The Community Aging in Place—Advancing Better Living for Elders (CAPABLE) model is designed to keep older adults in the community and to improve their ability to remain independent. Through a person-centered, team-based approach, CAPABLE offers older adults in the community the opportunity to improve their functional skills and to have improvements made where needed in the home. Researchers estimate that the CAPABLE intervention costs about $4,000 to administer and deliver and has the potential to save thousands more for payers and providers.

CAPABLE originated in the early 2010s from researchers at the Johns Hopkins University School of Nursing, which also administered the program for more than 10 years. As of October 2022, management of program operations and partnerships is transitioning to Care Synergy, which will operate as the national center for CAPABLE.

CAPABLE is an important model of restorative services, which are generally defined as “person centered and involve[ing] 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 are common in other countries (sometimes under the label of “re-ablement services”) but have limited reach in the United States. CAPABLE has potential to scale and fill the current gap in the availability of restorative services.²

CAPABLE at a Glance
CAPABLE’s approach relies on three professionals working in conjunction with the older person to identify and deliver services and supports in the home. Over a five-month period, the participating older adult receives visits from a registered nurse (RN), an occupational therapist (OT), and a handyperson (Exhibit 1). The registered nurse makes four home visits and helps the participant with medical-oriented goals. The occupational therapist conducts six home visits and helps the participant achieve goals related to functional tasks. The OT also helps identify potential environmental barriers in the person’s home and helps develop a scope of work for the handyperson, who makes those identified repairs or installations.

In a typical CAPABLE model, the handyperson’s scope of work has a budget of up to $1,300. The older adult drives goal setting with both the RN and the OT, and the services they receive are tailored to their specific needs and preferences.

The model is not designed for older adults living in a residential care setting or nursing home. As of October 2022, researchers are studying ways to apply CAPABLE to people living with dementia and ways to formally incorporate family caregivers into the model.³

Improved Skills and Safer Homes
The purpose of the RN’s and OT’s presences in the CAPABLE intervention is in part to improve the older adult’s functional capacity and skills.

Common components of this include working with the RN to improve medication management skills as well as pain management, balance, and falls prevention. Working with the OT, the older adult can work towards improving their ability to safely transfer from a bed and/or toilet, get dressed, and performing other activities of daily living (ADLs).

² Reinhard and Tilly, Promoting Choices through Restorative Services.
The handyperson works with the OT to make needed repairs to the older adult’s home. According to one study, the most common tasks for the handyperson were to install or fix railings on stairs and in entryways, install grab bars in a shower or tub, and make other repairs in bathrooms (e.g., raised toilet seats, nonskid treads in showers).

Each of these supports is relatively basic and simple to complete (compared to, for example, a hospital stay or relying exclusively on family caregivers), but together, they can significantly improve an individual’s independence and health outcomes.

Success in the Community

The CAPABLE model has been delivered to older adults at home since 2012, and as of October 2022, it is available in more than 40 communities in 20 states.¹

Many innovative models in long-term services and support and in health care show promise, but they do not always have a strong evidence base to demonstrate that the model improves outcomes and/or saves money. In the case of the CAPABLE model, however, there are multiple studies that provide evidence that it has been successful in improving outcomes specifically for community-dwelling older adults.⁵

The first major CAPABLE trial began in 2012 with funding from the National Institutes of Health and the Centers for Medicare & Medicaid Services (CMS). Through the CMS Health Care Innovation Award program, more than 100 Baltimore community residents received CAPABLE support. Research from this pilot found that the participants, most of whom were Black women, had success in improving their ADL performance and decreased home hazards by about half. This pilot also studied participant cost savings and found that CAPABLE saved public payers about $22,120 per participant.⁶

CAPABLE cost savings are often measured in comparison to potential nursing home costs, with the idea that CAPABLE as an intervention may delay or prevent entirely the need for an expensive nursing home stay. According to researchers, if CAPABLE could delay a nursing home stay by even three weeks, it could be cost neutral to public payers.⁷

An evaluation of CAPABLE in 2021 studied results in six pilots from across the country. This included urban and rural communities, multiple payers financing the services, six states, and a participant pool inclusive of Black, Hispanic, and white older adults. Each pilot found that CAPABLE reduced ADL and instrumental activity of daily living (IADL) limitations among participants. In addition, some of the pilots studied for and found improvements in falls efficacy, pain management, and depression among participants.⁸

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² AARP scaling paper.
⁵ Szanton et al., “CAPABLE Program Improves Disability in Multiple Randomized Trials.”
Where CAPABLE Exists

CAPABLE has spread to new locations across the country and importantly has seen growth in the types of organizations that offer the intervention (Exhibit 2).

In capitated models of health care and long-term services and supports, CAPABLE has been introduced in at least one Medicare Advantage plan and Program of All-Inclusive Care for the Elderly (PACE) organization. Researchers have suggested that CAPABLE may be a good match for managed care-type environments because of its potential to control costs.9

Philanthropic funding has helped bring CAPABLE to new communities. In Philadelphia, for example, the Hairston Foundation funded Heart Home Healthcare Services, a non-medical home care agency, to deliver CAPABLE to older adults in the area beginning in July 2021.10 In addition, CAPABLE has potential to blend into existing provider organizations of several types. A Meals on Wheels chapter in Texas, for instance, launched CAPABLE in September 2021 to serve older adults in the Austin area.11 In Baltimore, a primary care practice (Village MD) adopted the CAPABLE model.12 In other words, entities of all sorts have and can feasibly adopt CAPABLE into their existing service lines without needing to create a new organization or entity to bring CAPABLE services to their consumer base.

Veterans may also be able to benefit from CAPABLE, and the Department of Veterans Affairs (VA) has adopted the intervention on a pilot basis with plans to deploy it to nine sites throughout Pennsylvania13. The VA's dual role in financing and providing care for veterans they serve may position the department to fully realize the model’s potential both for consumers and for its own cost savings.

The American Rescue Plan and CAPABLE

The 2021 American Rescue Plan provided states with enhanced federal funding for Medicaid home and community-based services (HCBS). Through March 2025, states will receive an estimated $12.7 billion in additional federal funds, all of which must go to HCBS.14 States submitted proposals to CMS

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9 Szanton et al., “CAPABLE Trial.”
13 Based on AARP Public Policy Institute interview with Johns Hopkins University School of Nursing CAPABLE team.
14 CMS site.
in 2021 detailing how they intend to use their share of the funds, and at least three states—Colorado, Connecticut, and Indiana—indicated that they would use the American Rescue Plan Act (ARPA) HCBS dollars to invest in the CAPABLE model. Over time, additional states may adopt the model with these and/or other federal dollars.

As states begin to spend their ARPA HCBS dollars, it will be important to monitor how those funds are used and specifically how successful those states are at bringing CAPABLE to new communities and older adults.

**Challenges Ahead**

Although CAPABLE has potential to be a complementary model for multiple types of payers, no payer, public or private, covers CAPABLE on a national basis, and only two states offer CAPABLE statewide through Medicaid.

An article published in 2022 identified key limiting factors (“restrainers”) to the growth of CAPABLE. Foremost among these is financing, specifically a lack of a financing mechanism for the model under the current payment environment. Specifically, researchers identified that although CAPABLE focuses on functional improvement, payment systems like Medicare and Medicaid do not necessarily reimburse or incentivize efforts in that area. According to the article, “Medicare pays for medical interventions focused on disease and cure and Medicaid pays for LTSS services focused on maintenance,” leaving no complete payer fit for CAPABLE.

Among public payers, there is also potential for a misalignment between which programs pay for CAPABLE and which programs save from it. In integrated Medicare-Medicaid managed care plans, for example, researchers have identified a “wrong pocket” problem in which the person’s Medicaid coverage pays for CAPABLE services, but the savings are realized through less Medicare spending, benefiting one program (at least on paper) and not both.

Similar questions exist in other areas where CAPABLE may exist, including for those with one or more coverage source. For example, if Medicaid pays for an intervention but Medicare is the entity that realizes the cost savings, how does one reconcile that to ensure fairness for both programs? Similarly, if the provider delivers the intervention but the payer saves money, how does one ensure the provider is appropriately compensated? Those who wish to bring CAPABLE to scale must consider these questions to realize long-term success. Policy makers should consider ways to reconcile payment and shared savings as CAPABLE emerges as a model for people with multiple sources of coverage.

That may also be a reason for CAPABLE to grow in models where payment and delivery are integrated. In PACE, for example, one entity receives a capitated payment and then in turn is responsible for all care delivery. A PACE organization that deploys CAPABLE would be able to also realize any associated

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15 CMS site of state plans.

16 “Where We Work—CAPABLE,” Johns Hopkins School of Nursing, [https://nursing.jhu.edu/faculty_research/research/projects/capable/where-we-work.html](https://nursing.jhu.edu/faculty_research/research/projects/capable/where-we-work.html).


18 Szanton et al., “Drivers and Restrainers to Adoption and Spread of Evidence-based Health Service Delivery Interventions.”

19 Szanton et al., “Drivers and Restrainers to Adoption and Spread of Evidence-based Health Service Delivery Interventions.”
cost savings. Threading the needle between cost savings and provider payment is critical to CAPABLE’s scaling.

CAPABLE is by design a time-limited, short-term intervention. Although it can provide help to people and potentially delay need for more intensive LTSS, it cannot by itself provide people with all the supports they may need. As providers and payers consider bringing CAPABLE to their services, and states consider investing in the model, they must consider where to put CAPABLE in their respective continuums of care to make sure it does not exist in a silo and that people who participate in CAPABLE have a natural next place to go in their care journey.

Next Steps and Further Expansion

Since CAPABLE’s inception, the Johns Hopkins University School of Nursing has administered CAPABLE and works with sites hosting the model through technical assistance and research collaborations. In 2022, the school launched a search for a partner to help with operations and scaling of CAPABLE. Care Synergy, a network of home health and hospice agencies based in Colorado, was identified as that partner in October 2022. As program operations transition to Care Synergy, the organization will quickly become a key player in the future of CAPABLE.

Those interested in the expansion of CAPABLE have many places to look for next steps. As states continue to spend their Medicaid HCBS ARPA dollars, monitoring how those states that plan to invest in CAPABLE go about implementing those plans will be critical. This includes sustainability, because ARPA dollars expire in 2025, and the demand for restorative care among Medicaid HCBS enrollees will not go away just because the supplemental dollars do.

As Medicare Advantage plans continue to expand among the Medicare population, and those plans have greater flexibility to offer supplemental benefits to their beneficiaries, plans could add CAPABLE to those benefits and deliver the restorative services to more people. The same goes for others in a payer role, including PACE, the VA, and even private insurance plans. Each has the demonstrated capacity to bring CAPABLE to new communities, and with the right implementation, the model could reach older adults nationwide.

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