
CAPABLE Bundle Payment Model: Community Aging in Place—Advancing Better Living for Elders

Proposal for Physician-Focused Payment Model Technical Advisory Committee
October 2018

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Physician – Focused Payment Model Technical Advisory Committee
C/o US DHHS Assistant Secretary for Planning and Evaluation Office of Health Policy
200 Independence Ave. SW.
Washington, DC 20201

Re: CAPABLE Provider Focused Payment Model

Dear Committee Members,

On behalf of the Johns Hopkins School of Nursing, I would like to request a review and approval of an innovative model for older adults with chronic conditions and functional limitations, called CAPABLE. CAPABLE was tested in a Center for Medicare and Medicaid services Innovation program and has been shown to decrease difficulties with Activities of Daily Living while decreasing hospitalizations and nursing home admissions. The title of the proposal is "CAPABLE Provider Focus Payment Model."

Based on solid evidence, we propose that the implementation of this payment model will result in decreased hospitalizations decreased nursing home admissions, enhanced quality and improved ability for older adults with chronic conditions and functional limitations to function at home safely and independently.

Please see below for the project sponsor and primary point of contact:

Project Sponsor

A handwritten signature in black ink, appearing to read "P. Davidson".

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Primary Point of Contact

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

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October 19, 2018

Physician – Focused Payment Model Technical Advisory Committee
C/o US DHHS Assistant Secretary for Planning and Evaluation Office of Health Policy
200 Independence Ave. SW.
Washington, DC 20201

Dear Committee Members,

I am forwarding for PTAC review a joint proposal from the Stanford Clinical Excellence Research Center and the Johns Hopkins School of Nursing entitled “CAPABLE Provider Focused Payment Model.”

In our Stanford center’s year-long review of diverse evidence sources of interventions targeting improvement in measures of quality of care and efficient resource use, the CAPABLE program, developed and tested at the Johns Hopkins School of Nursing, stood out. The evidence in favor of this intervention is robust, demonstrating improvements in function and depression scores, and average Medicare savings of \$922 per member per month (PMPM). These savings continue for 24 months after completion of the 5-month intervention and are achieved by a reduction in hospitalizations and other preventable forms of institutionalization. The program prioritizes the preferences of older adults, who overwhelmingly prefer to remain independent in their homes.

Because CMS has historically been unable to reimburse services considered “non-medical” such as the home modifications included in CAPABLE, we sought advice from PTAC staff about whether PTAC had statutory authority to recommend such a program. Staff advised that such a regulatory determination requires submission of the proposal.

Thank you for your consideration of this evidence grounded PTAC proposal. Dr. Kendell Cannon will serve as our point of contact.

Sincerely,

Arnold Milstein

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Abstract

Community Aging in Place—Advancing Better Living for Elders (CAPABLE), is a program designed to improve the functional ability of older adults with chronic conditions and functional limitations. CAPABLE is a time-limited intervention performed by an interdisciplinary team of an occupational therapist (OT), registered nurse (RN), and “handyman” (henceforth handyworker). Intended patients include Medicare beneficiaries with at least two chronic conditions and difficulty with at least one activity of daily living (ADL). This population utilizes a larger proportion of healthcare resources compared to beneficiaries without chronic conditions and functional limitations.¹ These costs are driven largely by hospitalizations and long-term care such as nursing homes.² Ideally, any patient identified as high-risk could be enrolled by a health plan, or a healthcare provider could write a “prescription” for CAPABLE services. The intervention includes 10 home sessions (6 OT and 4 RN), each 60-90 minutes over the course of 4-5 months.³ The participant, together with the clinicians, identifies specific functional goals for which the occupational therapist provides assessment, education, and interactive problem solving. The OT also directs the handyworker to perform limited home repairs, adaptive modifications, or installation of assistive devices (up to \$1300 in 2013 USD). The nurse specifically addresses pain, depression, polypharmacy, common geriatric concerns and primary care communication.

While we outline several potential payment models in this proposal, after examining the pros and cons of each, we believe that, starting with a partial bundled payment with partial upside and moving towards a fully capitated model would facilitate the adoption and spread of the model, while providing higher financial incentives to those groups willing to take full risk of their populations. Given that there is not a model without drawbacks, we would also encourage continued discussion and evolution of the payment model to promote quality of outcomes.

Central to the premise of CAPABLE is prioritizing the needs of clients and working towards patient-centered outcomes. The CAPABLE bundle incorporates principles of motivational interviewing and interdisciplinary teamwork to identify and create individualized, client-directed plans of care. This program systematically targets both modifiable intrinsic (person-based) and extrinsic (environmental-based) risk factors to create a bio-behavioral-environmental program to increase functionality.⁴ Key components of the CAPABLE model are patient involvement in all goals, improving function, and addressing quality of life. In order to assure the quality and fidelity of the intervention, key quality metrics include measurement of ADL and IADLs, depression, and home hazard or fall risk. In practice, the ADL, IADL, and PHQ-8⁵ scores as well as a fall risk assessment are obtained before the intervention and again afterwards for comparison.

This program leverages evidence-based services that allow functionally limited older adults to remain independent in their communities. Creating a payment mechanism for this evidence based, high-value solution would promote scalability whereby the CAPABLE intervention could impact the greatest number of lives.

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I. Model Description

1. Background and Model Overview

This program, called Community Aging in Place—Advancing Better Living for Elders (CAPABLE), improves the functional ability of older adults with chronic conditions and functional limitations. CAPABLE is a time-limited intervention performed by an interdisciplinary team of an occupational therapist (OT), registered nurse (RN), and a “handyman” (handyworker). Potential participants include Medicare beneficiaries with at least two chronic conditions and difficulty with at least one activity of daily living (ADL), such as bathing, dressing, toileting, or eating. This population utilizes a larger proportion of healthcare resources compared to beneficiaries without chronic conditions and functional limitations.¹ These costs are driven largely by hospitalizations and long-term care such as nursing homes.² The intervention³ includes 10 home sessions (6 OT and 4 RN), each 60-90 minutes, over the course of 4-5 months (Table 1). The participant, together with the clinicians, identifies specific functional goals for which the occupational therapist provides assessment, education, and interactive problem solving. The OT also directs the handyworker to perform limited home repairs, adaptive modifications, or installation of assistive devices (up to \$1300 in 2013 USD). The nurse specifically addresses pain, depression, polypharmacy, and primary care communication. This program leverages evidence-based services that allow functionally limited older adults to remain independent in their communities. Implemented in a Medicare-Medicaid dual eligible population, this solution improved depression scores, reduced the number of ADLs considered “difficult” from an average of 4 to 2, and produced significant savings to Medicare and Medicaid.⁶ The savings continued for up to 24 months following completion of the 5-month intervention, largely driven by reductions in hospitalizations and long-term services and supports.⁷

Table 1. Home Visits and Collaboration with CAPABLE Clients over 4-month Period⁸

	OT Visit 1	OT Visit 2	After OT visit 2	OT Visit 3	OT Visit 4	OT Visit 5	OT Visit 6
Occupational Therapist (OT) and client together	Introduction; Function focused OT assessment. Fall risk and recovery education.	Determine client’s functional goals, conduct home safety assessment & identify necessary repairs or modifications.	Develop work order for home repairs/ modifications & sends to HW.	Brainstorm and develop action plan with client for client-identified goal #1.	Brainstorm and develop action plan with client for client-identified goal #2.	Brainstorm and develop action plan with client for identified goal #3; Review HW work and train participant on new assistive devices.	Wrap up; help participant generalize solutions for future problems. Review goals and client’s achievement of them.
Handyworker (HW)				HW visits client’s home; reviews repairs/modifications & associated costs with OT. Starts work and continues until complete.			
			RN Visit 1	After RN visit 1	RN Visit 2	RN Visit 3	RN Visit 4
Registered Nurse (RN) and client together			Introduction; Function-focused RN assessment	Make medication calendar for client.	Determine goals in RN domain together; start to	Complete Brainstorming/ Problem-solving	Review progress and use of strategies

			including pain, mood, strength, balance, medication information, Healthcare Provider (PCP) advocacy/ communication.	Review client's medications including, side effects, interactions and possible changes. Consult with pharmacist if on high-alert or more than 15 medications.	brainstorm goals. Demonstrate CAPABLE exercises. Review, clarify, and modify medication calendar. Consider how to improve communication with PCP. Develop correspondence to PCP.	process. Develop Action Plans with client. Assess PCP response to communication of client needs. Review/assess /trouble-shoot exercise regimen.	for all target areas. Complete Action Plans. Review RN section of Flipbook that summarizes program. Evaluate achievement of goals and readiness to change scale.
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2. Model from the patient's perspective:
 - a. Central to the premise of CAPABLE is prioritizing the needs of clients (patients) and working towards patient-centered outcomes. The CAPABLE bundle incorporates principles of motivational interviewing and interdisciplinary teamwork to identify and create individualized, client-directed plans of care. This program systematically targets both modifiable intrinsic (person-based) and extrinsic (environmental-based) risk factors to create a bio-behavioral-environmental program to increase functionality.⁴
3. Model from provider's perspective:
 - a. Interdisciplinary team of registered nurse (RN), occupational therapist (OT), and handyworker: Table 1 defines the roles of each member of the CAPABLE interdisciplinary team over the 4-5 month time period.
 - b. Patient's primary care provider (PCP): Ideally, the patient's PCP would play an integral role in identifying appropriate individuals for the intervention, ordering the intervention, and integrating the recommendations of the CAPABLE team into the patient's medical care plan.
 - c. Post-acute care providers, hospitals, or other medical institutions: To reduce re-hospitalization rates, these groups could identify individuals at risk and recommend them to the program.

II. Response to Criteria

1. Scope:
 - a. Define patient population: The participants included in the CAPABLE Studies met eligibility criteria that included living at home, reporting difficulty in at least 1 activity of daily living (ADL) or at least 2 instrumental activities of daily living (IADL), the ability to stand with or without assistance, and income <200% of the poverty line (NIH trial) or income <135% of the poverty line (Centers for Medicare & Medicaid Services study). Exclusion criteria for the initial studies were those individuals hospitalized ≥ 3 times in the previous year, actively receiving cancer treatment, had expected survival of < 1 year, were cognitively impaired, or had plans to relocate within 1 year of the intervention.⁹ While this

population has shown the greatest degree of cost savings to both Medicare and Medicaid, we believe that CAPABLE could be of benefit to those with higher incomes as well. An adaptation that includes individuals with cognitive impairment has also been described.¹⁰

- b. Define providers: Both the registered nurse (RN) and the occupational therapist (OT) receive individualized training in motivational interviewing, person-centered care, and follow a specialty-specific outline to perform assessments, provide education, and encourage interactive problem-solving skills. The handyworkers are contracted and work directly with the occupational therapist to perform the minor home repairs identified by the OTs during their assessments.
2. Quality and Cost: Measuring and identifying quality is key to ensuring that decreased utilization of additional services represent improvement in quality rather than simply decreasing costs through restriction/withholding of care. All models require monitoring of quality throughout the intervention, although the degree of difficulty calculating and assigning savings varies. Since one of the key values of the CAPABLE model is patient involvement in all goals, an ideal measure of quality would include determining the degree of “patient-centeredness” of the visits.¹¹ Additional quality metrics include measurement of ADL and IADLs, depression, and home hazard or fall risk. In practice, the ADL, IADL, and PHQ-8⁵ scores as well as a fall risk assessment are obtained before the intervention and again afterwards for comparison. We have included a list of recommended quality metrics below:
 - a. Top Quality Metrics:
 - i. Patient-centered visits¹¹
 - ii. Number of ADLs and IADLs considered “difficult” before and after intervention^{12,13}
 - iii. Depressive symptoms (PHQ-8⁵ or PHQ-9¹⁴) before and after intervention
 - iv. Participant satisfaction (post-intervention qualitative interview or HCAPS survey model)
 - v. CDC Fall Risk Assessment¹⁵ before and after intervention
3. Payment Methodology: This model would create a payment model for services currently only partially covered by Medicare. Under current Medicare rules, only skilled nursing and occupational therapy needs can be reimbursed and they differ from CAPABLE visits as they are usually reactive after an acute event and are not designed to optimize person-environment fit encouraged by the CAPABLE model. Stanford’s Clinical Excellence Research Center (CERC) independently identified CAPABLE as one of the top “high-value” interventions seen across the country. A component of the research modeled potential savings and costs if the intervention was targeted to older adults with multiple chronic conditions and functional limitations. We considered many financial models for CAPABLE including an upfront “bundled” charge for services. This model was based on evidence that suggests an average Medicare net savings of \$700 per member, per month (PMPM) for at least two years following the intervention.⁷ We also considered an advanced alternative payment model (APM), which could promote improved intervention fidelity/quality and decrease the risk of fraud. In addition to these two, we considered a spectrum of payment models ranging from partial bundled payment with varying degrees of upside and downside risk as well as full cost-sharing models that would likely require patient matching and control groups to identify payment amounts. While we believe the

intervention is best utilized in value-incentivized organizations, the adoption and spread of this model has been limited by the inability to provide payment mechanisms under Medicare Fee-for-Service (FFS), which maintains the majority of health funding for older adults. Ideally, the payment methodology would also allow organizations moving towards value-based care to charge for and deliver CAPABLE. Below we describe a spectrum of payment models, each having a variety of benefits and drawbacks as described below:

- a. Bundled payment for intervention: The CAPABLE model has been shown to provide direct savings to Medicare and Medicaid when implemented.^{2,7} While a lump sum is the easiest method for paying for the intervention, it introduces problems regarding volume similar to those present in our current FFS healthcare system. If implemented, it would need very strong quality metrics and parameters to ensure continued quality and value over volume. With strict limitations on quality, this payment model could be the simplest way to implement the model initially.
- b. Payment for only the cost of intervention (no margin) with secondary cost savings (upside) or cost savings/loss split (upside/downside): To avoid the identified quality issue described above, an alternative payment method would be for Medicare to pay for the intervention (standardized by region of country) and utilize combined quality/cost metrics to determine additional savings or repayment required. Given the significant value of this intervention for savings, this would likely be the most profitable for organizations to implement if willing to take full risk; however, it does require calculation of what individuals would otherwise have spent based on a pre-determined amount, matched controls, or equation-based metrics. Given the time and effort required to calculate potential savings, the administrative burdens could potentially cost more than the amount going directly to patient care.
- c. Partial bundled payment with bonus for meeting quality metrics: This method could cover half to 75% of the cost of the intervention with additional payments for meeting pre-defined quality metrics. Ideally, this would hold organizations accountable for the quality of the intervention in order to receive payment for the entire cost of intervention and/or ability to make a profit.

Our recommendation: Having carefully considered the pros and cons described above, we believe that in practice, starting with a partial bundled payment with partial upside and moving towards a fully capitated model would facilitate the adoption and spread of the model, while providing higher financial incentives to those groups willing to take full risk of their populations. Given that there is not a model without drawbacks, we would also encourage continued discussion and evolution of the payment model to promote quality of outcomes.

4. Value over Volume: This model is associated with a Medicare savings of \$922⁷ per member per month for up to 2 years and an additional \$86⁶ per member per month to Medicaid for up to a year. Capitated or “at risk” systems should be able to capture these savings, which were related to decreased hospitalizations, skilled nursing facility admissions, and specialty care. If expanded to the fee for service Medicare system, the

key to value over volume requires the very close measurement of quality as described above. If implemented as a partial lump sum with partial upside, moving towards a fully capitated model, this proposal will provide new incentives to deliver high-value care. For example, in the Michigan Medicaid waiver, the CAPABLE participants decreased hospital admissions compared to their matched comparators in the waiver.¹⁶

5. Flexibility: Currently, the 22 sites that have already implemented this model have displayed a significant variability in implementation styles. While the intervention can be tailored to implementing systems, the foundational pieces include the training and motivational interviewing and patient directed goals, the teaching of problem solving skills to patients. Within those parameters, there is significant flexibility with the Michigan waiver version of CAPABLE adding social work to visits as an option as one example.
 - a. Johns Hopkins University, which initially developed CAPABLE, has recently received funding from the Rita and Alex Hillman Foundation to employ an implementation scientist to measure this implementation variability and outcomes related to the variability. There is also a learning collaborative user group (Yammer platform) that current CAPABLE sites can access to share best practices and gain support for new ways to implement.
 - b. Model adaptation to account for changing technology: The use of home visits may be partially substituted with HIPAA-compliant RN or OT visits by tablet. This would be especially useful in rural areas where travel time is a cost-barrier and would only occur after a thorough in-home, in person assessment for the first visit.
6. Ability to be evaluated: The proposed PFPM will have evaluable goals for quality, cost and beneficiary experience. In our CMMI demonstration project and in our NIH randomized trial, we collected beneficiary reported difficulty with self-care (such as bathing and toileting), which drive hospitalization and other high-cost utilization. Data sources will include claims, administrative records and the electronic medical record (EMR) of the organizations implementing CAPABLE. This can be measured in relation to the same beneficiaries prior to CAPABLE participation or to a matched group not receiving CAPABLE.
 - a. Evaluation of the proposed model already underway: This program has already been evaluated with several trials including a randomized control trial from NIH. Results included reductions in disability and in inpatient and nursing home stays (please see attached articles in the supplemental materials). There are also evaluations of ongoing CAPABLE program implementations that are underway but not yet published including one of the innovations program of Trinity Health services (see Letter of Support) and the National Center for Healthy Housing.
7. Integration and Care Coordination: CAPABLE deploys an integrated team of providers. Our experience is that it is best to have one of the people on the team coordinate care but it is a flat hierarchy and it doesn't matter from a role perspective which role coordinates. In a few sites, a social worker functions as the care coordinator. We do not anticipate that this would require significant changes in the number or types of professional workforce. As more of hospital and nursing home patients shift to the community, more nurses and occupational therapists will likely flow to the community and be available to work in programs like CAPABLE.
8. Patient Choice: The focus and basis of this model is patient choice and patient-identified

goals for being able to age in place safely and independently. Key to the model is assessing the exact goals someone may have to be able to be safely at home, such as being able to sleep in a bed on the 2nd floor rather than a couch on the first floor, or being able to prepare easy healthy meals rather than be limited to microwaving packaged food. In addition, CAPABLE participation itself would be a choice with no beneficiary required to participate.

9. Patient Safety: The CAPABLE model is considered a safety approach as it improves the ability of older adults to take care of themselves, such as getting into the shower without falling. CAPABLE has been highlighted in the Institute for Healthcare Improvement (IHI) Reports to describe improving safety.¹⁷ National Council on Aging (NCOA) has approved CAPABLE as an evidence-based fall prevention program and therefore organizations applying to the Administration for Community Living (ACL) for money for fall prevention can use CAPABLE. CAPABLE is also considered a leading model in the care redesign for older adults with complex conditions and functional limitations [cite Better Care Playbook].
10. Health Information Technology:
 - a. Currently, EPIC is integrating CAPABLE into their global database, which would allow others to utilize these measures. Additionally, at its most basic level, the EMR would be used to record and track participants in progress note format; however, ideally, this model could also be formatted into an assessment that could facilitate improved workflows. Lastly, the trainings are currently undergoing a redesign utilizing video-game based technology to improve the reach of training and ability to try a variety of situations.
 - b. Learning collaborative as described above using the Yammer platform.

III. Appendices:

1. Diagrams/Supplemental Information:
 - a. Core CAPABLE Principles

Principle	Description of Principle	How we do it
Let the Client Drive	Identify client's personal goal and risk. Start with older adults' readiness.	Start with where the client is; goals are the participant's only. Clinicians use clinical knowledge to help clients achieve their goals. Client is not told what to do.
Promote Self-Efficacy	Clinician's believe that the client can make changes. Clients' believe that they can make changes. Clinician-client partnership is based on client goals. True power of change comes from the client.	Client identifies goals to work on. Praise changes, no matter how small. Clinician is not judgmental. Motivational Interviewing. Support client goals. Praise any changes the client is willing to make.
Connect Cultures	The home/community is a micro-culture that reflects the values, beliefs, & preferred approaches to self-care & life-style choices.	Use the cues you receive from the client's home to learn how to approach.
Solve Problems	CAPABLE is a systematic approach to helping older adults solve daily	Work together to solve client's own identified goals.

	care challenges. CAPABLE enhances self-efficacy. CAPABLE involves family members & caregivers when appropriate.	Teach problem-solving techniques that the client can generalize to future problems. Involve family members and caregivers to help.
Customize	Tailor the strategies to client-identified concerns, capabilities, environment, and cultural values. Tailor services to the environment through home visits.	Motivational Interviewing is focused around “clients-know-best” what they need. Develop and modify the Action Plans.
Interprofessional: Each profession supports the goals	Each discipline brings a different skill set to support the client’s own goals. No discipline is primary.	Occupational Therapist-Registered Nurse-Handyworker Team
Assess the environment	Assess the clients in their home. Tailor strategies to enhance the clients’ function in their environment.	Home visits assess both the person and the environment within the scope of each discipline.
Prevent	Preventive approach to improving function. Assess for risk around the agreed-upon target areas.	Focus on improving what the client wants to change.

b. Differences between Traditional Home Health RN and CAPABLE RN⁸

Role	Home Health RN	CAPABLE RN
Goal Setting & Plan of Care	Nurse-driven goal setting and plan of care, centered on the patient illness or injury, as identified by the client’s Healthcare Provider.	Client driven goal setting and plan of care, centered on the functional goals and activities of interest, identified by the client.
Collaboration with Client	Treatment provider to the client for a specific medical problem as directed by the client’s Healthcare Provider. Delivers treatments based on prescriptions from client’s Healthcare Provider.	Consultant to the client for achieving their functional goals. In partnership with the client, the RN helps to determine and shape the intervention by paying special attention to the clients’ preferences on nursing domains: pain, mood, incontinence, medications, fall prevention, sexual health and PCP communication.
Interdisciplinary Collaborations	Works separately from other specialists, but refers client to specialists and other services as needed (e.g., physical or occupational therapy, social work)	Integral part of interdisciplinary team that includes the client, an Occupational Therapist, and a Handyworker (and in consultation with a Pharmacist). RN refers client to social work services from local agencies as needed.
Provision of Nursing Care	Provides skilled nursing care (i.e., physical assessment, phlebotomy, administration of IV medications, wound care, and patient education) provided as prescribed by client’s Healthcare Provider.	Nursing care provided as needed, to meet client directed, functional goals, in consultation with interdisciplinary team and with an emphasis on prevention . Notifies client’s Healthcare Provider to

		urgent medical situations and recommends adjustments to medications/therapies requiring a prescription, i.e. orthostatic hypotension, foot wounds and issues around adherence.
Duration of Care	Home health services provided for up to 60 days per episode of care (as defined by Medicare; RN visit frequency may vary.	CAPABLE intervention delivered over 4 months ; RN sees client a maximum of 4 visits .
Focus on Medications	Reconciles client's medications with a general focus on side effects & interactions & notifies client's Healthcare Provider if any issues. Client education provided as needed.	Reconciles client's medications within seven nursing domains, client concerns, costs & high alert medications & notifies client's Healthcare Provider of medication issues. Additional medication activities include: <ul style="list-style-type: none"> • Creates & reviews with client, client friendly medication calendar. • Troubleshoots issues related to medication adherence. Works with Pharmacist in situations where client is on high alert medications or >15 medications.
Focus on Pain	Performs pain assessment as directed by client's illness or injury. Provides client pain education such as: pain identification, pharmacological & non-pharmacological approaches to pain management.	Performs assessment for pain focusing on how pain impacts client function & progress towards client identified goals of care. Provides client specific education on pain such as: identification, alleviation or prevention, & pharmacological & non-pharmacological approaches to pain management.
Other Demands on RN	Supervise other home health workers (licensed practical nurses or home health aides). RN may be on call nights, weekends, or holidays. Physically demanding. May require bending, lifting, or standing.	RN does not supervise other home health workers. No need for RN coverage on nights, weekends, or holidays. Limited amount of bending/lifting/standing.

c. Differences between Traditional OT and CAPABLE OT

	Traditional Occupational Therapy	CAPABLE Occupational Therapy
Interdisciplinary Collaborations	The OT, PT, speech language pathologist (SLP), or RN often work individually on a specific injury or illness to achieve short and long-term goals.	The OT, RN, and handyworker collaborate on goals set by the participant to ensure safety and functionality inside and outside of home.
Focus on Function & Environment	The OT directs attention to assisting the patient around the illness or injury.	The OT focuses on function and environment, and the intertwining between the person and environment.
Provision of Occupational Therapy Care	Provides skilled occupational therapy. Evaluates and treats using strategies (e.g., range of motion, home exercise program) and adaptive equipment (AE), adaptive devices (AD), assistive technology (AT), durable medical equipment (DME), and environmentally controlled units for the participant.	Use preventive methods and strategies shown and discussed with the participant, and provide AE, AD, AT, and DME plus home repairs within a fixed budget.
Education	The OT continuously provides education to the participant and caregivers as needed for as long as he or she is providing services.	The OT serves as a consultant to the participant and his or her family, and as a facilitator who guides the participant through problem solving strategies and developing solutions that can later be generalized when the team is no longer present.
Referrals & Role	Referrals to OT vary state by state.	Participants are found via community resources or health organizations to target the population needing this intervention and do not necessarily require a prescription by an MD. The OT serves as a consultant for participants' functional goals, not as the treatment provider.
Duration of Care	The OT cannot open a case in the home setting; the OT determines whether the participant needs continuation to achieve goals—no predetermined time.	The OT is the first out of the three disciplines to visit the participant in his or her home, establishes rapport, and has a six-visit maximum.

2. List of places already implementing model

CAPABLE Program Replication/Scale Up (updated 9/2018)		
U.S. Programs	Organization	Payment Mechanism
California (San Diego)	The National Center for Healthy Housing has coordinated funding to pilot CAPABLE at 4 locations (NC, PA, VT, CA).	Foundation funded
Colorado (Denver)	Colorado Visiting Nurse Association	Hospital conversion. Foundation funded. Value based evaluation compared to Colorado all-payor database
Illinois (Chicago Suburbs)	Northwest Housing Partnership plus Attuned Health	Initial Foundation funding
Maine (Bath + 3 other sites)	Bath, ME Housing Authority Partners and Mid-Coast Health to add an OT and RN in 4 new sites.	Accountable Care Organization
Maryland (Baltimore)	JMAP - Johns Hopkins Medical Alliance for Patients	Accountable Care Organization
Maryland (Baltimore)	Johns Hopkins Hospital implemented through JH Home Care	Financial incentive to prevent hospitalizations and improve health due to Maryland all-payor hospital waiver.
Maryland (Bel Air)	Habitat for Humanity National Grant site.	Funded through Harry and Jeanette Weinberg Foundation and local foundations
Maryland (Montgomery County)	Habitat for Humanity National Grant site.	Funded through Harry and Jeanette Weinberg Foundation and local foundations
Massachusetts (Lowell)	Veterans Administration	Pilot in Lowell, MA. Paid by AARP Foundation and in-kind VA. Veterans Administration is a single payer for all services and can scale internally
Michigan (Flint, Saginaw, Grand Rapids, Detroit)	Michigan Medicaid waiver through organizations that have contracts with the Waiver services. Examples, an Area Agency on Aging, a Home health agency	Home and Community based Waiver saves money to the state if people avoid nursing home admission.
Michigan (Muskegon)	Mercy Health which is part of Trinity Health	Accountable Care Organization

Minnesota (Minneapolis)	Habitat for Humanity National Grant site. Allina Health Care is the health care partner	Funded through Harry and Jeanette Weinberg Foundation and local foundations
New York (New York City)	Visiting Nurse Association of New York City	NIH funding for randomized controlled trial with evaluation through all-payor database.
North Carolina (Greensboro)	The National Center for Healthy Housing has coordinated funding to pilot CAPABLE at 4 locations (NC, PA, VT, CA).	Funded through HUD and Harry and Jeanette Weinberg Foundation
Pennsylvania (Wilkes-Barre)	The National Center for Healthy Housing has coordinated funding to pilot CAPABLE at 4 locations (NC, PA, VT, CA).	Funded through HUD and Harry and Jeanette Weinberg Foundation
Pennsylvania (Philadelphia)	Habitat for Humanity National Grant site. Thomas Jefferson University and Drexel University are health partners.	Drexel and Thomas Jefferson University are paying staff time for OTs and RNs.
Tennessee (Memphis)	Separate Habitat for Humanity grant and also, nursing home error money	Separate Weinberg Foundation funding plus Plough Foundation
Vermont (Burlington)	The National Center for Healthy Housing has coordinated funding to pilot CAPABLE at 4 locations (NC, PA, VT, CA).	Funded through HUD and Harry and Jeanette Weinberg Foundation
Non-U.S. Programs		
Australia	Clients with mild cognitive impairments, adaptation of CAPABLE called I-HARP	Medical Research Council funding

3. Letters of Support:

- a. AARP - Susan Reinhardt, RN, PhD; Senior Vice President and Director
- b. Trinity Health - Anna Marie Butrie; Vice President, Innovation & Program Services
- c. Institute for Healthcare Improvement - Maureen Bisogano; President Emerita and Senior Fellow
- d. SNP Alliance - Cheryl Phillips, MD; President and CEO



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AARP Public Policy Institute

June 28, 2018

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

Dear Dr. Szanton,

On behalf of the AARP Public Policy Institute, I submit this letter in strong support of the Johns Hopkins and Stanford Center for excellence in research or to the Physician -Focused Payment model Technical Advisory Committee for a care bundle of the CAPABLE program.

From my vantage point as Senior Vice President and Director of the AARP Public Policy Institute, I know how rare and important it is to create research that can scale past the walls of academia. I have watched as CAPABLE was tested in both a CMMI Innovation Center project and an NIH randomized controlled trial. I have watched as it has scaled to 22 test sites in 11 states.

I can clearly see both the importance of the program and a limiting factor of not having a payment mechanism for the bundle of services. I strongly support a payment model for CAPABLE in fee-for-service Medicare.

Sincerely,

Susan C. Reinhard, RN, PhD
Senior Vice President and Director
AARP Public Policy Institute





July 9, 2018

Sarah L. Szanton, PhD, ANP, FAAN
Health Equity and Social Justice Endowed Professor
Director, Center on Innovative Care in Aging
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Joint Appointment with the Department of Health Policy and Management,
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Baltimore, MD 21205

Dear Dr. Szanton,

We applaud Johns Hopkins University and Stanford CERC collaboration in submitting a Physician Focused Payment model Technical Advisory Committee for a care bundle of the CAPABLE program. We are pleased to provide this letter of support for your application.

The CAPABLE model is highly innovative with a strong evidence base built from both CMMI funding and NIH trials. The CAPABLE program aids older adults in living more functional lives at home and helps to avoid hospital admissions and ER visits for vulnerable patients in our communities. Although there is extensive national interest in CAPABLE, scaling the program has been limited by the lack of a payment mechanism for fee-for-service Medicare.

Trinity Health has piloted a version of CAPABLE at our Mercy Health site in Muskegon, Michigan through the use of Trinity Health Innovation Program funds. Based on pilot results, there is an interest in scaling CAPABLE to other sites across Trinity Health. Our scaling capabilities are hampered by the lack of a payment model for this innovative service in fee-for-service Medicare. If the PTAC was to approve the proposed Payment Model for CAPABLE, we would hope to be able to offer CAPABLE services to fee-for-service beneficiaries who meet eligibility criteria for this innovative program in additional Trinity Health facilities.

Sincerely,

Anna Marie Butrie
Vice President, Innovation Program & Services

CC:

Jim Purvis, Innovation Consultant
Judith Kell, HUB Operations Mgr., Musk Comm. Health Project
Carrie Harnish HUB Operations Mgr., Musk Comm. Health Project

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August 7, 2018

Sarah L. Szanton, PhD, ANP, FAAN
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525 North Wolfe Street, #424
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Dear Dr. Szanton,

I am excited to hear that Johns Hopkins University and Stanford CERC are collaborating to submit a Physician Focused Payment model Technical Advisory Committee for the CAPABLE program. At IHI, we are always interested in new models of care that improve health, while saving costs. CAPABLE is a strong example of this.

The CAPABLE model has been tested with both CMMI funding and NIH trials. You have shown that the costs of this modest program (less than \$3,000) can avert more than \$22,000 in Medicare costs. Much of this saving is due to decreased hospitalizations. We are so impressed that CAPABLE has already spread to 22 sites in 11 States. At IHI, we have highlighted CAPABLE in our No Place Like Home: Advancing the Safety of Care in the Home book, and in our podcast.

This extensive national interest in CAPABLE is strong but has been limited by lack of a mechanism for reimbursement. We write this letter in strong support of your PTAC proposal so that this important program has the potential to reach more vulnerable older adults.

Sincerely,

A handwritten signature in cursive script that reads 'Maureen Bisognano'.

Maureen Bisognano
President Emerita and Senior Fellow
Institute for Healthcare Improvement



August 13, 2018

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
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525 North Wolfe Street, #424
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Dear Dr. Szanton,

The SNP Alliance is excited to support your PTAC Physician Focused Payment model Technical Advisory Committee for a care bundle of the CAPABLE program. As you know we have independently identified that CAPABLE is an evidence-based program that can improve the lives of those dually eligible for Medicaid and Medicare while saving costs through averting preventable hospitalizations and nursing home admissions. We are thrilled to provide this letter of support for your application.

While the CAPABLE bundle has an extensive evidence base built from both CMMI funding and NIH trials, its uptake is currently limited due to lack of a payment mechanism. This is a drawback for extensive scaling.

The SNP Alliance is dedicated to improving policy and practice for frail, disabled and chronically ill beneficiaries. Our member special needs plans and Medicare-Medicaid plans serve over 1.6 million high risk and vulnerable individuals. We are in the middle of a process to test whether some of our members can usefully adopt CAPABLE as it currently exists. The ability to scale CAPABLE outside of a managed care environment is hampered by the lack of a payment model for this innovative service in fee-for-service Medicare. If the PTAC was to approve the proposed Payment Model for CAPABLE, other providers and health care systems would hope to be able to offer CAPABLE services more widely to serve these vulnerable beneficiaries.

Sincerely,

Cheryl Phillips, M.D.

President and CEO, SNP Alliance

cphillips@snpalliance.org / 202.203.8004

4. Supporting Research:

Health Affairs March 2017 36:3

Innovative Home Visit Models Associated With Reductions In Costs, Hospitalizations, And Emergency Department Use

By Sarah Ruiz, Lynne Page Snyder, Christina Rotondo, Caitlin Cross-Barnet, Erin Murphy Colligan, and Katherine Giuriceo

Abstract: While studies of home-based care delivered by teams led by primary care providers have shown cost savings, little is known about outcomes when practice-extender teams—that is, teams led by registered nurses or lay health workers—provide home visits with similar components (for example, care coordination and education). We evaluated findings from five models funded by Health Care Innovation Awards of the Centers for Medicare and Medicaid Services. Each model used a mix of different components to strengthen connections to primary care among fee-for-service Medicare beneficiaries with multiple chronic conditions; these connections included practice-extender home visits. Two models achieved significant reductions in Medicare expenditures, and three models reduced utilization in the form of emergency department visits, hospitalizations, or both for beneficiaries relative to comparators. These findings present a strong case for the potential value of home visits by practice-extender teams to reduce Medicare expenditures and service use in a particularly vulnerable and costly segment of the Medicare population.

Journal of the American Geriatric Society 2018 66:614-620

Medicaid Cost Savings of a Preventive Home Visit Program for Disabled Older Adults

By: Sarah L. Szanton, Y. Natalia Alfonso, Bruce Leff, Jack Guralnik, Jennifer L. Wolff, Ian Stockwell, Laura N. Gitlin, and David Bishai

Abstract:

BACKGROUND/OBJECTIVES: Little is known about cost savings of programs that reduce disability in older adults. The objective was to determine whether the Community Aging in Place, Advancing Better Living for Elders (CAPABLE) program saves Medicaid more money than it costs to provide. **DESIGN:** Single-arm clinical trial (N = 204) with a comparison group of individuals (N = 2,013) dually eligible for Medicaid and Medicare matched on baseline geographic and demographic characteristics, chronic conditions, and healthcare use. We used finite mixture model regression estimates in a Markov model.

SETTING: Baltimore, MD

PARTICIPANTS: Individuals aged 65 and older with reported difficulty with at least one activity of daily living.

INTERVENTION: CAPABLE is a 5-month program to reduce the health effects of impaired physical function in low-income older adults by addressing individual capacity and the home environment. CAPABLE uses an interprofessional team (occupational therapist, registered nurse, handyman) to help older adults attain self-identified functional goals.

MEASUREMENTS: Monthly average Medicaid expenditure and likelihood of high- or low-cost use of eight healthcare service categories.

RESULTS: Average Medicaid spending per CAPABLE participant was \$867 less per month than that of their matched comparison counterparts (observation period average 17 months, range 1–31 months). The largest differential reduction in expenditures were for inpatient care and long-term services and supports.

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