

Dissemination of the CAPABLE Model of Care in a Medicaid Waiver Program to Improve Physical Function

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BACKGROUND/OBJECTIVES: Of older adults, 42% report problems with daily function, and physical function is the most important consideration for aging individuals. Thus, we implemented a model of care focused on improving physical function and examined health and use outcomes and satisfaction.

DESIGN: A 3-year participatory, single-group pretrial/post-trial benchmarked to a usual care cohort that was evaluated prior to the study.

SETTING: Four Medicaid home and community-based waiver sites in Michigan.

PARTICIPANTS: The participants included 34 clinicians and 270 Medicaid beneficiaries 50 years and older.

INTERVENTION: Community Aging in Place, Advancing Better Living for Elders (CAPABLE), an evidence-based model of care that improved physical function in older adults, was implemented using evidence-based strategies.

MEASUREMENT: Characteristics (age, race, and sex), health outcomes (comorbidities, instrumental/activities of daily living [I/ADLs], pain, depression, and falls), and emergency department and hospitalization visits preintervention/postintervention and in the usual care cohort were examined. We also measured Medicaid beneficiary's satisfaction with care for those who received CAPABLE.

RESULTS: Improved mean \pm SD ADLs (preintervention, 8.51 ± 3.08 ; postintervention, 7.80 ± 2.86 ; $P = .01$) and IADLs (preintervention, 6.43 ± 1.31 ; postintervention,

5.62 ± 1.09 ; $P < .01$), a decrease in falls by 14% (from 34.8% preintervention to 20.8% postintervention; $P < .01$), and fewer hospitalizations (from 0.43 ± 1.51 preintervention to 0.23 ± 0.60 postintervention; $P = .03$) were found. Post-CAPABLE means were significantly better compared with a usual care cohort for IADLs (6.73 ± 1.27 ; $P < .01$) and hospitalizations (0.47 ± 2.66 ; $P < .01$). Satisfaction with care was high, and 98.1% recommended CAPABLE as a way to help remain living in the community.

CONCLUSION: Improved ADLs and IADLs, a reduction in fall rates, fewer hospitalizations, and high satisfaction with care occurred in this population as a result of the use of CAPABLE. CAPABLE may be one solution to helping vulnerable, low-income older adults with poor physical function to remain living in the community. *J Am Geriatr Soc* 67:363–370, 2019.

Key words: physical function; Medicaid waiver; evidence-based model; adaptation; implementation

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The World Report on Aging and Health confirms that physical function is the most important consideration for individuals who are aging.¹ Older adults want to be able to function day to day² so they can accomplish activities of daily living (ADLs) that are important to them.^{3,4} A projected 72 million Americans are expected to reach the age of 65 years by 2030.⁵ Of older adults in the United States, 42% report problems with daily function.⁵ Functional challenges are expected to increase due to the obesity epidemic⁶ and living longer with chronic conditions,⁷ particularly among low-income adults.⁸ Poor function is also the primary modifiable predictor of nursing home placement and a driver of increased healthcare cost.⁹ It can also lead to an increased risk of falls and poor quality of life.⁹ Given these issues, implementing evidence-based

models of care to enhance physical function in older adults, particularly in Medicaid programs, should be viewed as a public health priority.

MEDICAID WAIVER PROGRAM

Each state has a Medicaid Home and Community-Based Waiver Program. The goal of the waiver programs is to support disabled and older adults living in the community in lieu of nursing home placement. In Michigan, the waiver is provided by contract with 20 entities (eg, area agencies on aging and private companies). Usual waiver care in Michigan includes care planning, management, and coordination by registered nurses (RNs) and social workers (SWs), with home visits every 3 to 6 months and monthly telephone calls. An initial assessment occurs, and services are provided to support beneficiaries at home. Services include personal care, psychological counseling, personal emergency response system, medication setup, and home-delivered meals. In addition, supportive devices (ie, tub bench and raised toilet seat), supplies (ie, blue pads and adult diapers), and home alterations (ie, grab bars and widening doors) that are medically necessary are provided. Supplies and modifications must prevent, diagnose, or treat an illness, injury, condition, disease, or its symptoms and meet accepted standards of medicine. Follow-up interactions include assessment of services delivered and implementation of the plan of care.

Prior to this study, the Michigan waiver had not used occupational therapists (OTs) or an evidence-based model of care. Among the 20 waiver sites statewide, there were 10 different models of care. For example, at one site, the SW oversees care management for the majority of the waiver beneficiaries, while at another the RN and SW conduct joint oversight. With few exceptions, evidence-based models of care are rarely implemented within a waiver setting.¹⁰

PURPOSE

The purpose of this article is to describe the impact of a geriatric model of care on health outcomes and emergency department (ED) visits and hospitalizations in the Michigan Medicaid Home and Community Based Waiver Program (“waiver”). We report on outcome data on Medicaid beneficiaries who received Community Aging in Place, Advancing Better Living for Elders (CAPABLE) compared to those who did not and beneficiary satisfaction with CAPABLE. We also report on implementation strategies used for this study.

MODEL DESCRIPTION

The model of care, entitled CAPABLE, was designed to reduce the effect of problems with physical function among low-income older adults living at home by addressing an individual’s capabilities and the home environment.^{11,12} CAPABLE was adapted from the Advancing Better Living for Elders (ABLE) program. ABLE used a person-directed, consultative model involving five home sessions conducted by OTs and one home session conducted by physical therapists who identified daily functional concerns of older adults. OTs provided instruction in use of a range of strategies and techniques, including home alterations, assistive

devices (eg, shower chair and reacher), and environmental modifications (eg, grab bar and ramps) installed by a handyman, to enable beneficiaries to achieve self-identified functional goals.^{13,14} ABLE improved self-care and reduced mortality in older adults living in the community^{13,14} and was particularly effective for the oldest old and those with high functional challenges.

Expanding upon ABLE, CAPABLE is a 16-week structured program delivered by OTs who conduct six home visits and provide assistive devices, RNs who conduct four home visits, and a handyman who provides home alterations (ie, installs devices, makes environmental modifications, and performs home repair).^{15–19} Similar to ABLE, the CAPABLE interdisciplinary team provided consultation with older adults to help them identify daily activity goals (eg, taking a shower and walking to the bathroom), evaluated barriers to achieving those goals, and attained outcomes collaboratively.^{11,18} The OT assists older adults to perform ADLs, instrumental ADLs (IADLs), and discretionary activities that are challenging at home, such as functional mobility, meal preparation, bathing, and dressing. The RN targets underlying issues that influence ADLs, IADLs, and discretionary activities at home, such as pain reduction, improvement in mood, fall prevention, medication review and management, primary care physician communication, incontinence management, sexual health, and smoking cessation.

CAPABLE has demonstrated a 49% reduction in the number of ADL difficulties; and 75% of beneficiaries improved their level of ADL performance from baseline to follow-up at 5 months.¹⁷ CAPABLE has been adopted by organizations in 23 cities and rural areas in 12 states, through varied innovations in payment policy, such as accountable care organizations, hospital readmission prevention programs, community development organizations, and a pilot in the Veterans Administration. However, to date, published results from implementation of CAPABLE have primarily been in research settings.

Model Adaptation

In prior work, Normalization Process Theory²⁰ underpinned identification of adaptations of CAPABLE to fit the Michigan waiver population and setting. Normalization Process Theory²⁰ focuses on the dynamic processes that lead to embedding innovations into practice. Adaptations included the following: Ns were assigned as team leaders rather than the OT, SWs were added to address social and emotional needs, RNs conducted the medication reviews rather than a pharmacist, and care coordination among the RN, OT, and SWs occurred face to face, by telephone, by Skype, or by E-mail with the supervisor rather than only by face to face. We also allowed flexibility in the number and type of home visits delivered rather than using a prescribed number by discipline and increased delivery of CAPABLE from 20 to 32 weeks. Finally, a toolkit was developed with 12 common aging issues and was provided as a handout to beneficiaries on the first CAPABLE home visit. Some issues included aging in place; bathing, grooming, dressing, toileting, and eating; managing and taking medications; and fall prevention. Home alterations were done when medically necessary (Medicaid rule).

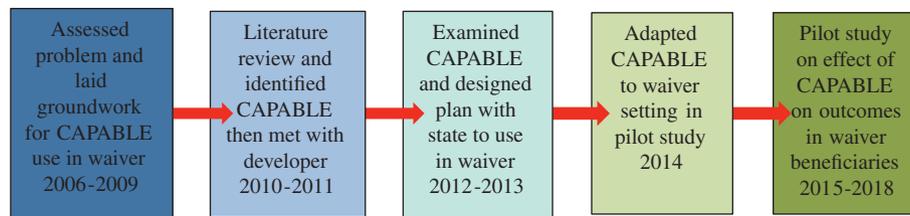


Figure 1. Multiyear process to implement Community Aging in Place, Advancing Better Living for Elders (CAPABLE) in a waiver setting for Medicaid beneficiaries.

Implementation Model and Strategies

Study investigators, site managers, and the policymaker had a long-term working relationship (Figure 1). Kotter's 8-Step Change Model guided implementation and assisted in creating a sense of urgency, building a coalition, creating and communicating the vision, enlisting stakeholders, removing barriers, generating short-term wins, and sustaining the change.²¹ To create the climate for change, a multifaceted coalition of stakeholders and champions, which included investigators, policymakers, quality reviewers, and site managers, formed a vision and coauthored the grant application.

To engage the sites, the vision was communicated to 34 clinicians (RNs = 11, SWs = 7, OTs = 6, and managers = 10), who were trained in CAPABLE using a three-phased approach. In phase 1, clinicians reviewed lessons online, read published articles, and reviewed core concepts and approaches. In phase 2, clinicians reviewed discipline-specific roles, which included the components of CAPABLE and specific tasks to conduct, with the educators. In phase 3, after each clinician conducted five home visits, educators reviewed the electronic health records (EHRs) of beneficiaries who received CAPABLE. Remediation occurred, if needed, until fidelity to the model of care occurred.

Mean instruction time in CAPABLE was 51.5 (SD = 34.5-68.5) hours. Preferred method of education (N = 13) was assessed, and 92.3% (n = 12) preferred visual, 84.6% (n = 11) preferred hands-on, 69.2% (n = 8) preferred audio, and 61.5% (n = 7) preferred interactive learning. Facilitation occurred at two levels: managers at the site who reviewed the EHRs, conducted weekly interdisciplinary coordination meetings, and provided clinicians feedback; and the investigators who conducted the CAPABLE education via online or face-to-face sessions and reviewed fidelity to the intervention via telephone and E-mail. Investigators provided monthly feedback on audit data, to include the number of Medicaid beneficiaries enrolled in CAPABLE.

METHODS

Design

A 3-year community-based participatory research²² single-group preintervention to postintervention design was used. This design allowed evaluation of changes from pre- to post-CAPABLE using a matched samples methods. To better interpret changes due to CAPABLE, we also compared postintervention outcomes to a usual care group cohort who received care prior to the study. This comparison

allowed us to benchmark benefits or lack thereof resulting from CAPABLE.

Sample

The intervention group included a convenience sample of 270 waiver beneficiaries who were already receiving waiver services or were newly enrolled between 2015 and 2017 (Figure 2). Mean time in the waiver was 872.1 days (SD = 1138.1 days). The benchmark usual care comparison group included 1350 waiver beneficiaries who received usual care between 2010 and 2014 and were matched (5:1 ratio) on age, race, and sex to the intervention group (1350:270).

Setting

The setting for our study was four waiver sites in Michigan. The Home and Community-Based Services 1915(c) waiver in Michigan provides care to over 15,000 Medicaid, low-income, nursing home-qualified older and disabled adults. These adults choose to live in the community, and most are dually eligible Medicare and Medicaid recipients. To be eligible for the waiver in Michigan, beneficiaries must meet Medicaid-defined nursing facility level-of-care criteria. These criteria include a need for assistance with at least ADLs or IADLs, income that is less than 300% of the federal poverty level, and having a caregiver who agrees to provide assistance, but does not need to reside in the beneficiary's home.

Eligibility

Medicaid beneficiary inclusion criteria for both the intervention and comparison groups were being an adult 50 years or older and already cared for in the waiver. Beneficiaries for the CAPABLE group were self-identified as in need of improved physical function, and willing and able to participate. Exclusion criteria for both groups were no enrollment in the waiver and younger than 50 years, and for the CAPABLE group, no need to improve physical function.

Measures and Data Collection

Data on demographic characteristics (age, race, and sex), health status (comorbidities, I/ADLs, pain, depression, and falls), and ED visits (with or without hospitalization) and hospitalizations collected during usual care on the Minimum Data Set-Home Care (MDS-HC) in the EHR were

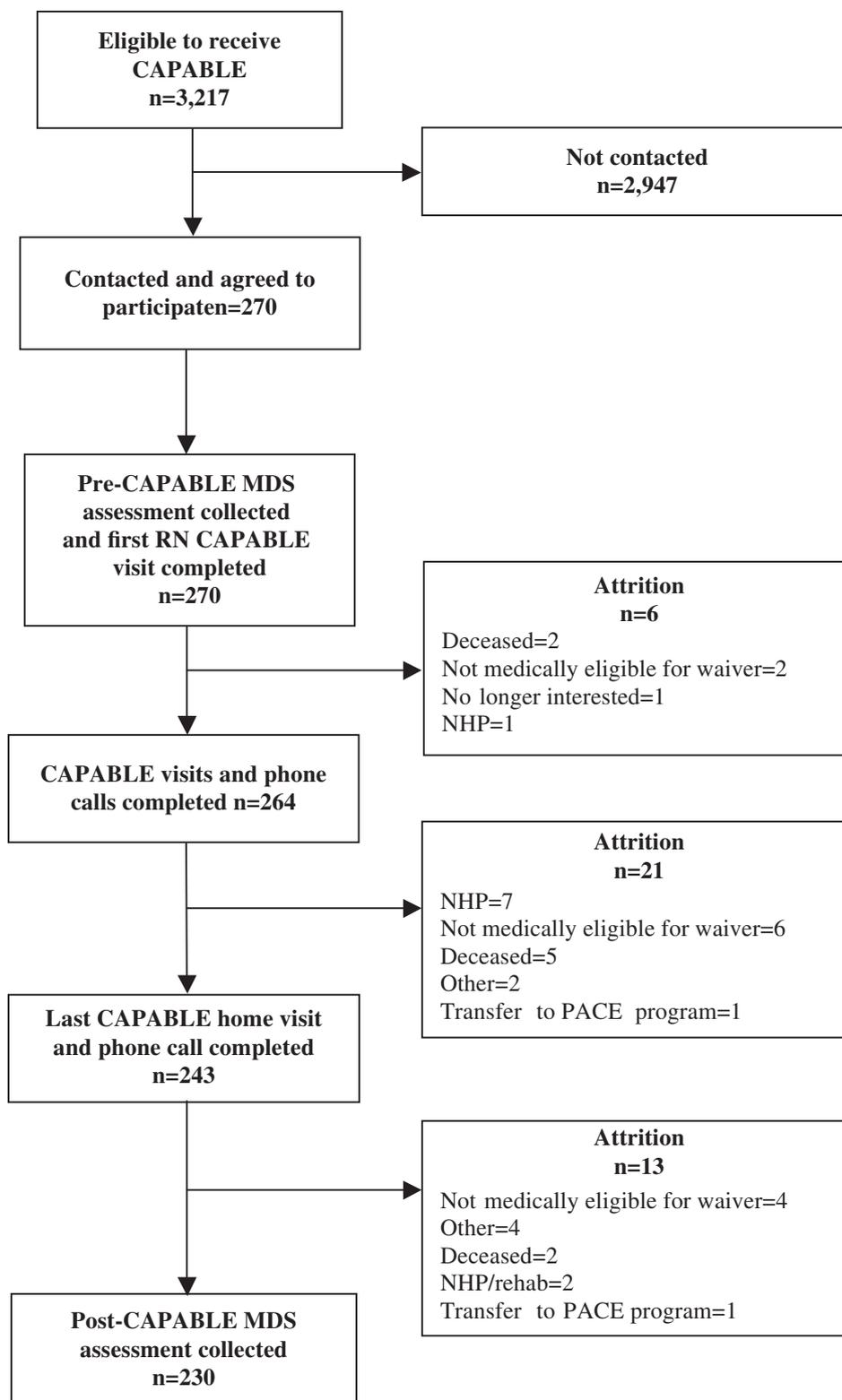


Figure 2. Consolidated Standards of Reporting Trials (CONSORT)-like chart for group who received Community Aging in Place, Advancing Better Living for Elders (CAPABLE) in this study.

provided to investigators. The MDS-HC is a self-reported, person-centered assessment for the collection of minimum essential nursing data, developed by InterRai, with reliability and validity, and used in the waiver since 1993.^{23,24} MDS-HC data from the comparison group who did not receive the intervention were from the most recent

assessment within the 5 years prior to the study. MDS-HC data from the group who received the intervention were from two time points: the assessment that occurred just prior to start of the intervention (preintervention) and the first assessment completed immediately following the intervention (postintervention).

Table 1. Descriptive Statistics for Sociodemographic Characteristics of Beneficiaries in the No-, Pre-, and Post-CAPABLE Groups at Baseline^a

| Characteristics | Usual care comparison group (N = 1350) | Pre-CAPABLE group (N = 270) | Post-CAPABLE group (N = 240) |
|---------------------------------|--|-----------------------------|------------------------------|
| Age, y | 66.71 ± 7.54 (1350) | 65.81 ± 13.29 (212) | 65.48 ± 13.46 (184) |
| Comorbid conditions | 4.80 ± 2.23 (1347) | 4.54 ± 2.20 (269) | 4.47 ± 2.17 (230) |
| Comorbid Charleston Index Score | 1.84 ± 1.58 (1347) | 1.77 ± 1.57 (269) | 1.76 ± 1.55 (230) |
| Race | | | |
| White | 1025 (82.2) | 167 (79.2) | 144 (78.3) |
| African American | 207 (16.6) | 36 (17.1) | 32 (17.4) |
| Other | 6 (0.5) | 1 (0.5) | 1 (0.5) |
| Ethnicity | | | |
| Hispanic | 13 (1.0) | 5 (2.4) | 5 (2.70) |
| Non-Hispanic | 1333 (99.0) | 206 (97.6) | 179 (97.3) |
| Sex | | | |
| Male | 323 (23.9) | 52 (24.0) | 43 (22.7) |
| Female | 1027 (76.1) | 165 (76.0) | 198 (77.3) |

Abbreviation: APABLE, Community Aging in Place, Advancing Better Living for Elders.

^aData are given as mean ± SD (number) or number (percentage).

Data on hospitalizations and ED visits within 90 days and falls within 30 days from the date of the MDS-HC assessment were extracted. The MDS-HC I/ADL, pain, and depression summed scores were calculated per InterRai protocol,²⁵ with higher scores reflecting more problems (worse outcomes). Comorbidity was measured using the Charlson Index Score.²⁶ Data in fidelity to CAPABLE were collected when care was provided and included assessment (RN and OT), interdisciplinary coordination, and follow-up. Data on CAPABLE satisfaction were collected by survey at the end of the intervention via a tool used and validated in prior work.

Statistical Analyses

Data were summarized using descriptive statistics for the intervention group pre-CAPABLE (n = 270) as well as post-CAPABLE (n = 240) and for the usual care benchmark group (n = 1350). Matched-pairs *t*-tests or McNemar's test was used in the analysis of the intervention group from pre- to post-CAPABLE to determine individual change. To benchmark postintervention outcomes against the usual care comparison group, post-CAPABLE outcomes were compared to those in the usual care group using independent *t*-tests or χ^2 tests. To explore the characteristics of the beneficiaries associated with significant pre- to post-CAPABLE changes, the analysis of covariance was used to relate the change scores in the intervention group to demographic characteristics and comorbidity and their interactions. When interactions were not significant at the .10 level (selected for exploratory analysis), they were removed from statistical models, and models with main effects were retained. For the outcome of falls, logistic regression analysis related the log-odds of post-CAPABLE falls to the explanatory variables listed above while controlling for pre-CAPABLE falls. Descriptive statistics were used to summarize satisfaction. SAS 10.0 software was used for analyses.

RESULTS

There were no differences between the pre-CAPABLE intervention and benchmark usual care comparison group on age, race, and sex (Table 1). Post-CAPABLE sample also

had the same distributions of age, race, and sex as those in pre-CAPABLE. The mean (SD) numbers of home visits delivered by OTs, RNs, and SWs were 4.16 (1.98), 3.60 (1.23), and 0.21 (0.75), respectively, for the 270 waiver beneficiaries who received CAPABLE. There were a mean (SD) of 2.46 (1.89) interdisciplinary coordination actions conducted on average. Slightly higher number of comorbid conditions was found in those who received CAPABLE compared to the usual care group (mean [SD], 4.80 [2.23] to 4.54 [2.20]; *P* = .04). However, as expected, due to the inclusion criteria, the intervention group pre-CAPABLE had worse ADL scores, more pain, and more falls than the usual care comparison group.

ADLs improved in those who received CAPABLE (mean ± SD, 8.51 ± 3.08 pre-CAPABLE vs 7.80 ± 2.86 post-CAPABLE; *P* = .01) (Table 2) to the level at which post-CAPABLE ADLs were not different from the usual care group (*P* = .45). IADLs also improved in those who received CAPABLE (mean ± SD, 6.43 ± 1.31 to 5.62 ± 1.09; *P* < .001) and were significantly better post-CAPABLE than in the usual care group (mean ± SD, 6.76 ± 1.27; *P* < .01 for independent groups' comparison). CAPABLE did not change depression or pain scores, and pain remained to be worse post-CAPABLE compared to the usual care group (mean ± SD, 2.68 ± 1.23 to 2.43 ± 1.49; *P* < .01). However, worse pain was present pre-CAPABLE and therefore the intervention did not significantly change the pain levels.

No changes in number of ED visits over the past 90 days were found pre- to post-CAPABLE, and the means were not different from the usual care comparison group. The intervention group had a reduction in hospitalizations over the past 90 days from pre- to post-CAPABLE (mean ± SD, 0.43 ± 1.51 to 0.23 ± 0.60; *P* = .03). The post-CAPABLE mean number of hospitalizations was significantly lower than in the usual care comparison group (mean ± SD, 0.23 ± 0.60 to 0.47 ± 2.66; *P* < .01). Fourteen percent fewer beneficiaries experienced at least one fall post-CAPABLE compared to pre-CAPABLE (20.8% vs 34.8%; *P* < .01). When benchmarked against the usual care comparison group, the rate of falls was significantly lower post-CAPABLE (20.8% vs 30.6%; *P* < .01).

Table 2. Summary of Outcomes (ADLs Summed Score, Numbers of ED Visits and Hospitalizations, and Rate of Falls) of No-, Pre-, and Post-CAPABLE Beneficiaries^a

| Variable | Usual care comparison group | Pre-CAPABLE | Post-CAPABLE | Pre- to Post-CAPABLE | Post-CAPABLE against usual care comparison |
|-----------------------------------|-----------------------------|-------------------|-------------------|----------------------|--|
| | | | | <i>P</i> value | <i>P</i> value |
| ADL score | 7.95 ± 3.35 (1346) | 8.51 ± 3.08 (269) | 7.80 ± 2.86 (230) | .01 | .45 |
| IADL score | 6.76 ± 1.27 (1346) | 6.43 ± 1.31 (270) | 5.62 ± 1.09 (230) | <.01 | <.01 |
| Depression score ^b | 0.94 ± 1.06 (1350) | 0.92 ± 0.99 (270) | 0.86 ± 0.96 (230) | .45 | .25 |
| Pain score ^c | 2.43 ± 1.49 (1344) | 2.63 ± 1.32 (270) | 2.68 ± 1.23 (230) | .76 | .01 |
| No. of ED visits | 0.27 ± 0.81 (1350) | 0.32 ± 0.74 (270) | 0.27 ± 0.65 (210) | .63 | .94 |
| No. of hospitalizations past 90 d | 0.47 ± 2.66 (1350) | 0.43 ± 1.51 (269) | 0.23 ± 0.60 (230) | .03 | <.01 |
| No. of falls past 30 d | | | | | |
| 0 | 935 (69.4) | 176 (65.2) | 182 (79.1) | <.01 | <.01 |
| ≥1 | 413 (30.6) | 94 (34.8) | 48 (20.8) | | |

Abbreviations: DL, activity of daily living; CAPABLE, Community Aging in Place, Advancing Better Living for Elders; ED, emergency department; IADL, instrumental ADL.

^aData are given as mean ± SD (number) or number (percentage).

^bDepression score range is from 0 (not present) to 3 (exhibits daily in past 3 days); higher is worse depression.

^cPain score range is from 0 (no pain) to 10 (unbearable pain); higher is worse pain.

Demographic characteristics and comorbidity were not predictive of changes in ADL scores pre- to post-CAPABLE, but changes in the IADL differed according to age and comorbidity (Table 3). Among those younger than 65 years, greater improvement in the IADL scores was seen among those with more comorbid conditions, while this effect was not present among those 65 years or older (difference between age groups in comorbidity slope, 0.12; SE, 0.06; *P* = .07). In the analysis of change in the number of hospitalizations, among those 65 years and older, females had greater reduction in the number of hospitalizations than males, while no sex difference existed among those younger than 65 years (*P* = .05 for the interaction term, Table 3).

Log-odds of falls post-CAPABLE differed according to age and comorbidity as well as race and sex. Among those 65 years or older, odds of falls increased with comorbidity, but for those younger than 65 years, comorbidity was not associated with odds of falling (*P* = .02 for age-by-comorbidity interaction, Table 3). Nonwhite males had higher odds of falling than white males, with no difference by sex among whites (*P* = .05 for sex-by-race interaction, Table 3). However, this finding should be interpreted with

caution due to relatively small counts of falls when broken down by race and sex.

Documentation of fidelity to CAPABLE was 100% for RN and OT assessments (270 of 270 and 251 of 251, respectively) and 98.5% (262 of 266) for a CAPABLE plan of care. Documentation of interdisciplinary coordination at three time points ranged from 73.6 to 75.3% (184 of 250, 176 of 239, and 171 of 227), and follow-up was at 66.1% (156 of 227).

Regarding beneficiary satisfaction with the model of care, 98.1% (*n* = 203 of 207) would recommend CAPABLE as a way to help remain living in the community. Additionally, 99.5% (*n* = 205 of 206) felt just right/satisfied/very satisfied with the content of clinician interactions regarding CAPABLE; and 96.6% (197 of 204) felt just right/satisfied/very satisfied with the timing of clinician interactions.

DISCUSSION

Similar to the original CAPABLE trials,¹⁷ we found improved ADLs and IADLs. Waiver beneficiaries who received CAPABLE had improved physical function and the

Table 3. Summary of Associations of Changes in Pre- to Post-CAPABLE Outcomes with Demographic Characteristics and Comorbidity

| Predictor | ADL change | | IADL change | | Change in No. of hospitalizations | | Falls | |
|------------------------------|------------------|----------------|------------------|----------------|-----------------------------------|----------------|------------------|----------------|
| | Coefficient (SE) | <i>P</i> value | Coefficient (SE) | <i>P</i> value | Coefficient (SE) | <i>P</i> value | Coefficient (SE) | <i>P</i> value |
| Age: ≥65 vs <65 y | -0.11 (0.30) | .70 | -0.74 (0.32) | .02 | 0.51 (0.35) | .13 | 2.14 (0.94) | .02 |
| Sex: Female vs male | 0.05 (0.35) | .88 | -0.28 (0.17) | .10 | 0.09 (0.25) | .73 | 0.02 (0.49) | .96 |
| Comorbidity | -0.07 (0.06) | .31 | -0.07 (0.05) | .12 | 0.06 (0.04) | .12 | -0.04 (0.12) | .76 |
| Race: nonwhite vs white | 0.01 (0.37) | .97 | 0.20 (0.19) | .29 | 0.20 (0.21) | .34 | 1.27 (1.16) | .27 |
| Comorbidity*age ≥65 vs <65 y | | | 0.11 (0.06) | .07 | | | 0.39 (0.18) | .03 |
| Sex*age ≥65 y | | | | | -0.76 (0.39) | .05 | | |
| Sex*race: female nonwhite | | | | | | | -2.66 (1.38) | .05 |

Abbreviations: DL, activity of daily living; IADL, instrumental ADL.

ability to perform self-care activities. This improvement in ADLs and IADLs may have supported the 14% reduction in the fall rate in this sample. Additionally, CAPABLE beneficiaries' fall rates (20.8%) were lower than the usual care benchmark comparison group (30%) and the reported national average for community-dwelling older adults.²⁷ Future studies should examine underlying causes for the lower fall rates.

Our findings showed fewer hospitalizations in this vulnerable population in the usual care assessment just prior to and after the intervention compared to the mean for older adults in the United States (0.29).²⁸ Fidelity to documentation of implementation of CAPABLE occurred at a high rate for assessment and planning; however, interdisciplinary coordination and follow-up were suboptimal. One limitation was that we found it challenging to identify CAPABLE documentation within the EHR, which may have influenced some fidelity rates. A high percentage of CAPABLE beneficiaries were satisfied with CAPABLE, similar to the original trial.^{18,29}

In sum, in this highly vulnerable Medicaid waiver population, CAPABLE reduced falls and improved physical function, which is the primary modifiable predictor of nursing home placement and cost.^{9,17} Greatest benefits of CAPABLE in terms of IADL improvement or reduction in hospitalizations were seen among those 65 years or older who had more comorbid conditions (for IADLs) or were female (for hospitalizations). These findings help identify subgroups that could be targeted first in the administration of CAPABLE, if the available resources are limited. CAPABLE may be a solution to helping vulnerable older adults with poor physical function to remain living in the community.

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