to take the medications and what they were prescribed for. Not long after, the participant became more alert and was able to set her own goals. One of her goals was to be able to go downstairs. She had been upstairs for two years--her family brought food to her. She wanted to wash her hair in the kitchen sink. Part of the reason I like to tell this story is I think it is a good example of letting people choose their own goals. No nurse or occupational therapist would walk in and say, "I think you should wash your hair in the kitchen sink." It is not a bad idea, but it just would not occur to anyone. It is a really specific task that would not be my goal, but it was incredibly motivating for her because is what *she* wanted to do.

When she began the program, it took her thirty minutes to walk down the hall to reach the bathroom. During our brainstorming and action planning session, our participant came up with the idea to put plastic deck chairs along her hallway so that she could sit and rest during her walk. She was deconditioned to the point that walking a few feet, sitting, standing up and walking a few more feet, and siting down was a lot of exercise. Our visits are spaced a month apart but because the plan was hers, she was determined to become mobile and worked toward her goal. We mounted double railings and good lighting on the stairs. We also raised the bed and made it firmer with a board under the mattresses and installed a strong grab bar so that she could use it to push herself up. By the end of the four months, she was able to get herself out of bed. The first time this happened, her husband burst into tears. She was eventually able to go downstairs and wash her hair in the kitchen sink.

A few months after CAPABLE ended, her granddaughter called us and said that the whole family, including our former par, was going to Atlantic City. We were overjoyed. We were moved beyond words. Our participant had been nodding off on her commode chair all day before we met her, and now was able to get herself out of bed, move about her home, and take a family trip.

JG: Thank you for this inspiring discussion.

SS: Thank you for your interest in CAPABLE.

Appendix A
Publications by Sarah Szanton

Szanton, S.L Leff, B.L., Wollf, J.L., Roberts, L. Gitlin, L.N Innovative home-based care model reduces disability and promotes aging in place *in press at Health Affairs*.

Szanton, S.L. Aging in Place: Innovative Teams (2017 publication date) chapter in *Nursing Research shaping Health Policy:* Springer Publishers. Edited by Patricia Grady and Ada Sue Hinshaw.

Szanton, S.L. Thorpe, R.J., Boyd, C., Tanner, E.K., Leff, B., Agree, E., Xue, Q.L., Allen, J.K., Weiss, C., Seplaki, C.L., Guralnik, J.M., Gitlin, L.N. (2011). CAPABLE: A bio-behavioral-environmental intervention to improve function and health-related quality of life of disabled, older adults. *Journal of the American Geriatrics Society,* 59(12): 2314-2320. PMCID: PMC3245364.

Pho, A. Tanner. E.K., Roth, J., Greeley, M., Dorsey, C., Szanton, S.L. (2012) Nursing Strategies for Promoting and Maintaining Function among Community-Living Older Adults: The CAPABLE Intervention. *Geriatric Nursing*. *Nov-Dec;* 33(6)439-45 (with Master's student).

Gitlin, L.N., Szanton, S.L., Hodgson, N. (2014) It's Complicated – But Doable: The Right Supports Can Enable Elders With Complex Conditions To Successfully Age In Community. *Generations*. 37(4): 51-61.

Szanton, S.L. Klimmek, R. Roth, J., Savage, J., Nkimbeng, M. (2014) Improving unsafe environments to support aging independence with limited resources. Invited manuscript *for Nursing Clinics of North America* issue: Facilitating Aging in Place: Safe, Sound, and Socially Secure. 49 (2) 133-145 PMCID: PMC4074077.

Szanton, S.L., Wolff, J.W., Leff, B.L., Thorpe, R.J., Tanner, E.K., Boyd, C., Xue, Q., Guralnik, J. Bishai, D. Gitlin, L.N., (2014) CAPABLE trial: a randomized controlled trial of nurse, occupational therapist and handyman to reduce disability among older adults: rationale and design. *Contemporary Clinical Trials* 38(1):102-112. PMCID: PMC4074085.

Szanton, S.L., Wolff, J.W., Roberts, L. Leff, B.L., Thorpe, R.J., Tanner, E.K., Boyd, C., Xue, Q., Guralnik, J. Bishai, D. Gitlin, L.N. (2015) Preliminary data from CAPABLE, a patient directed, team-based intervention to improve physical function and decrease nursing home utilization: the first 100 completers of a CMS Innovations Project *Journal of the American Geriatrics Society* 63(2):371-374.PMCID: PMC4498670.

Smith, P.D., Boyd, C., Bellantoni, J., Roth, J., Becker, K., Savage, J., Nkimbeng, M. Szanton, S.L., (2016) Communication between primary care providers and nurses within the home: an analysis of process data from CAPABLE *Journal of Clinical Nursing (with a doctoral student),* 25(3-4) 454-462. PMCID: PMC4738578.

Szanton, S.L., Gitlin, L.N., Meeting the demographic and health care financing imperatives through focusing on function: the CAPABLE studies *Public Policy and Aging Report* 6.16.

Gitlin, L.N., Szanton, S.L., DuGoff, E.H. (2011). Supporting Individuals with Disability Across the Lifespan at Home: Social Services, Technologies, and the Built Environment. "White paper" commissioned by the SCAN Foundation.

Bridges, A., Szanton, S.L., Evelyn-Gustave, A., Smith, F. Gitlin, L. Home Sweet Home: Interprofessional Team Helps Older Adults Age in Place Safely. *OT Practice,* 9.9.13.

Gleason, K. Tanner, EK, Boyd, C.M., Saczynski, J.S., Szanton, S.L. (2016) Factors Associated with Patient Activation in an Older Adult Population with Functional Limitations *online ahead of print at Patient Education and Counseling* (with PhD student) PMCID: 772754.

Smith, P.D., Becker, K.L., Roberts, L., Walker, J.L., Szanton, S.L. Associations among pain, depression, and functional limitation in low-income, home-dwelling older adults: an analysis of baseline data from CAPABLE. In press at *Geriatric Nursing* (with nursing student and post-doc).