Item S1. Focus group moderator guide.

Informing a Tailored Intervention for Older Adults with ESRD and Functional Difficulties

PART 1. Introduction

A. Greetings

Greet the participants warmly and similarly, with same words.
Example: "I'm glad you came today; thank you for coming"

Pick a seat for yourself where you can face everyone without turning around – for example the head of the table.

Thank each by name and introduce yourself:
"My name is _____, and I will be your moderator today"

B. The Purpose [5 minutes]

After everyone is seated and ready to begin:

- Thank you again for coming.
- CAPABLE is a program currently taking place in Baltimore City that is helping older people like you function better at home.
- Discuss the different components of CAPABLE

*CAPABLE – Community Aging Place: Advancing Better Living for Elders

- Involves home visits from a nurse, an occupational therapist and a handyman working with you to improve your health and function over a 4 month period
- Clients have 10 sessions with the clinicians: 4 from the nurse and 6 from the occupational therapist, while the handyman comes as many times as needed to complete the home repairs and modifications.
- The nurse works on goals such as pain, mood, medication management, incontinence, fall prevention, PCP communication, smoking cessation, **6:15pm**

nutrition, energy conservation etc.

- The occupational therapist works on goals such as bathing, dressing, eating, functional mobility, safety, hygiene and grooming, meal preparation, memory, vision etc.

- In each session, you are working in collaboration with the clinician to determine the best method to perform a task, suitable repairs or equipment that can help you accomplish the goals you set at the first session with the clinician.

- The handyman does home repairs and modifications identified by you and the occupational therapist during the first two sessions.

- People with chronic kidney disease have more difficulty taking care of themselves than the average person. They get tired more easily and this makes it hard for them to do the things they use to do, like shower, cook and clean etc. or do it as quickly as they use to.

- We want to create a new program that will:

  1) Use the parts of CAPABLE that are beneficial to people with kidney disease.
  2) Include other components that are not in CAPABLE but could be useful for people with end stage renal disease.

- Our goal today is to:

  1) Discover which parts of CAPABLE can work best for people with chronic kidney disease.

  2) Find out if there are any components that you feel are missing in CAPABLE that will be helpful for someone that is living with and dealing with chronic kidney disease.

- We will use the information you provide to us during this session to develop the new prevention program that will directly target the problems that people with chronic kidney disease face.

As you heard when you agreed to participate, our discussion will be tape recorded. Our research coordinator is going to turn on the tape recorder now. We use tape recorders so we can recall all the information you have shared with us. When the tapes are transcribed, you will be identified by a number only. The transcriptionist is off site, so your identity will be confidential. Does anyone

have any questions?

C. Introduction of Participants and Rules [10 min]

We deeply appreciate your coming today. Every opinion is important, and I'm looking forward to hearing from each of you. We have just a couple of rules:

1) Everyone participates
2) Every opinion is important – and because we want to hear from everyone, I may have to cut you off to give others a chance to share.
3) Our meeting is confidential – between ourselves. What is said here stays here.
4) The tape recorder needs help - try to speak clearly.
5) All cell phones or pagers off

We'll be talking together for about an hour and a half. Feel free to get some refreshments quietly during the conversation.

<u>Introductions</u>

Let's start with a brief introduction from each of you. Please state ***"I am Number XX"*** when you first speak. This is for the transcriptionist, so he or she will be able to know the sound of your voice, in case we want to link your comments. [Go around the table …]

6:20 pm

PART 2. Discussion

Okay that's great. Let's get started with our discussion.

Knowledge/Beliefs

A. What types of challenges to you think people on dialysis face in taking care of themselves every day?

B. Do you think you or people on dialysis face more challenges taking care of themselves everyday than a person who is not on dialysis?

B. Do you think the things in your house can make it unsafe for you to live there?

C. Do you think the way you do things such as taking a bath, cooking etc. can be **6:30 pm**

unsafe?

D. Do you think making changes to the way you do things or making physical changes/modifications to your house can make it safer for you or improve your health? (Ex: like adding a railing to your stairway)

E. Do you know what client- directed approach means?

F. Do you think setting your own health goals can increase your motivation to accomplish these goals?

G. Do you think your health problems can hinder your interactions with your friends and family? If yes, how?

H. Do you think the way your home is set up can affect your interaction with the outside world? For example, if you had steep stairs and weak legs, could that affect the number of times you leave the house?

Needs

A. Did functional limitations and how your house is laid out influence your decision to start dialysis in a center as opposed to at home?

B. If you were to get a kidney transplant, would you be able recover at home?

C. Do you have any difficulty managing you medical problems – (reaching/talking to your doctor, taking medications, pain, incontinence, frequent falls, mood changes etc.)? If so, what type of problems?

D. Do you get tired easily? Do you need any strategies to manage your tiredness?

E. Are there places or things in your house you don't go to or use? Why?

F. Are there things in your house that you will consider unsafe? Are there things that can be done to make these places or things safer and easier to use?

G. Do you feel comfortable asking your family members to help you clean/manage your house and medical problems?

H. How do you get around in the community? Do you drive?
If you do not drive, who brings you to dialysis, doctor's appointments, the market, church etc.?

I. How often are you in-touch with your family, friends, church, etc.; and how often **7:00 pm**

do you attend community engagements? If not often, why?

Acceptable Interventions

A. Would you welcome a research nurse, occupational therapist and a handyman coming into your home? Why or why not?

B. Would you be willing to let a handy man make repairs or changes in your home?

C. Would you be willing to try (use) the things, repairs/modifications and strategies that you and the research staff discuss during your sessions?

D. Do you think 10 sessions over 4 months is enough time for you to set a goal, work toward it and reach attainable results?

E. Would you be ready to receive/read written information that is beneficial to you from research clinicians?

PART 3. Conclusion

For each group:

We are going to turn off the tape recorder now and then we'll have a few minutes for any other comments you want to give to me.

Thank the participants for coming.

Item S2. CAPABLE Targeted areas, goals, and treatment approaches[1]

EXAMPLE GOALS	TREATMENT APPROACHES
Housing safety: Repair built environment to ↓ fall risk and ↑ mobility	1) OT assesses house for safety and mobility risks. With participant, creates prioritized list for HM such as: fix holes in floors, stabilize shaky banisters, add second banisters, lower cabinets to participants' reach, install bathroom safety equipment.
Self-care: ↑ ability to independently conduct ADLs and IADLs	1) For each participant-identified area of concern, the OT (a) observes performance; (b) with participant, identifies solutions for priority concerns; (c) orders, installs, and trains participant in use of adaptive devices. 2) The HM installs adaptive devices such as raised toilet seats, and shower chairs, safe kitchen step stools, lighting.
Functional mobility: ↑ increase ability to stand to cook, walk down steps	OT assesses for safe transfer, distance walking, safe shoes and other functional mobility needs such as bath shower chair, car swivel seat, stamina, energy conservation, cane, walker or rolling walker.
Medication management: ↑ ability to follow safe medication regimen	RN helps participant identify medication management problems and solutions such as 1) patient education on medication need; 2) dose timing; 3) physical reminders and pictorial medication schedule; 4) identify medications with fall implications 5) uncover issues with side effects, interactions or financial considerations.
Balance and strength: ↑ stand, balance, recover from falls and near falls	1) RN implements NIA Go4Life[2] exercise with participant; 2) RN assesses interest in exercise bands; 3) OT trains in fall prevention and recovery; 4) OT and RN reinforce balance and strength strategies at each visit.
Depression: Enhance skills for mood management	RN uses a modified Behavioral Activation approach to help participant link mood to specific daily activities and to increase daily pleasant events. This complements goals depressed participants make for other areas such as self-care or functional mobility.
Pain: Decrease pain to facilitate function	1) RN assesses global pain and function-specific pain 2) RN advocates with PCP regarding pain medication; 3) RN educates participant on timing and dosing of pain medication; 4) RN offers other pain management techniques such as topical non-steroidal anti-inflammatory cream, distraction, mobility, and heat.
Communication with Provider: ↑ patient activation to facilitate safe management	1) RN provides Health Passport; 2) low-vision medication schedule; 3) letters from RN to nephrologist and/or PCP on medication issues; 4) RN refers participants to new PCP if they don't have one, or to home visiting PCP if unable or unwilling to leave home; 5) patient activation training by RN.

Abbreviations: OT=Occupational Therapist; HM=Handy Man; ADL=Activities of Daily Living; IADL=Independent Activities of Daily Living; PCP=Primary Care Provider; RN=Registered Nurse

1. Szanton SL, Wolff JW, Leff B, et al. CAPABLE trial: a randomized controlled trial of nurse, occupational therapist and handyman to reduce disability among older adults: rationale and design. *Contemporary clinical trials.* 2014;38(1):102-112.
2. National Institute on Aging. https://go4life.nia.nih.gov/ . Accessed January 7, 2018.

Figure S1. Flow diagram of trial participation.

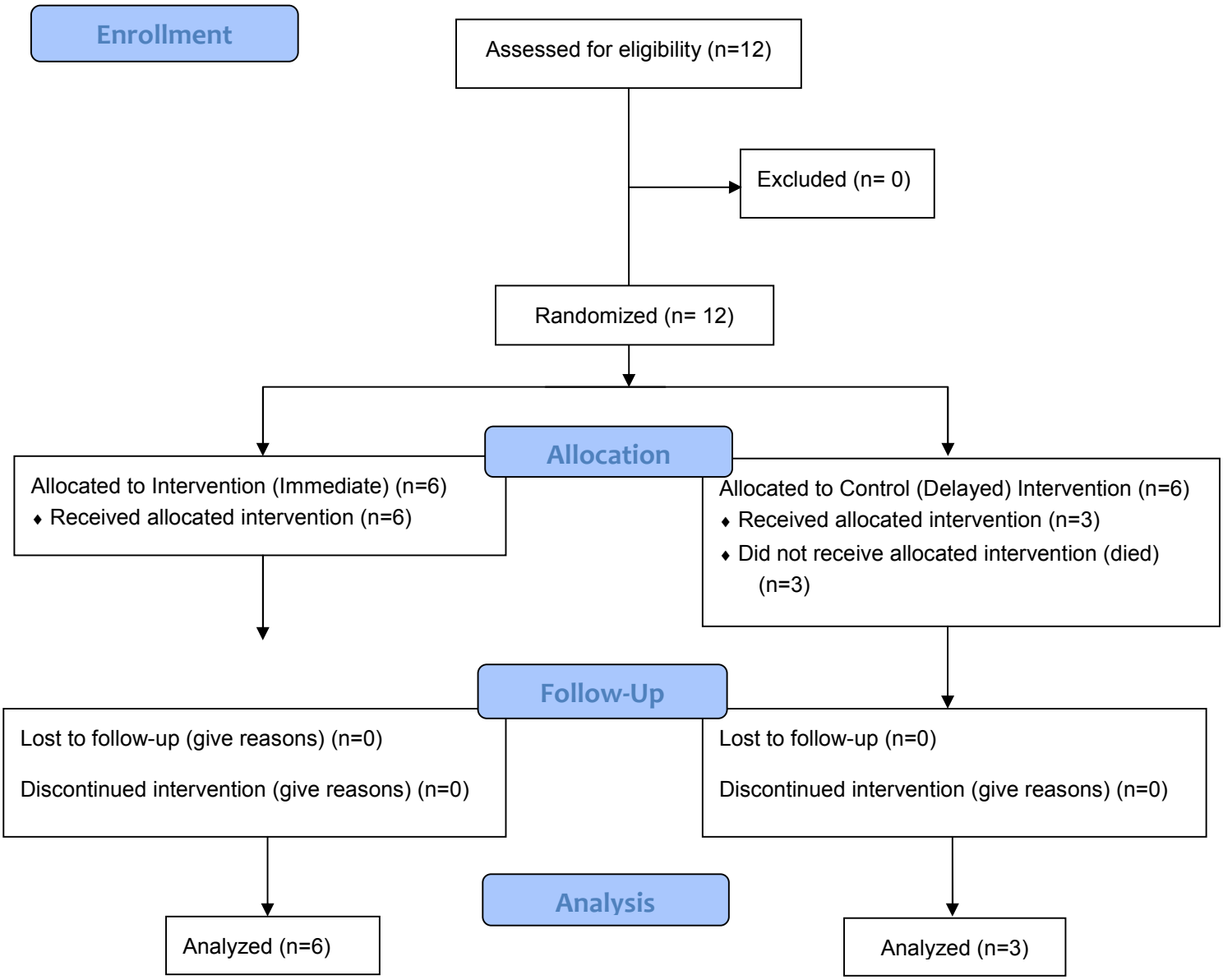

Figure S2: Dot Plots of Individual Participants' Outcomes, by Intervention Group