BIO: **Deborah Paone, DrPH, MHSA**

Throughout her 25-year career Dr. Deborah Paone has worked across disciplines and settings in healthcare and aging services—bridging policy, practice, and research—to integrate health and social care services for older adults, people with disabilities and family caregivers.

She founded Paone & Associates, LLC in 2002 and has provided consultation to providers, health plans, government agencies, community service organizations, and research centers.

Deborah maintains her consulting practice while serving as Performance Evaluation Lead & Policy Consultant to the Special Needs Plan Alliance (DC) and as the **Implementation & Evaluation Director – CAPABLE, for Johns Hopkins University (Baltimore).**

Previously, she was VP for the National Chronic Care Consortium (Minneapolis) and Director of the Section for Aging and Long-Term Care Services for the American Hospital Association (Chicago).

Dr. Paone assisted the State of Minnesota in their development and implementation of the Minnesota Senior Health Options program, conducting educational meetings, learning collaboratives, and surveys to capture early learning as health plans and provider networks developed their care coordination approaches for the dually-eligible population. She also conducted a study of care coordination methods. MSHO served as the model for special needs health plans and set the standard for integrated dual care programs nationally.

Deborah has a Doctor of Public Health from the University of North Carolina-Chapel Hill, a Master of Health Services Administration from the University of Michigan, and a Bachelor of Arts in Gerontology from the University of Rochester.

CAPABLE

A national evidence-based program developed by Johns Hopkins with dissemination support through the CAPABLE National Center

Community Aging in Place, Advancing Better Living for Elders (capablenationalcenter.org)

What is CAPABLE?

- Evidence-based
- Home-based
- Person-directed
- Interprofessional
- Long-term impact
- Behavioral change

CAPABLE Participants

- Adults – age 50+
- With functional limitations
- Living at home or in an apartment
- Cognitively intact

How CAPABLE works

An interdisciplinary team uses motivational interviewing, active listening, and coaching communication methods to enable the participant to achieve their self-prioritized goals

Participant

- Self-assessment
- Readiness to change
- Drives own goals and priority settings
- Brainstorms options/solutions; Develops Action Plan in own words
- Makes progress between visits; Exercises, reads material, practices within home
- Practices tips for safe, independent living
- Uses new skills and equipment

Occupational Therapist

- Functional/Mobility assessment
- Home risk; modifications & equipment needs
- Fall prevention, equipment guidance

Registered Nurse

- Medical history, current healthcare providers
- Key health issues/risks
- Pain, medication review

Handy Worker

- Receives work order; confers with participant
- Obtains and installs equipment
- Makes minor home repairs/modifications

CAPABLE at a Glance

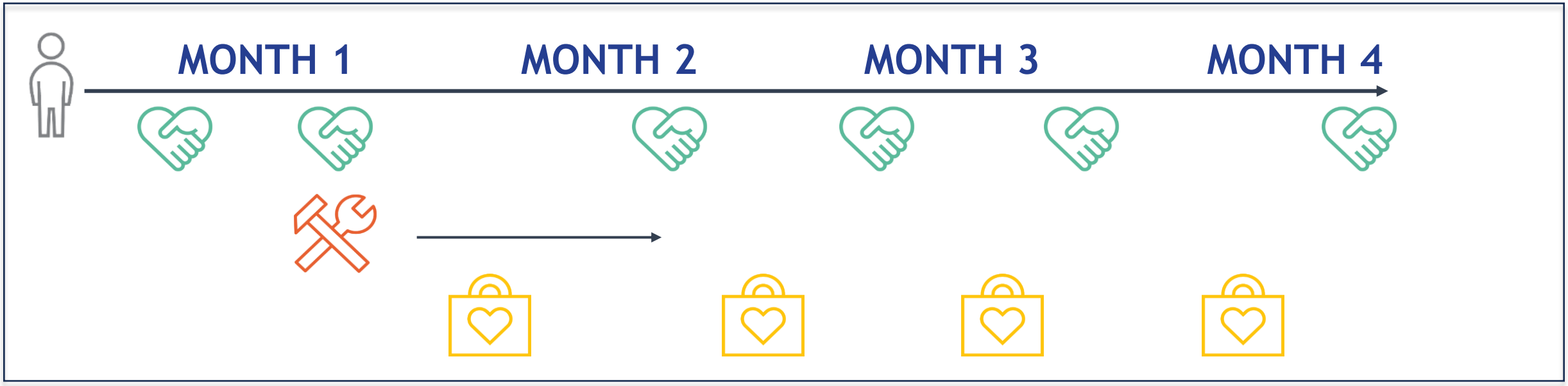
CAPABLE is delivered in the home during **10 visits** over
4 months through an inter-professional **team** including the participant:

Occupational Therapist

Registered Nurse

Handy-worker

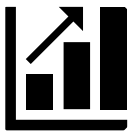
Participant



Program Benefits

6 to 7 x return on investment

Roughly $3,000 in program costs yielded more than $30,000 in savings in medical costs driven by reductions in both inpatient and outpatient expenditures.*



Improved physical function

Participants had difficulty with an average of 3.9 out of 8.0 Activities of Daily Living (ADLs) at baseline, compared to 2.0 after five months.

Improved motivation

The change in physical environment further motivates the participant. Addressing both the people and the environment in which they live allows the person to thrive.

Reduced symptoms of depression

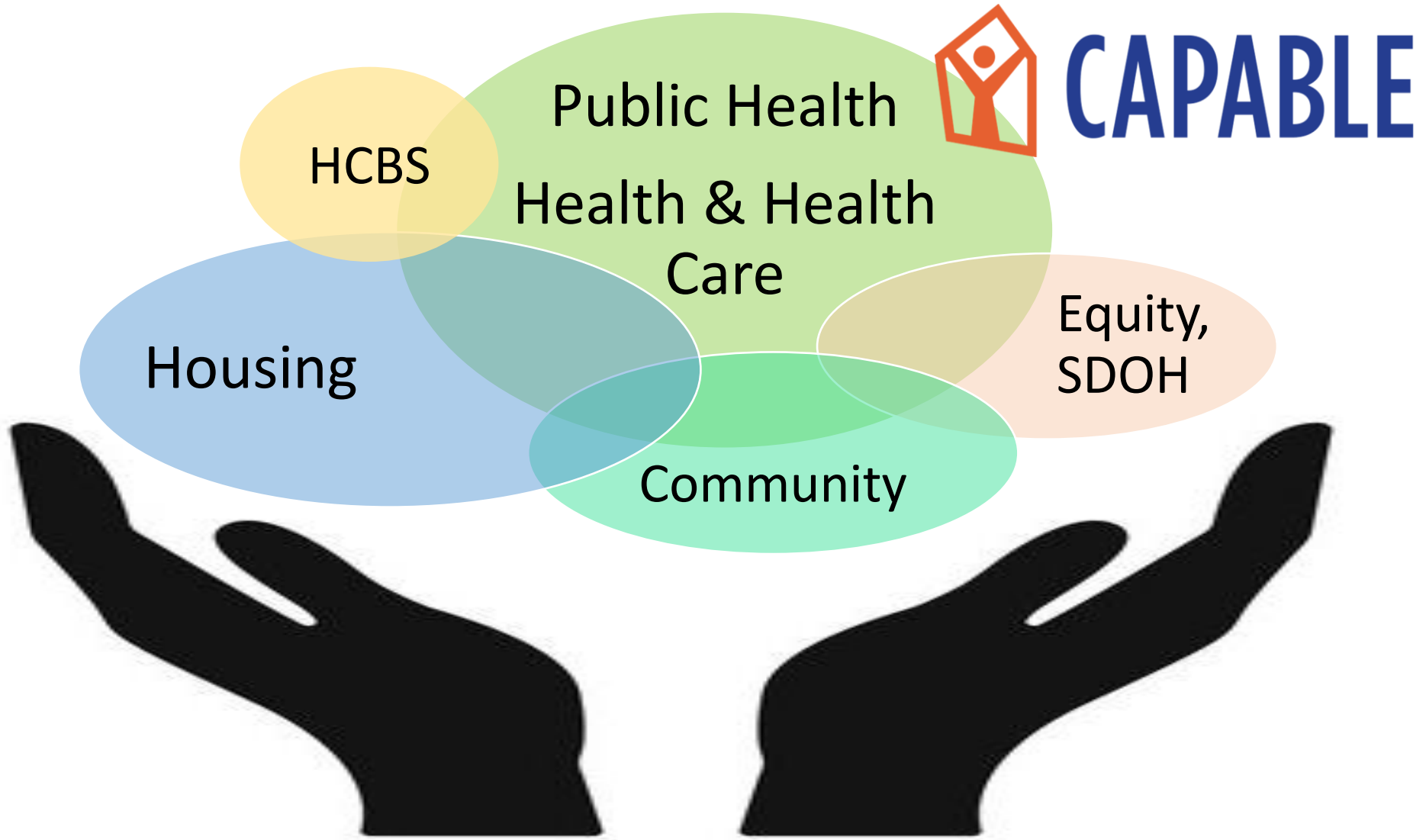
Symptoms of depression lessened, and ability to do important tasks, such as grocery shop and manage medications improved.

*Ruiz et. al, 2017

Keys to Success

- Strengths and goals developed by participant
- Clinicians provide resources to achieve those goals
- Unleashes participant's motivation
- Person/environmental fit
- Helps demonstrate that function can be improved/is not lost
- Builds self-efficacy for new challenges

CAPABLE Intersections



Perspectives on Value Equation

STAKEHOLDER	TOP VALUE of CAPABLE
Potential Participant	***Improved quality of life***
Organization offering CAPABLE Leadership (Board, C-Suite)	***Service, mission, reputation, cover costs, strategic direction***
Partners	***Service, mission, payment, long-term partnership interest/strategic***
OT, RN, and Handy-worker	***Service excellence and satisfaction***
Local senior service providers	***Ability to refer their clients to a proven, effective program***
Private Philanthropist or Foundation	***Proven effectiveness, Health Outcomes & Community impact***

Perspectives on Value Equation

STAKEHOLDER	TOP VALUE of CAPABLE
Primary care providers	*Fewer patient falls/calls; improved patient health and self-care at home*
Hospital & ED (in value-based arrangement)	*Fewer hospital readmissions; fewer ED visits*
Managed care organization	*Reduced hospital/ER costs and improved member satisfaction*
Federal Medicare Program	*Reduced Medicare costs due to avoided hospital/ER costs; better quality outcomes*
State Medicaid Program	*Reduced Medicaid costs due to avoiding early admissions to a nursing home; better quality outcomes*
City/Town Services (EMT, Fire)	*Reduce "pick up from floor calls"*

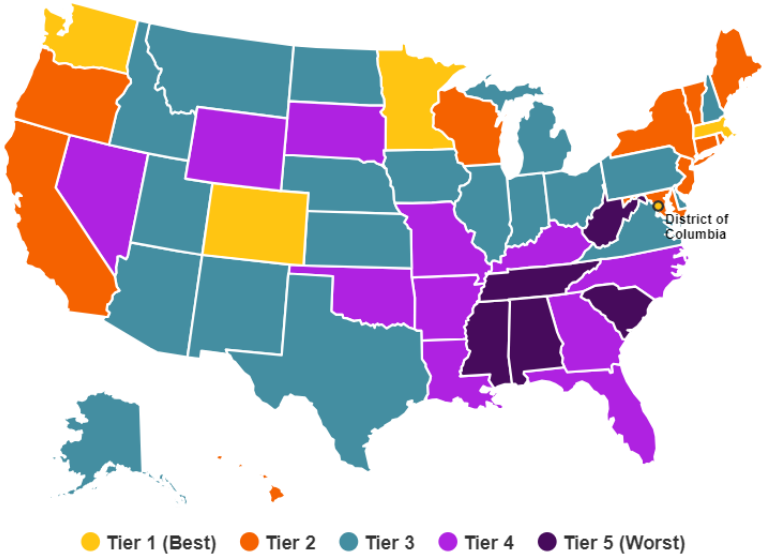
State Implementation & Financing Pathways

The CAPABLE program has unique capabilities that can benefit states.

As Medicaid agencies, health departments, and legislatures work towards supporting older adults in their communities, implementing CAPABLE can play a key role in achieving these goals, while saving Medicaid dollars.

For example, a state pursuing **LTSS rebalancing efforts** can look to CAPABLE as a proven home and community-based service for older adults that will reduce the likelihood of nursing home admission.

States can even be awarded policy innovation points in AARP's LTSS Scorecard for supporting CAPABLE availability as it is an evidence-based proven program to support "aging in community"



State Implementation Pathways

Implementation Opportunities

- Building off existing home-based innovations by home health agencies or AAAs
- Public health falls prevention campaigns or programs
- Initiatives to expand HCBS or home modification services
- Initiatives to lower acute care spending
- Initiatives to promote aging in place or improve quality of life for older adults, such as a Multisector Plan on Aging (MPA)

Implementation Pathways

- State legislation (e.g., requiring CAPABLE implementation, grant program for initiatives relevant to CAPABLE such as falls prevention, home modifications, etc.)
- Required benefit inclusion (e.g., via State Medicaid Agency Contract (SMAC), Medicaid waivers, or State Plan Amendment (SPA))
- Innovation-driven demonstration project or concentrated pilot program

State Financing Pathways

Financing Pathways

- State Medicaid dollars
- Non-Medicaid state dollars (e.g., state grants programs, public health funding)
- Federal funding (e.g., CMMI demonstrations, HUD grants)
- Tax revenues tied to public health, older adults, or aging in place
- Innovation-driven demonstration project or concentrated pilot program
- American Rescue Plan Act (ARPA) or similar federal special grant funding (ARPA funding has been leveraged by states as a financing pathway to fund CAPABLE implementation in Colorado and other states).

State Examples

Colorado – *Piloting CAPABLE as a Potential Medicaid Benefit*

- **Background**: Colorado's first CAPABLE site was established in 2017 through grant funding and expanded to a second site with support from the state to test CAPABLE as a Medicaid benefit.
- **State funding established**: 2022
- **Financing pathway(s)**: State ARPA funding allocation in coordination with CMS
- **Implementation pathway(s)**: The Colorado Department of Health Care Policy & Financing (HCPF), at the direction of state legislation, created a partnership with the state's existing implementation site, the Colorado Visiting Nurse Association (CVNA), to operate the pilot through December 2024. HCPF also partnered with the Colorado Evaluation and Action Lab (University of Denver) to evaluate findings and help determine the long-term viability of CAPABLE as a potential Medicaid benefit within Colorado.
- **Referral source**: Clients come from a variety of sources, as long as they are verified as Medicaid eligible; CVNA markets directly to potential participants.
- **Implementing organizations**: Home health agency, construction/housing company

Minnesota – *CAPABLE through Non-Medicaid State Funding*

- **Background**: Minnesota's first CAPABLE site was established in 2018 through private grant funding by the Twin Cities Habitat for Humanity. Through the state's Live Well at Home grant program, two sites received state funding for two years to establish CAPABLE programs; both sites have since closed following grant completion.
- **State funding established**: 2019 (Rural MN Habitat for Humanity); 2020 (Minnesota River AAA).
- **Financing pathway(s)**: State-funded through the Live Well at Home grant program.
- **Implementation pathway(s)**: The Live Well at Home grant program is a longstanding initiative designed to promote healthcare innovation and aging in place.
- **Referral source**: Pre-existing client base, provider referrals, and community word-of-mouth.
- **Implementing organizations**: AAA, Habitat for Humanity location, home health agency.

Best Practices

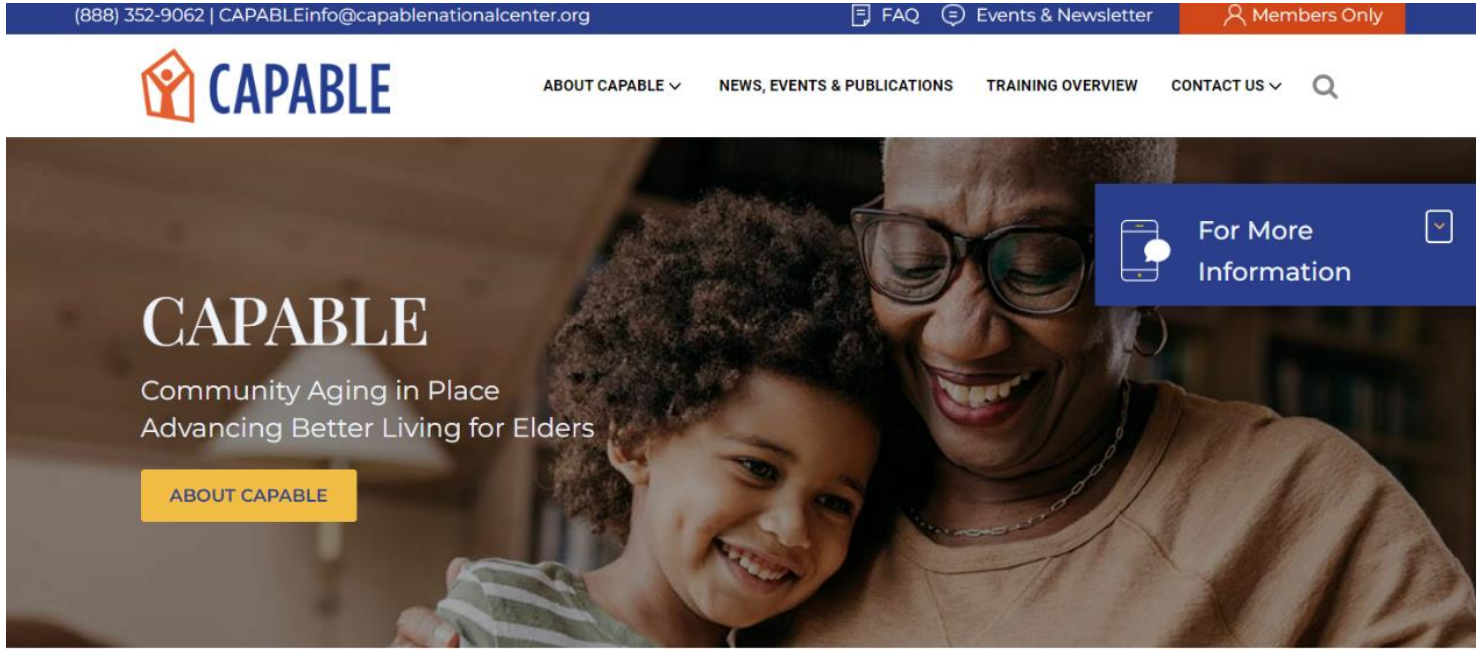
Across CAPABLE implementations to date, there have been lessons learned and identified best practices for states as they consider their own CAPABLE implementations:

1. **Identify and engage key stakeholders and champions early on:** Having a home health entity and a housing organization engaged early in the process can help facilitate implementation and long-term success for a new CAPABLE site.
2. **Prioritize evaluation:** Facilitating and ensuring evaluation of CAPABLE sites will help build an ongoing value story and attest that the program is delivering meaningful outcomes for participants, which will aid in securing sustainable funding.
3. **Establish reasonable and realistic recruitment and referrals:** Identifying and establishing a recruitment strategy that is reasonable, and realistic in the early stages of implementation can facilitate a successful launch as everyone understands what it takes to build momentum, clarity on participant fit, and understanding of selection criteria. Partnerships with AAAs and HCBS service delivery networks will help identify candidates and grow the program.
4. **Consider sustainability:** Ongoing state support of the identified financing and implementation pathways is critical to ensure continued access to CAPABLE for the state's target populations. A two-year grant is not usually sufficient. Create public-private partnerships, such as with private philanthropic foundations, counties, or cities.

Additional References:

https://www.ncoa.org/article/evidence-based-program-capable

https://capablenationalcenter.org/news-events-publications/



CAPABLE

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