

WHO Integrated Care for Older People (ICOPE) implementation pilot programme Findings from the 'ready' phase

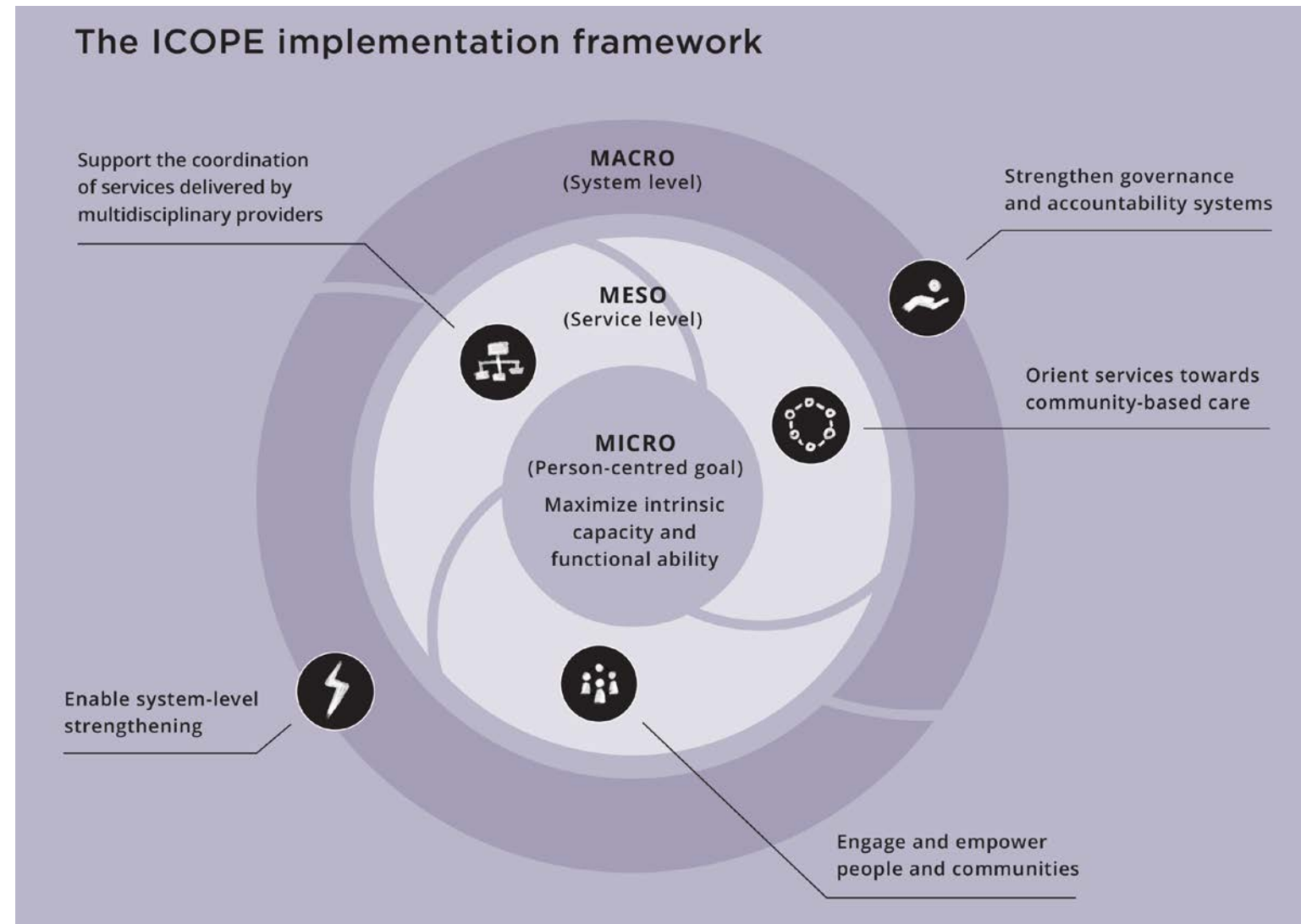
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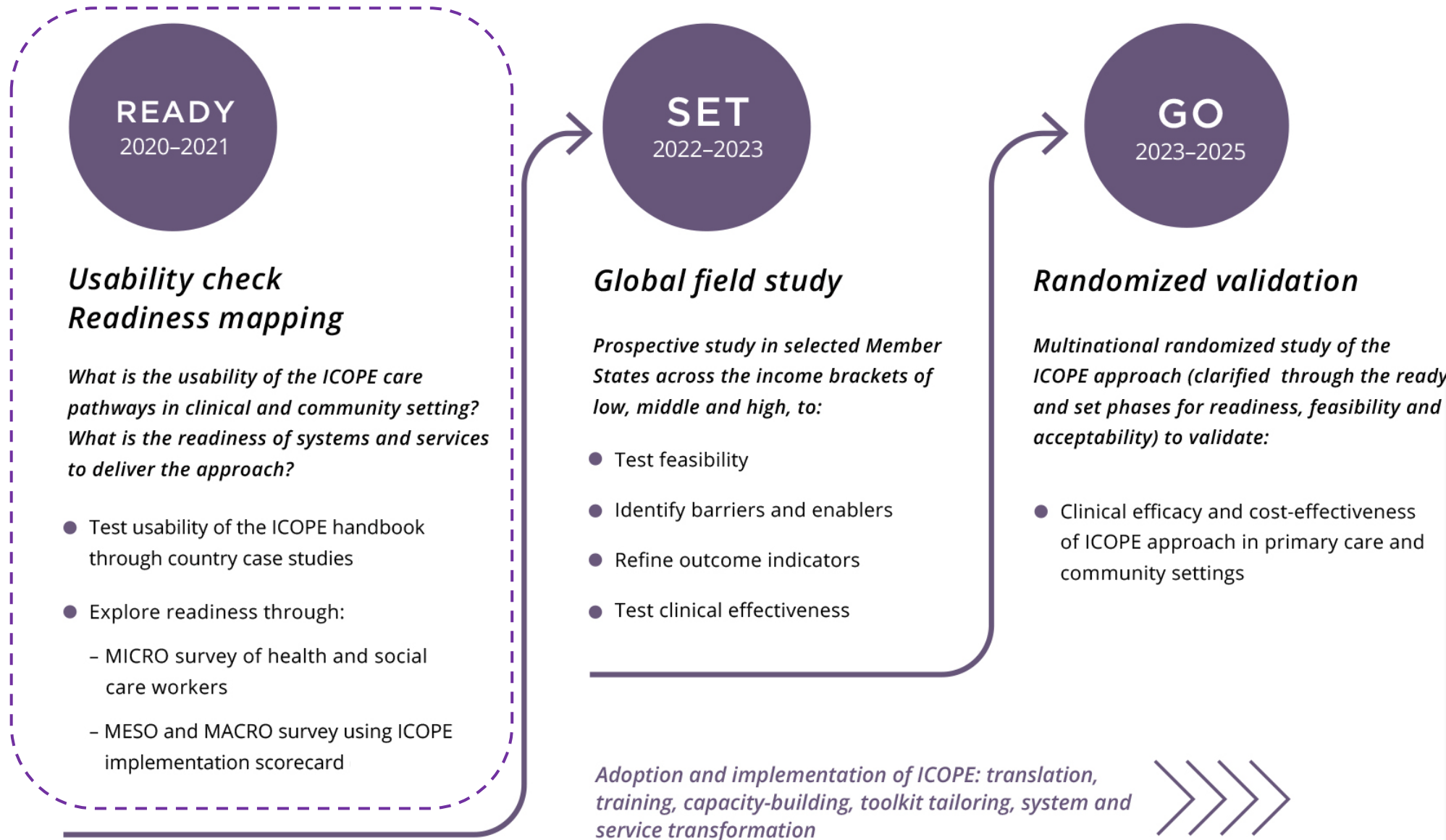
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Integrated care for older people

Continuum of care that will help to **reorient health and social services** towards a more **person-centred** and **coordinated model of care** that supports **optimising intrinsic capacity and functional ability** for older people



Phases of ICOPE Implementation Pilot Program



Country case studies



OCCITANIE (FRANCE)

- Ongoing since January 2020 (Data to November 2021)
- 1 711 health and care workers, 410 nurses
- Large urban site
 - Primarily in Toulouse city
 - 30% of 6 million population aged 60 years and over (17)
- 10 903 participants
 - Mean age, 76 (18–108 years with 96% aged 60 or more)
 - 61% female



CANILLO (ANDORRA)

- July to September 2020
- The study team comprised two geriatricians and a geriatric nurse. It also engaged primary care doctors to ensure follow-up care
- Small urban site
 - Small town in mountainous area
 - 18% of 4 422 population aged 60 years and over (15)
 - 798 over 60 years: 18%
 - 523 over 65 years: 12%
- 72 participants
 - Mean age, 73 (65–92 years)
 - 54% female



RAJASTHAN (INDIA)

- January to May 2021
- Fifteen public health students were trained to implement the screening step of ICOPE
- Rural site
 - Two villages in the Jodhpur district of Rajasthan
 - 8% of 69 million population aged 60 years and over (18)
- 451 participants
 - Mean age, 68 (65–98 years)
 - 46% female

CHAOYANG (CHINA)

- June 2020 to August 2021
- Over 22 000 health workers, including primary care physicians, nurses, rehabilitation therapists and social workers, and over 200 partner organizations and facilities
- Large urban site
 - Largest district in Beijing city
 - 21% of 3.45 million population aged 60 years and over (16)
- 874 participants
 - Mean age, 82.8 (70–100 years)
 - 61% female



Country case study: Screening (step1): cases of potential decline in intrinsic capacity

Condition associated with decline in capacity	Rate of positive cases (%)			
	CANILLO (N=72)	CHAOYANG (N=874)	OCCITANIE (N=10 903)	RAJASTHAN (N=451)
Cognitive decline	56	14	60	32
Loss of mobility	24	31	35	52
Visual impairment	82	45	68	49
Hearing loss	Not included	20	51	68
Malnutrition	17	16	19	34
Depressive mood	39	26	38	19
Mean age (years)	73 (65-92)	83 (70-100)	76 (60-108)	68 (65-98)

ICOPE implementation readiness at service and clinical levels:

Survey results of 29 Member States with 260 respondents

Strong engagement with the ICOPE approach from health and care workers

Enablers:

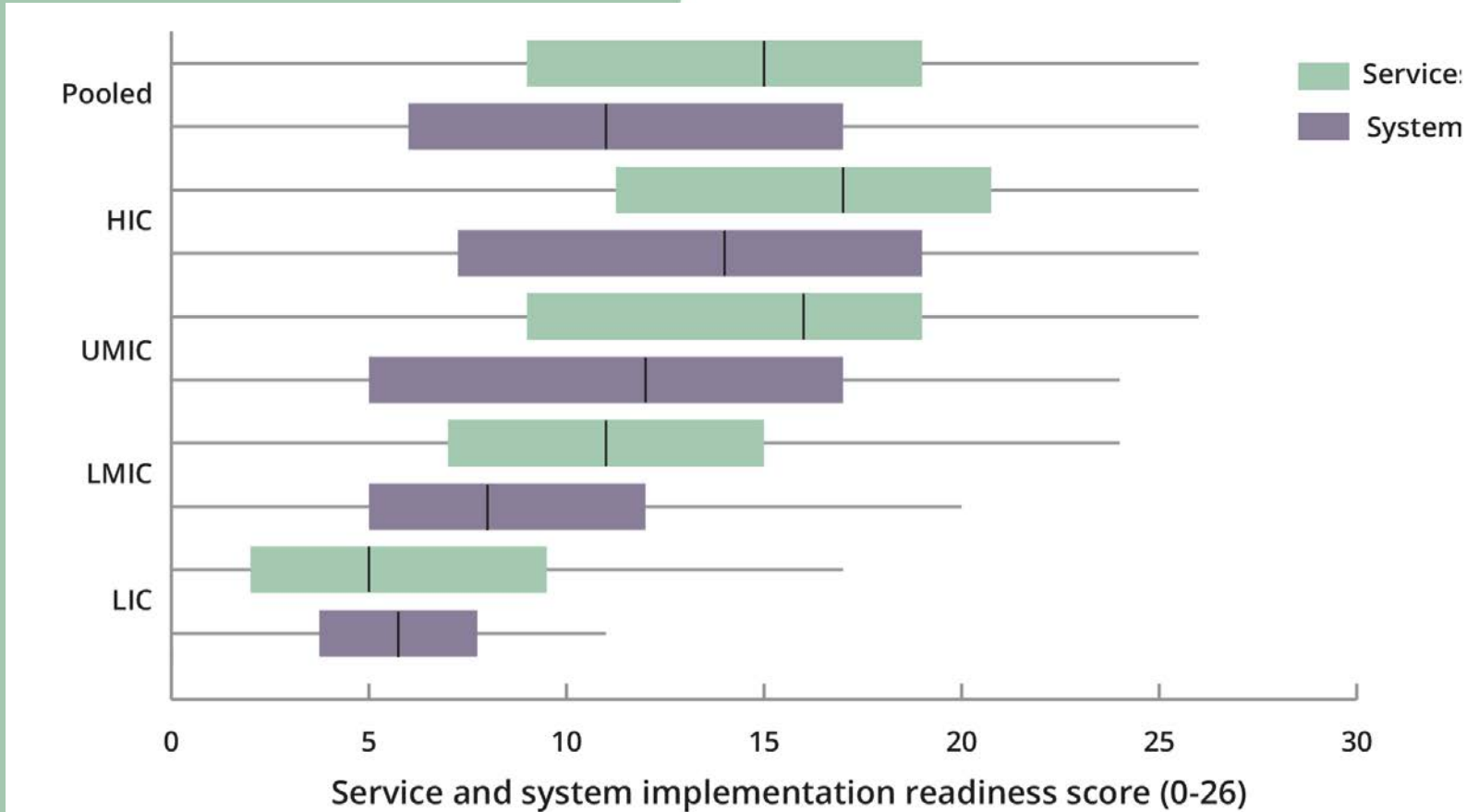
- Engagement of older people and their caregivers is key thorough all steps of the ICOPE care pathway;
- Establishment of local networks of multidisciplinary stakeholders;
- Training on intrinsic capacity assessment by local and national authorities.

Barriers:

- Lack of workforce capacity (available staff, time, skills);
- Insufficient support to implement care pathways from screening to the develop and monitor care plan, and support caregivers;
- Fragmented infrastructure and system on health and social care

ICOPE implementation readiness at service and system levels:

Survey results of 35 Member States with 259 respondents



The median scores with the first and third quartile are presented as a box with bars (minimum and maximum scores)

HIC: High income, UMIC: Upper middle income, LMIC: Low middle income, LIC: Low income

Learning gained in the ICOPE pilot ready phase


Opportunities

1. **Positive attitudes from health and care workers** towards the principles of integrated care **and high levels of commitment** to adoption and implementation of ICOPE;
2. **Proactive engagement of older people and their communities is crucial** across all steps of the pathway;
3. ICOPE is **feasible to implement in different contexts**. The value of **local co-design and adaptation** to suit local context and to optimize local workforce engagement and training.



Learning gained in the ICOPE pilot ready phase

Issues for further consideration

- **Human resources** identified as the main barrier to ICOPE implementation: shortages of health and care workers, lack of time, lack of skills and training;
 - **Financing:** health economics assessment needed to support development of sustainable financial model, including reimbursement for staff time;
 - **Use of digital technologies** provides potential opportunities and barriers. Issues of access, interoperability, integrity, data governance and usability need to be addressed;
 - **Lack of coordination and collaboration within and between health and social care systems** could provide a barrier to ICOPE implementation. But ICOPE could also provide opportunities to strengthen how systems and services work together
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Next steps

- Next phase (SET) of pilot study in a few countries, to develop programme indicators, test the clinical effectiveness and economic analysis
- Country case studies: subsequent phases to reach significantly higher numbers of older people
- Further commitments by policy makers:
 - Support from Government of *France* for scale up of ICOPE approach in five regions;
 - Andorran* Health Care Service to establish population wide prevention strategy for older people
 - Development of a system of integrated care for older people by Government of *China*
 - Initiation of ICOPE pilot by Government of *Chile*
 - Integration of ICOPE data into national electric health database by Government of *Qatar*



Acknowledgment

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Tribute to Islene Araujo de Carvalho

<https://www.who.int/publications/i/item/9789240048355>

