Promoting Choices through Restorative Services: International Innovations

Susan C. Reinhard and Jane A. Tilly
AARP Public Policy Institute

Introduction

As the LTSS Choices series emphasizes, people who need long-term services and supports (LTSS) have four basic requirements: a place to live, services and supports, a workforce to provide those services and supports, and connection to others in the community. People require LTSS when they have difficulty performing daily living activities. Evidence-based services that improve functional independence can help people choose to live in their own homes and stay engaged with their families and friends in their own communities.

This Spotlight highlights a multidisciplinary intervention that strengthens a person’s ability to function. This intervention, which is available in many countries, is known as reablement, restorative care, or restorative services. These services are backed by evidence and cost-effective. They can be incorporated into many current delivery systems in the United States and other countries. Scaling them will require transformation of existing models, creation of new models, or both.

Integrating restorative services into health and LTSS systems is important for at least two reasons. One is that 30 percent to 60 percent of hospitalized older adults develop a new dependency in daily activities and only 68 percent recover to their previous...
level of functioning six months after discharge. Another reason is that home care often does not focus enough on promoting a healthy lifestyle, daily routines, social support, exercise, autonomy, and control. As a result, older adults can become mired in an avoidable dependent role.

Innovators have developed and tested restorative services in many countries to promote health and independence, generally in the context of home care. These services provide short-term rehabilitation, occupational therapy, and other assistance to help people carry out the daily activities that are important to them. In the United States, Australia, and New Zealand, restorative services interventions started around 2000. Sweden, Denmark, and Norway also began using this approach in the early 2000s. Several countries, including Denmark, New Zealand, Australia, and the United Kingdom, have integrated restorative services into their national health care policy. Other countries, like the Netherlands and Norway, are still studying these services.

This Spotlight explores the evidence of the impact of restorative services. First, we define restorative services. Then, we review roughly 20 years of evidence related to the efficacy of these services by summarizing international and country-specific studies. Finally, we make recommendations for policy makers.

**Definition of Restorative Services**

While the definition of restorative services varies among the countries that have tested and implemented these services, there are some common shared themes. Generally, restorative services involve person-centered, goal-oriented services for older people at risk of functional decline, often after an accident or illness. Restorative services are intensive, time limited, and multidisciplinary. They can include exercise and training, behavioral change, self-management and healthy aging training, equipment, and environmental modifications. Services generally last 4 to 12 weeks.

The ReAblement Network developed a formal definition of restorative services through a Delphi study conducted in 2018–19. The goal was to achieve expert agreement on the characteristics, components, aims, and target groups of restorative care. The method involved 4 web-based survey rounds with 82 experts from 11 countries. The final definition of restorative services was accepted by 79 percent of participating experts. Out of the study came agreement that restorative care is person centered and involves a holistic approach to improving individuals’ physical or other functioning, to increase or
maintain their independence in meaningful activities of daily living at their place of residence, and to reduce their need for long-term services.

Restorative services involve multiple visits that a trained and coordinated interdisciplinary team delivers. The team conducts an initial comprehensive assessment followed by regular reassessments and the development of goal-oriented support plans. Restorative services support individuals to achieve their goals through participation in daily activities, home modifications, and assistive devices as well as involvement of their social network. Restorative services are inclusive, regardless of age, capacity, diagnosis, or setting.

In short, restorative services differ from traditional home care in that they reorient services toward promoting independence, rather than treating disease and creating dependency. The evidence presented below documents the potential that restorative services have for improving the lives of older adults and perhaps reducing their use of health and LTSS.

**Systematic Reviews of the Evidence about the Impact of Restorative Services**

The most recent seven systematic literature reviews of restorative services, published between 2009 and 2019, show that those who receive restorative services have better functioning and lower use of health and LTSS, and their cost of services may be lower compared with those who received the usual care.

**Improved Function and Decreased Service Use**

Reviews from 2015-19 found that restorative services improve individuals’ abilities and decrease service use. Participants’ function improved and their dependence on others decreased.\(^8\) Restorative services also improved health-related quality of life.\(^9,10,11\) Improvements are durable because research indicates that restorative services are more effective than usual care in improving function at 9 to 12 months and decrease the number of people who need higher levels of personal care.\(^11\)

These recent reviews indicate that service utilization decreased for those who received restorative services.\(^12\) Research from Australia demonstrates lower use of home care, nursing homes, and emergency departments.\(^13\) Evidence about hospital readmission is mixed, with some studies reporting that restorative services reduce readmission and others reporting the opposite.

An earlier review from 2009 examined restorative services interventions conducted in the early and mid-2000s, finding that participants experienced functional improvements and reduced need

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\(^12\) Tessier et al., “Effectiveness of Restorative Services.”

\(^13\) Aspinal et al., “New Horizons.”
of services.\textsuperscript{14} US and UK programs from that period resulted in participants having shorter and less intensive home care after hospital discharge.\textsuperscript{15} In the United Kingdom, research revealed that reduced health service use and the benefits to participants persisted up to two years postintervention. Single services, especially aides, equipment, and environmental modifications, resulted in less functional dependency and reductions in personal care use and increased prevention of disability.

**Reducing Costs**

The systematic reviews indicate that restorative services for older adults also have a high probability of reducing costs when compared with standard home care.\textsuperscript{16,17} For example, in more recent studies, home care and health care costs were lower among restorative services participants than those receiving standard home care only.\textsuperscript{18} A systematic review of the cost-effectiveness of restorative services identified 13 relevant studies.\textsuperscript{19} Ten of the studies found restorative services to be cost-effective when compared with inpatient rehabilitation, home care, day hospital rehabilitation, or a waiting list control. Studies in the United States and United Kingdom indicate that restorative care is no more expensive than regular home care and reduced use of institutions.\textsuperscript{20} Aids, equipment, and environmental modifications also led to recoupment of the costs of services over the life of the client.

**A Global Perspective**

It is important to understand the generally positive results of restorative services in the context of individual countries’ approaches to providing them. Below we describe those experiences, particularly the structure of each country’s unique restorative services and the variety of positive results that are associated with them.

**Australia**

Australia’s Home Independence Program uses health care professionals as care managers to promote an individual’s engagement in a broad range of daily activities, using task analysis and simplification, assistive technology, exercise programs, self-management training, and medication and nutrition management.\textsuperscript{21,22} The intervention lasts 12 weeks or until the participant achieves his or her first goals.

\textsuperscript{14} Ryburn et al., “Enabling Independence.”
\textsuperscript{15} Ryburn et al., “Enabling Independence.”
\textsuperscript{16} Bauer et al., “Home Care Restorative Services.”
\textsuperscript{17} Whitehead et al., “Interventions to Reduce.”
\textsuperscript{18} Aspinal et al., “New Horizons.”
\textsuperscript{20} Ryburn et al., “Enabling Independence.”
\textsuperscript{22} Gill Lewin et al., “A Randomised Controlled Trial of the Home Independence Program, an Australian Restorative Home-Care Programme for Older Adults,” *Health & Social Care in the Community* 21, no. 1 (2013): 69–78.
A randomized-controlled trial tested this program versus usual care for participants when they were first referred to the home care agency.\textsuperscript{23,24} At 12 months, the intervention group was less likely to require ongoing personal care and was more independent in instrumental activities of daily living (IADLs). The intervention group’s health services use and costs were analyzed over 2 years. The intervention group used fewer hours of home care and personal care at each data collection point. Fewer participants in the intervention group qualified for residential care or used emergency department services. Also, this group’s hospital and home care costs were lower compared with the control group’s. Over 2 years, average home care costs per intervention participant were at least 30 percent lower compared with those receiving usual care.

Individuals in the randomized-controlled trial of Australia’s Home Independence Program had a 5-year follow-up period.\textsuperscript{25} Examination of individuals’ service records in the intervention and control groups occurred at 2, 12, 24, 36, 48, and 57 months. Those who received restorative services used less home care over 3 years and less personal care for the entire postintervention period of 57 months, which amounted to median cost savings of AU$12,500 per person over 5 years.

In an experiment, non-health professionals served as case managers in the Home Independence Program.\textsuperscript{26} No control group was involved. Half of the 70 clients at 3 months and three-quarters at 12 months were not using health services. An additional 20 percent of the clients were receiving fewer services than they were before. These results were at least as good as those that occurred with health professionals providing care management.

The Australian Home Independence Program has some strong results for individuals who received restorative services. Their function improved over time and outcomes were better in comparison with a control group. In addition, cost savings data were strong.

**England**

Restorative services in England involve assessments during which participants create their goals with the assistance of the assessor.\textsuperscript{27} Trained workers then visit the person in his or her home to provide services for four to six weeks. Workers focus on completed tasks with the person rather than completing the tasks for him or her. Researchers have studied several types of restorative care in England. One intervention involved an occupational therapist helping participants improve their daily functioning using goal setting, training, adaptations, and support.\textsuperscript{28} Participants were encouraged to carry out tasks independently. These services were provided in addition to usual home care. The randomized-controlled trial had 30 participants, half of which were in the control group. The

\textsuperscript{23}Lewin et al., “Comparison of the Home-Care and Healthcare Service.”

\textsuperscript{24}Lewin et al., “Randomised Controlled Trial.”

\textsuperscript{25}Gill Lewin et al., “Evidence for the Long-Term Cost Effectiveness of Home Care Restorative Services Programs,” *Clinical Interventions in Aging* 8 (2013): 1273.


intervention and control groups both improved from baseline, with the intervention group’s function improving more. However, these results were not statistically significant.

Another study tested three different models of restorative care delivery with 186 participants. One model involved an occupational therapist delivering occupational therapy and restorative services, another involved workers delivering restorative services only, and the third mixed restorative services with a standard home care model. Because recruitment proved difficult, it was not possible to compare the three different service models. All measures of participants’ health, mental health, and use of services improved at discharge and were largely maintained at six months. The only measure that did not improve was related to IADLs. Lack of a control condition means that improvements may have occurred over time anyway.

In a third study, researchers analyzed administrative data from clients receiving restorative services in Essex, England. Excluding clients who died, 68 percent of clients did not need home care after receiving restorative services. People who were less likely to benefit from restorative services were ages 95 or older or had severe physical disability, dementia, or frailty. People who lived in deprived neighborhoods were also less likely to benefit.

The English results indicate that restorative services could be helpful to participants; however, the results were not strong since most of the studies did not have control conditions.

**Japan**

The Japanese restorative services program—known as CoMMIT—was tested against regular home care in that country. The CoMMIT program encourages participants to develop self-management skills that help ensure adequate oral health care, nutrition, and performance of daily and social activities. The program involves 12 modules that address individualized training in self-management and daily activities. Participants set their own goals for improvement.

Researchers tested CoMMIT in a randomized-controlled trial. The intervention lasted five months. Then the 375 participants were followed for three months. Participants were ages 65 and over with a mild disability and no dementia or end-stage cancer. In the intervention group, 11.1 percent of participants had complete independence from home care after three months versus 3.8 percent in the control group. No differences occurred regarding adverse events.

This relatively large trial in Japan had very positive results for restorative services, which had a heavy focus on self-management.

**New Zealand**

New Zealand’s Promoting Independence Program provides restorative care that includes a comprehensive geriatric assessment, care plan, case management, and rehabilitation services delivered...
in a person's home or in a short-stay residential facility. Researchers conducted a randomized-controlled trial of case management-based restorative care on institution-free survival of 105 older adults who were at high risk of institutionalization. The study’s follow-up period was two years. A nonsignificant reduction in number of deaths of 8.8 percent occurred in residential care and an additional 7.2 percent reduction in deaths occurred for those receiving restorative care when compared with usual home care. Caregiver burden was not affected. There were no significant differences in service use or other outcome measures. This study, like many of those in the United Kingdom, had results that trended toward demonstrating the benefits of restorative services; however, they did not realize statistically significant results.

**Norway**

Researchers in Norway tested restorative services, which incorporated assessments that focused on identifying those five daily activity limitations that participants most wanted to improve. Older adults prioritized outdoor and social activities. Participants’ preferred services were rehabilitation related to functional mobility, personal care, household management, and community engagement. Women were more likely to prioritize personal care, while men prioritized recreational activities. People with higher education were more likely to prioritize socialization.

The services focused on enabling participants to perform the activities themselves. Participants did so with assistive technology and individualized exercises. The intervention lasted 10 weeks and included 61 older participants (the study did not specify the age range) in one Norwegian town. Participants were assessed at baseline, 3 months, and 9 months.

Restorative services led to better outcomes at lower cost compared with usual home care. Participants rated their performance of and satisfaction with daily activities more highly than did those in usual care. Restorative services were more cost-effective compared with usual care because participants had fewer home visits—88 visits versus 158 visits for the control group at six months postintervention. Participants’ time receiving care was less than that of the control group. Restorative services participants received more rehabilitation time and less nursing time when compared with the control group.

Participants with higher baseline functional scores and motivation to improve had better outcomes. Women generally, as well as men and women with a fracture, also had better outcomes. Factors that

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35 Kjerstad and Tuntland, “Restorative Services.”

36 Tuntland et al., “Restorative Services.”

37 Kjerstad and Tuntland, “Restorative Services.”

38 Tuntland et al., “Restorative Services.”
predicted poorer function were pain, dizziness/balance problems, or having a neurological condition other than stroke.

**Taiwan**

We found reports on two studies in Taiwan. In one, researchers tested a simplified restorative services program that was adjusted to each participant’s ability and primarily assisted him or her with mobility activities that could be carried out in the hospital for 30 minutes per day. The randomized-controlled trial tested this intervention in comparison with a group that received reminders to complete the restorative services program each day. A control group received usual care. The participants were 114 hospitalized older adults who could walk independently before admission. Quality of life, mobility, and hand grip strength improved in the restorative services group compared with the control group. While the intervention for this study occurred in the hospital, and not in the participants’ homes, it relied on a restorative approach and had positive results, like those of more traditional restorative models.

In another Taiwanese study, researchers surveyed home care workers and the people and families they worked with in an intervention. The study compared the experiences of 86 people in a three-month restorative services intervention group versus a control group of 100 people in standard home care. Staff working with consumers receiving restorative services saw improved self-reliance skills, job satisfaction, and sense of achievement at work compared with the control group’s staff. The intervention improved consumers’ quality of life and satisfaction with their workers. Caregivers of those in the restorative care group experienced increased independence and reduced burden. Both consumers and workers in the restorative care group had higher mutual support than did those in the control group.

**United States**

We reviewed two restorative services models tested in the United States. The first model involved exercise, behavioral change, self-management, environmental adjustments, adaptive equipment, training, counseling, and medication adjustments. Researchers compared the 770 participants’ hospital readmissions and length of home care episodes versus usual care for posthospitalization patients. Participants in the intervention were more likely to remain at home; were less likely to use the emergency department; and had shorter home care episodes, better self-care scores, better home management, and better mobility. Participants receiving restorative home care were 32 percent less likely to be readmitted to the hospital compared with those receiving usual care. The average length of the home care episode was 20.3 days in the restorative care group versus 29.1 days for those receiving usual care.

The second model—Community Aging in Place, Advancing Better Living for Elders (CAPABLE)—is a five-month program during which participants choose three achievable goals for each licensed

39 Parsons et al., “Randomized Controlled Trial.”


professional who serves them to help them achieve. An occupational therapist visits six times and helps participants choose their functional goals and devises plans for meeting them. A registered nurse visits four times and works with participants to develop health-related goals and coordinates with the participants’ physician and family. A home modifier spends eight hours making home modifications to help participants meet their goals.

Researchers measured 281 older participants’ activities of daily living (ADLs), IADLs, and depression before and after the intervention. Participants were dually eligible for Medicare and Medicaid and had disabilities. Participants were cognitively intact, whereas the comparison group members may have had a cognitive impairment. At baseline, participants had 3.9 difficulties on average with basic daily activities, compared with 2 at five months. Seventy-five percent of participants improved their ADL performance and 65 percent improved their IADL performance. Fifty-three percent of participants experienced improved depression scores. An extension of the original study found that monthly average Medicaid costs per participant were $867 per month less than those of the matched group. The largest reductions in expenditures were for inpatient care and use of LTSS.

The researchers followed up by testing the CAPABLE model in a randomized-controlled trial. The control group received an “attention” intervention of 10 home visits of 60 minutes each. The visits involved sedentary activities. The 300 participants were ages 65 and older, were cognitively intact, had difficulty with at least one ADL or two IADLs, and had incomes at or below 200 percent of the federal poverty level. Participants in the program experienced a 30 percent reduction in the severity of their ADL scores. Participants said that they had easier lives, could take better care of themselves, and had more confidence in managing their daily lives.

A literature review involving six trials of CAPABLE found that each of the studies demonstrated that participants experienced clinically significant reductions in their IADL and ADL limitations. In the studies that reported on rates of depression and falls, both declined among participants. Likewise, the two studies that assessed cost savings demonstrated that CAPABLE reduced costs of care, even after factoring in the cost of the intervention. One study followed participants for seven months and found that participants’ function continued to improve.

CAPABLE is based on restorative care principles, but it lasts quite a bit longer than the typical intervention. Like the very short, hospital-based intervention in Taiwan, CAPABLE has positive results for participants.

**Recommendations**

Restorative care can give older adults more choice over their lives and has the potential to improve health-related quality of life, function, and independence. These improvements could enable people to choose to live in their own homes for longer and stay engaged with their families and friends in their

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own communities. Beyond improving individuals’ lives, restorative services reduce the use of LTSS and other health care services. Research also documents costs savings in multiple countries when restorative services are provided. Thus, given all such benefits, policymakers and other stakeholders should look to restorative care in efforts to transform LTSS.

While restorative services generally are delivered in a person's home, we found similar programs could be effective in other settings, as evidenced by the successes in Taiwan, where the researchers successfully tested a restorative care model in a hospital setting, and New Zealand, where restorative care was used in a short-stay residential setting. This suggests existing programs, like PACE46 programs, may benefit from the consumer-directed focus on rehabilitation on which restorative services are based. Many PACE programs rely on an adult day health care setting, which could incorporate restorative services. Similarly, assisted living settings and nursing homes could also seek to incorporate restorative services into their programs.

Restorative services could also be provided under Medicare, Medicaid, and certain state-based programs. Medicare has home health and skilled nursing facility benefits that could adopt a more consumer-directed focus with their rehabilitation-related services. Medicare Advantage47 plans could also provide such services given that they have the flexibility to do so. Medicare also helps fund PACE programs and Special Needs Plans48, which could cover restorative services. State Medicaid programs could choose to cover restorative services through the many options they have to provide home- and community-based services in lieu of institutional care to those people who qualify. Some states provide home- and community-based services with their own funds. Thus, they set their own rules for service availability and have the flexibility to cover restorative services.

Our recommendation is that federal and state policy makers consider implementing restorative services, which are person centered and consumer directed, in relevant government programs. We also recommend that state policy makers consider the CAPABLE model in the United States.

As evidenced in our review of the research, restorative services should include the following components:

1. Using person-centered and self-directed principles
2. Focusing on the participant’s functional goals
3. Providing an interdisciplinary assessment and care planning aligned with the participant’s goals. Occupational therapy and access to equipment and home modifications are particularly important.
4. Providing a flexible range of services
5. Ensuring that participants have early access to restorative services posthospitalization and upon entering home care

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46 Program of All-Inclusive Care for the Elderly (PACE) is a type of home- and community-based service that provides medical services and supports everyday living needs for certain older adults, most of whom are eligible for benefits under both Medicare and Medicaid. These services are provided by an interdisciplinary team of professionals.

47 Medicare Advantage plans provide Part A (Hospital Insurance) and Part B (Medical Insurance) coverage. Medicare Advantage plans may offer extra coverage, such as vision, hearing, dental, and/or health and wellness programs. Most include Medicare prescription drug coverage (Part D).

48 Medicare Special Needs Plans (SNPs) are a type of Medicare Advantage plan (like a Health Maintenance Organization or Preferred Provider Organization). Medicare SNPs limit membership to people with specific diseases or characteristics. Medicare SNPs tailor their benefits, provider choices, and drug formularies to best meet the specific needs of the groups they serve.
**Conclusion**

Restorative care can give older adults more choice over their lives and has the potential to improve health-related quality of life, function, and independence. These improvements could enable people to choose to live in their own homes for longer and stay engaged with their families and friends in their own communities. Beyond improving individuals' lives, restorative services reduce the use of LTSS and other health care services. Research also documents costs savings in multiple countries when restorative services are provided. Thus, given all such benefits, policymakers and other stakeholders should look to restorative care in efforts to transform LTSS.

**Appendix**

Please see more information about the source articles referenced in the appendix.

**About the Authors**

Susan C. Reinhard, RN, PhD, FAAN, is senior vice president and director of the AARP Public Policy Institute and serves as the chief strategist for the Center to Champion Nursing in America and Family Caregiving Initiatives.

Jane A. Tilly, DrPH, is an independent consultant who has conducted research and policy analysis related to aging, health, and long-term services and supports for over 20 years.

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## Appendix

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<tr>
<td>F. Aspinal et al., “New Horizons: Reablement-Supporting Older People towards Independence,” <em>Age and Ageing</em> 45, no. 5 (2016): 574–78.</td>
<td>There is no one unified definition of reablement. Generally, it involves person-centered, goal-oriented services for older people at risk of functional decline, often after an accident or illness. The intervention lasts 4 to 12 weeks. In addition to helping people function better at home, this service helps people reconnect with their communities.</td>
<td>Literature review</td>
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<td>Limited available evidence about the effectiveness and cost-effectiveness of reablement. It appears to help people improve their ADL functions. Evidence is contradictory regarding quality of life, safety, and physical activity. Research from Australia shows lower use of home care, nursing homes, and emergency departments. Other studies show less need for personal care or readmission to hospitals. Home care and health care costs were lower among reablement participants in more recent studies.</td>
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<tr>
<td>A. Bauer, M. Tinelli, and D. Guy, <em>Home Care Reablement for Older People: Economic Evidence</em> ([London]: Care Policy and Evaluation Centre, London School of Economics and Political Science, 2019).</td>
<td></td>
<td></td>
<td>Literature review and policy analysis</td>
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<td>Home care reablement leads to improved functioning and a decrease in dependence as well as reductions in ongoing home care use. Across different age groups, home care reablement for older people also has a high probability of reducing costs when compared with standard home care.</td>
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<td>B. Beresford et al., “Outcomes of Reablement and Their Measurement: Findings from an Evaluation of English Reablement Services,” <em>Health &amp; Social Care in The Community</em> 27, no. 6 (2019): 1438–1450.</td>
<td>Reablement in England involves assessment wherein the participant creates his or her goals with the assistance of the assessor. Trained workers then visit the person in his or her home to provide services for four to six weeks. The focus is on doing with the person rather than doing for or to them. Reablement services were delivered in three different models, one of which involved an occupational therapist, another a reablement caseload only, and the third a mixed reablement and standard home care caseload. Individuals received services 12 times a week.</td>
<td>Prospective cohort study of three English reablement programs with varying service delivery models. The study used standard self-report measures. Data were collected at baseline, discharge, and six months after discharge. Researchers measured health and social care-related quality of life, mental health, daily activities, and use of paid and unpaid health and community services. There was no control condition.</td>
<td>186 participants</td>
<td>Recruitment was difficult, so it was not possible to compare the three different service models. All measures of health, mental health, and use of services improved at discharge and were largely maintained at six months. The only measure that didn’t was related to IADLs. At six months, all measures had improved. Lack of a control condition means that improvements may have occurred over time anyway.</td>
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<td>Y. H. Chiang et al., “Evaluation of Reablement Home Care: Effects on Care Attendants, Care Recipients, and Family Caregivers,” <em>International Journal of Environmental Research and Public Health</em> 17, no. 23 (2020): 8784</td>
<td></td>
<td>Surveys of home care workers and the people and families they worked with in Taiwan. Comparisons between the experiences of those in the three-month reablement intervention group and those receiving usual home care.</td>
<td>86 people in the intervention group and 100 in usual care</td>
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<td>The reablement home care intervention improved the self-reliance skills, job satisfaction, and sense of achievement at work of staff compared with the control group. The intervention's impact on consumers was to improve their quality of life and satisfaction with their workers. Caregivers experienced increased independence and reduced burden. Consumers and workers had higher mutual support.</td>
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<td>A. Cochrane et al., “Time-Limited Home-Care Reablement Services for Maintaining and Improving the Functional Independence of Older Adults,” Cochrane Database of Systematic Reviews 10 (2016).</td>
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<td>The literature review included two randomized-controlled trials from Australia and Norway. Usual care was the control condition.</td>
<td>811 participants ages 65 and older</td>
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<td>Reablement may be more effective than usual care in improving function at 9 to 12 months. Reablement may decrease the number of people needing higher levels of personal care and may decrease costs. Reablement may not affect death or hospital admission.</td>
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<td>A. Cochrane et al., “Home-Care ‘Re-Ablement’ Services for Maintaining and Improving Older Adults’ Functional Independence (Protocol),” The Cochrane Library 11 (2013): 1–12.</td>
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<td>Reablement is different from traditional home care in that it orients services toward promoting independence, rather than treating disease and creating dependency. This service offers intensive, time-limited, multi-disciplinary care that is person centered and goal directed. Services usually last 6 to 12 weeks and can include exercise and training, behavioral change, self-management and healthy aging training, equipment, and environmental modifications.</td>
<td>Five essential elements of reablement are: participants must need formal care or be at risk of functional decline, services are time limited, services must be delivered in the person’s home, interventions focus on maximizing independence, and services are person centered and goal directed.</td>
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<td>kehrung in life satisfaction and job satisfaction, and a sense of accomplishment. Caregivers experienced increased independence and reduced burden. Consumers and workers had higher mutual support. It also decreased the number of people needing higher levels of personal care and decreased costs. It did not affect death or hospital admission.</td>
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<td>R. Faria et al., “Economic Evaluation of Social Care Intervention: Lessons Drawn from a Systematic Review of the Methods used to Evaluate Reablement,” <em>Health Economics and Outcome Research</em> 2 (2016): 107.</td>
<td>Systematic review and evaluation of research methods for estimating cost-effectiveness of reablement</td>
<td>Researchers found 13 relevant studies. Ten of them found reablement to be cost-effective. Four studies found no difference in effectiveness but did find cost savings. Two studies found cost savings and effectiveness. Two studies found no significant differences. Comparators were inpatient rehabilitation, home care, day hospital rehabilitation, or a waiting list control. One study’s comparator was unclear.</td>
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<td>J. Francis, M. Fisher, and D. Rutter, <em>Reablement: a Cost-Effective Route to Better Outcomes</em> (London: Social Care Institute or Excellence, 2011).</td>
<td>Reablement services commonly focus on dressing, using the stairs, washing, and preparing meals. The United Kingdom began offering reablement services widely no later than 2010.</td>
<td>Literature review and policy analysis.</td>
<td>Research evidence indicates that reablement promotes independence, prolongs the ability to live at home, and reduces the need for care. Occupational therapists are commonly associated with reablement, but not always. Specific training in reablement appears to be important, and workers can be trained to carry out occupational therapy–related tasks successfully. Complaints about reablement relate to handling handoffs to regular home care and the amount of help with domestic tasks. Reablement requires upfront investment but realizes savings of up to 60 percent in subsequent community care costs. Health care costs don’t appear to be reduced.</td>
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<td>S. Hattori et al., “Effects of Reablement on the Independence of Community-Dwelling Older Adults with Mild Disability: a Randomized Controlled Trial,” <em>International Journal of Environmental Research and Public Health</em> 16, no. 20 (2019): 3954.</td>
<td>Comparison of the CoMMIT program plus regular home care to regular home care only. The CoMMIT program encourages participants to develop self-management skills to ensure adequate oral health care, nutrition, and performance of physical and other daily activities and social activities. The program involves 12 modules that address individualized training in self-management and daily activities. Participants set their own goals for improvement.</td>
<td>Randomized-controlled trial in Japan. Five-month intervention program with three-month follow-up period.</td>
<td>375 participants ages 65 and over with a mild disability and no dementia or end-stage cancer</td>
<td>Complete independence from home care after three months was 11.1 percent in the intervention group and 3.8 percent in the control group. No difference in adverse events.</td>
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<td>E. Kjerstad and H. K. Tuntland, “Reablement in Community-Dwelling Older Adults: a Cost-Effectiveness Analysis alongside a Randomized Controlled Trial,” <em>Health Economics Review</em> 6, no. 1 (2016): 1–10.</td>
<td>In the United States, Australia, and New Zealand reablement started around 2000. Sweden, Denmark, and Norway also began using this approach in the early 2000s.</td>
<td>Participants were assessed at baseline, three months, and nine months. Assessments focused on identifying those five daily activity limitations that were most important to participants. The focus was on enabling participants to perform the activities themselves. Assistive technology and exercises were incorporated. The intervention lasted about 10 weeks.</td>
<td>Cost-effectiveness analysis of reablement versus usual home care in a Norwegian town</td>
<td>61 older adults. Participants could not be eligible for institutional care, be terminally ill, or have moderate to severe cognitive impairment.</td>
<td>Older adults prioritized outdoor and social activities. Reablement led to better outcomes at lower costs compared with usual home care. Participants rated their performance of and satisfaction with daily activities more highly than did those in usual care. Reablement was more cost-effective compared with usual care because participants had fewer home visits (88 visits v. 158 visits for the control group at six months postintervention). Participants’ time receiving care was less in the control group. Expenditures on home visits were less in the intervention group.</td>
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<td>G. Lewin et al., “A Comparison of the Home-Care and Healthcare Service Use and Costs of Older Australians Randomised to Receive a Restorative or a Conventional Home-Care Service,” <em>Health &amp; Social Care in the Community</em> 22, no. 3 (2014): 328-36.</td>
<td>The Home Independence Program uses health care professionals as care managers to promote individuals’ engagement in a broad range of daily activities, using task analysis and simplification, assistive technology, exercise programs, self-management training, medication, and nutrition management. The intervention lasts 12 weeks or until the participant achieves his or her first goals.</td>
<td>Randomized-controlled trial in Australia of Home Independence versus usual care for participants when they are first referred to the home care agency. Their health services use and costs were analyzed over two years.</td>
<td>750 older adults, with 375 adults ages 65 and older in the intervention group and 375 in the control group. They could not be receiving post-acute care.</td>
<td>The intervention group used fewer hours of home care and personal care at each data collection point for two years. At the one-year and two-year follow-ups, the intervention group was less likely to use personal care. Fewer qualified for residential care or used emergency department services. The intervention group’s hospital and home care costs were less too. Over two years, average home care savings per intervention participant were at least 30 percent lower compared with those receiving usual care.</td>
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<td>G. Lewin, K. Concanen, and D. Youens, “The Home Independence Program with Non-Health Professionals as Care Managers: An Evaluation,” <em>Clinical Interventions in Aging</em> 11 (2016): 807.</td>
<td>Australia’s Home Independence Program delivered by non-health professionals care managers</td>
<td>This was a test of whether non-health professionals could deliver reablement. No control group was involved.</td>
<td>70 clients</td>
<td>Half of clients at 3 months and three-fourths at 12 months were not using health services. These results were at least as good as those with the health professionals providing reablement. Approximately an additional 20 percent of the clients were receiving a lower amount of services.</td>
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<td>Gill F. Lewin et al., “Evidence for the Long Term Cost Effectiveness of Home Care Reablement Programs,” <em>Clinical Interventions in Aging</em> 8 (2013): 1273.</td>
<td>As of 2015, Australia reformed its home care system to emphasize preventive and restorative services.</td>
<td>Individuals from the community and upon hospital discharge participated in the randomized-controlled trial of Australia’s Home Independence Program 5-year follow-up. Examination of individuals’ service records in intervention and control groups occurred at 2, 12, 24, 36, 48, and 57 months.</td>
<td>Individuals from the community and upon hospital discharge participated in the randomized-controlled trial of Australia’s Home Independence Program 5-year follow-up. Examination of individuals’ service records in intervention and control groups occurred at 2, 12, 24, 36, 48, and 57 months.</td>
<td>Those who received enablement services used less home care over 3 years and less personal care for the entire postintervention period of 57 months, which amounted to median cost savings of AU$12,500 over 5 years.</td>
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<td>G. Lewin et al., “A Randomised Controlled Trial of the Home Independence Program, an Australian Restorative Home-Care Programme for Older Adults,” <em>Health &amp; Social Care in the Community</em>, 2, no. 1 (2013): 69–78.</td>
<td>Several countries have integrated reablement into their national health care policy—Denmark, New Zealand, Australia, and the United Kingdom. Other countries, like the Netherlands and Norway, are still studying it.</td>
<td>The Home Independence Program uses health care professionals as care managers to promote a participant’s engagement in a broad range of daily activities, using task analysis and simplification, assistive technology, exercise programs, self-management training, and medication, and nutrition management. The intervention lasts 12 weeks or until the participant achieves his or her first goals.</td>
<td>Randomized-controlled trial in Australia of Home Independence versus usual care for participants when they are first referred to the home care agency. Data collection occurred at baseline, 3 months, and 12 months.</td>
<td>750 older adults, with 300 adults compared on function and quality of life</td>
<td>At 12 months the intervention group was less likely to need ongoing personal care and the intervention group was more independent in IADLs.</td>
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<td>S. F. Metzelthin et al., “Development of an Internationally Accepted Definition of Reablement: a Delphi Study,” <em>Ageing &amp; Society</em> (2020): 1–16.</td>
<td>A Delphi study was conducted in 2018–19 to agree on the characteristics, components, aims, and target groups of reablement. The method involved four web-based survey rounds of 82 reablement experts from 11 countries. The resulting definition of reablement was accepted by 79 percent of participating experts.</td>
<td>A definition of reablement, agreed on by 79 percent of experts: “Reablement is a person-centered, holistic approach that aims to enhance an individual’s physical and/or other functioning, to increase or maintain their independence in meaningful activities of daily living at their place of residence and to reduce their need for long-term services. Reablement consists of multiple visits and is delivered by a trained and coordinated interdisciplinary team. The approach includes an initial comprehensive assessment followed by regular reassessments and the development of goal-oriented support plans. Reablement supports an individual to achieve their goals, if applicable, through participation in daily activities, home modifications and assistive devices as well as involvement of their social network. Reablement is an inclusive approach irrespective of age, capacity, diagnosis or setting.”</td>
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<td>J. G. M. Parsons et al., “A Randomized Controlled Trial to Determine the Effect of a Model of Restorative Home Care on Physical Function and Social Support among Older People,” Archives of Physical Medicine and Rehabilitation 94, no. 6 (2013): 1015–1022.</td>
<td>Studies indicate that 30 percent to 60 percent of hospitalized older adults develop a new dependency in daily activities and only 68 percent recover to their previous level of functioning six months after discharge.</td>
<td>The simplified reablement program was adjusted to the participant’s ability and primarily addressed mobility activities that could be carried out in the hospital for 30 minutes per day.</td>
<td>Randomized-controlled trial of a simplified reablement program occurring daily in the hospital. A second group received reminders to perform the reablement program each day and the control group received usual care.</td>
<td>114 hospitalized older adults who could walk independently before admission and lived in Taiwan. People who needed ICU or hospice care were excluded.</td>
<td>Quality of life, mobility, and hand grip strength improved in the reablement group compared with the control group.</td>
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<td>T. H. Rooijackers et al., “Process Evaluation of a Reablement Training Program for Homecare Staff to Encourage Independence in Community-Dwelling Older Adults,” BMC Geriatrics 21, no.1 (2021): 1–15.</td>
<td>Stay Active at Home training involves education about motivating clients to engage in daily and physical activities, implementing goal setting and planning, involving clients’ social networks, and assessing clients’ capabilities.</td>
<td>A process evaluation of training home care workers in restorative care. The evaluation was conducted in conjunction with a 12-month cluster randomized-controlled trial in the Netherlands.</td>
<td>154 home care staff members, 23 of whom were nurses trained in restorative care.</td>
<td>The program was implemented as intended, with staff accepting the program and valuing its practical training approach (e.g., role plays) and teamwork. Staff implementation of restorative care in practice varied. Factors that positively affected implementation were digital care plans, the organization’s funding, and new clients. Factors working against implementation were resistance to change from clients or caregivers, complex care needs, time pressure, and staff shortages.</td>
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Many argue that home care often does not focus enough on promoting a healthy lifestyle, daily routines, social support, and control. This happens despite the fact that they are strongly linked to the health and independence of older adults. A result, older adults can become more dependent on others. This role-dependent care has reduced their quality of life and can lead to an emotional and physical burden for caregivers. Restorative care has developed to promote health and independence using one type of therapy or multiple therapies.

### Methods

A literature review of single-service and multiple restorative interventions was conducted. Multicomponent restorative care programs of the mid- and early 2000s provide evidence that they result in reduced hospitalizations, reduced admissions to institutions, and reduced demands on caregivers. Single-service, especially aids, equipment, and environmental modifications, have preventive outcomes, such as less ADL dependency and reductions in personal care use and prevention of disability. Regarding costs, these studies show that restorative care is no more expensive than regular home care. It reduced use of home care and institutional services. Environmental modifications and equipment also led to a recoupment of the costs of services over the lifetime of the client.

### Participants

105 participants in New Zealand.

### Results

There was a nonsignificant reduction in institutional care and an additional 12 percent related to death for those receiving restorative care compared with usual care. The follow-up period was 2 years.


The Promoting Independence Program provides restorative care that includes a comprehensive geriatric assessment, care plan, comprehensive rehabilitation services, and equipment. The follow-up period was 2 years. The program was delivered at a person’s home or in a short-stay residential facility.
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<td>S. L. Szanton et al., “Medicaid Cost Savings of a Preventive Home Visit Program for Disabled Older Adults,” <em>Journal of the American Geriatrics Society</em> 66, no. 3 (2018): 614–620.</td>
<td></td>
<td>Community Aging in Place, Advancing Better Living for Elders (CAPABLE) is a five-month program wherein participants choose three achievable goals for each licensed professional. An occupational therapist visits six times and helps participants choose three functional goals and devises plans for meeting them. A registered nurse visits four times and works with the participant to develop health-related goals and coordinates with the participant’s physician and family. A home modifier spends eight hours making home modifications to help participants meet the goals they set.</td>
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<td>204 dually eligible participants in CAPABLE living in the United States, compared with 2,013 matched dual eligibles</td>
<td>Monthly average Medicaid costs per participant were $867 per month less than for the matched group. The largest reductions in expenditures were for inpatient care and use of LTSS.</td>
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<td>S. L. Szanton et al., “CAPABLE Program Improves Disability in Multiple Randomized Trials,” <em>Journal of the American Geriatrics Society</em> (2021).</td>
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<td>CAPABLE is a 10-session program that involves an occupational therapist, nurse, and handy worker. These professionals work together to help older adults meet their functional goals.</td>
<td>Literature review.</td>
<td>The review encompassed 6 trials with 1,144 older adults with low incomes and disabilities who received CAPABLE services. Their experiences were compared with 4,236 matched controls.</td>
<td>Each of the six studies showed that participants experienced clinically significant reductions in their IADL and ADL limitations. In the studies that reported on depression and falls, participants improved. Likewise, the two studies that assessed cost savings showed that CAPABLE reduced costs of care. Savings took into account the costs of the intervention. One study followed participants for seven months and found that participants’ function continued to improve.</td>
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<td>S. L. Szanton et al., “Effect of a Biobehavioral Environmental Approach on Disability among Low-Income Adults: A Randomized Clinical Trial,” <em>JAMA Internal Medicine</em> 179, no. 2 (2019): 204–211.</td>
<td>CAPABLE is a five-month program wherein participants choose three achievable goals for each licensed professional. An occupational therapist visits six times and helps participants choose three functional goals and devises plans for meeting them. A registered nurse visits four times and works with the participant to develop health-related goals and coordinates with the participant’s physician and family. A home modifier spends eight hours making home modifications to help participants meet the goals they set.</td>
<td>Randomized-controlled trial in the United States. The control group received an “attention” intervention, which was 10 home visits of 60 minutes each and involved sedentary activities.</td>
<td>300 participants were ages 65 and older, were cognitively intact, had at least one ADL or two IADLS, and had incomes at or below 200 percent of poverty; 152 participants were in the intervention group.</td>
<td>30 percent reduction in ADL scores in the intervention group, along with the intervention participants saying their lives were easier, helped them take care of themselves, and helped them gain confidence in managing their daily lives.</td>
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<td>S. L. Szanton et al., “Home-Based Care Program Reduces Disability and Promotes Aging in Place,” <em>Health Affairs</em> no. 9 (2016): 1558–1563.</td>
<td>CAPABLE is a five-month program wherein participants choose three achievable goals for each licensed professional. An occupational therapist visits six times and helps participants choose three functional goals and devises plans for meeting them. A registered nurse visits four times and works with the participant to develop health-related goals and coordinates with the participant’s physician and family. A home modifier spends eight hours making home modifications to help participants meet the goals they set.</td>
<td>Pre–post measurement of participants’ ADLs, IADLs, and depression. No control group.</td>
<td>281 adults ages 65 and older, in the United States, who were dually eligible for Medicare and Medicaid and had disabilities. Participants were cognitively intact, whereas the comparison group members may have had impairments in this area.</td>
<td>At baseline, participants had 3.9 difficulties with basic daily activities, compared with 2 at five months. Seventy-five percent of participants improved their ADL performance and 65 percent of participants increased their IADL performance. Fifty-three percent experienced improved depression scores.</td>
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<td>M. E. Tinetti et al., “Effect of a Restorative Model of Posthospital Home Care on Hospital Readmissions,” Journal of the American Geriatrics Society 60, no. 8 (2012): 1521–1526.</td>
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<td>Restorative care involved exercise, behavioral change, self-management, environmental adjustments, adaptive equipment, training, counseling, and medication adjustments.</td>
<td>Comparison of hospital readmissions and length of home care episodes for people receiving restorative care versus usual care post-hospitalization. Quasi-experimental design with matched control group.</td>
<td>770 participants receiving home care from an agency after hospitalization. They could not be completely functionally dependent or have significant cognitive impairment. Participants receiving restorative home care were 32 percent less likely to be readmitted to the hospital compared with those receiving usual care. The average length of home care episode was 20.3 days in the restorative care group versus 29.1 days for those receiving usual care.</td>
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<td>M. E. Tinetti et al., “Evaluation of Restorative Care vs Usual Care for Older Adults Receiving an Acute Episode of Home Care,” JAMA: The Journal of the American Medical Association 287, no. 16 (2002): 2098–2105.</td>
<td></td>
<td>Restorative care involved exercise, behavioral change, self-management, environmental adjustments, adaptive equipment, training, counseling, and medication adjustments.</td>
<td>Comparison of hospital readmissions and length of home care episode for people receiving restorative care versus usual care post-hospitalization. Quasi-experimental design with matched control group.</td>
<td>770 participants receiving home care from an agency after hospitalization. They could not be completely functionally dependent or have significant cognitive impairment. Participants in the intervention were more likely to remain at home; were less likely to use the emergency department; and had shorter home care episodes, better self-care scores, home management, and better mobility.</td>
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<td>H. Tuntland et al., “Reablement in Community-Dwelling Older Adults: A Randomised Controlled Trial,” BMC Geriatrics 15, no. 1 (2015): 1-11.</td>
<td>Reablement is geared toward achieving a person’s own activity goals.</td>
<td>Ten weeks of multi-component rehabilitation in the participants’ homes. The control condition was usual home care.</td>
<td>Randomized-controlled trial in Norway.</td>
<td>61 older adults with functional decline who lived at home. Most were women who lived alone. Participants in the intervention experienced increased self-perceived activity performance and satisfaction with their performance. Reablement participants received more rehabilitation time and less nursing time when compared with the control group.</td>
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<td>H. Tuntland et al., “Everyday Occupations Prioritised by Older Adults Participating in Reablement. A Cross-Sectional Study, ” Scandinavian Journal of Occupational Therapy 27, no. 4 (2020): 248–258.</td>
<td>Cross-sectional study of older adults’ preferences regarding reablement priorities in Norway</td>
<td>738 older adults across Norway</td>
<td>Cross-sectional study of older adults’ preferences regarding reablement priorities in Norway</td>
<td>The factors that predicted better outcomes were higher baseline functional scores, being female, having a fracture, being motivated to improve, and having high motivation to improve. Factors that predicted poorer function were having a neurological condition other than stroke, pain, or dizziness/balance problems.</td>
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<td>H. Tuntland et al., “Predictors of Outcomes Following Reablement in Community-Dwelling Older Adults, ” Clinical Interventions in Aging 12 (2017): 55.</td>
<td>Analysis of factors that predict self-care, productivity, and leisure performance and the individual’s satisfaction with those performances 10 weeks following the intervention</td>
<td>712 participants in 34 Norwegian towns</td>
<td>Randomized-controlled trial</td>
<td>The intervention involved an occupational therapist helping participants to improve ADLs using goal setting, training, adaptations, and support. Participants were encouraged to carry out tasks independently. The intervention group’s function improved more. The researchers did not report statistically significant findings because of wide confidence intervals.</td>
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<td>P. J. Whitehead et al., “Occupational Therapy in HomEcare Re-Ablement Services (OTHERS): Results of a Feasibility Randomised Controlled Trial, ” BMJ Open 6, no. 8 (2016): e011868.</td>
<td>A feasibility study for a larger trial.</td>
<td>30 participants; 15 in the intervention and 15 in the control group. Participants could not be receiving end-of-life care or need two or more people to assist them in transferring.</td>
<td>Randomized-controlled trial</td>
<td>The intervention and control groups both improved from baseline, but the intervention group’s function improved more. The researchers did not report statistically significant findings because of wide confidence intervals.</td>
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<td>P. J. Whitehead et al., “Interventions to Reduce Dependency in Personal Activities of Daily Living in Community Dwelling Adults Who Use Homecare Services: A Systematic Review. ” Clinical Rehabilitation 29, no. 11 (2015): 1064–1076.</td>
<td>Literature review of 13 studies with control conditions published no later than 2014. Five studies involved reablement/restorative care; others involved rehabilitation. The control condition was regular home care.</td>
<td>4,975 participants in 13 studies</td>
<td>Literature review of 13 studies</td>
<td>The majority of studies found that participants receiving interventions scored significantly better on all outcomes measured. Five studies found improvement in function both between the interventions and control conditions. Four studies found improved quality of life for participants in the intervention.</td>
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