ICOPE
INTEGRATED CARE FOR OLDER PEOPLE

Implementation framework

Guidance for systems and services

World Health
Organization

ICOPE

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Integrated care for older people (ICOPE) implementation framework: guidance for systems and services

Contents

Acknowledgements

Abbreviations

FA   functional ability

HR   human resources

IC   intrinsic capacity

ICOPE   integrated care for older people

ICT   information and communications technology

PREM   patient- or person-reported experience measure

PROM   patient- or person-reported outcome measure

SDG   sustainable development goal

WHO   World Health Organization

ICOPE

Background

The need for the ICOPE approach

The integrated care for older people (ICOPE) approach has been developed by the World Health Organization (WHO) in the context of populations around the world ageing rapidly. This demographic transition will impact on almost all aspects of society and create new and complex challenges for health and social care systems. From 2015 to 2050, the proportion of the global population aged 60 years and over will nearly double.[1] Many of these people are likely to experience losses in their health, including developing multimorbidities, and to live in low- and middle-income settings.

At the same time, the world has united around the United Nations 2030 agenda for sustainable development. This pledges that no one will be left behind and that every human being will have the opportunity to fulfil their potential with dignity and equality.[2] The sustainable development goals (SDGs) within the 2030 agenda demonstrate a renewed global commitment to reinvigorate and reorganize health systems. This in turn is underpinned by target 3.8 for universal health coverage (UHC), whereby all people and communities have access to the quality health services they need without the risk of financial hardship. But unless structural and social adaptations are implemented and quality care is assured, many of the ambitions outlined in the SDGs will not be achieved.[3,4]

Aligning health systems and services to the needs of older people

The WHO *World report on ageing and health* and the subsequent *Global strategy and action plan on ageing and health* help to ensure that societal responses to population ageing are aligned with the ambitious 2030 agenda.[1,5] Both call for action to ensure the needs of older populations are being met by appropriately aligned health and long-term care systems.

A transformative approach is needed in the way health systems and the services within them are designed – to ensure care is of high quality, integrated, affordable, accessible and centred on the needs and rights of older people.[3] Integrated care, particularly for older people and people with chronic health conditions, is widely accepted as a mechanism to improve health outcomes and system efficiency.[3]

Building sustainable long-term care systems

WHO defines long-term care as "the activities undertaken by others to ensure that people with significant loss of intrinsic capacity can maintain a level of functional ability consistent with their basic rights, fundamental freedoms and human dignity".[1] These activities include social care, health care and the contribution of other sectors, such as transport – and all of these should be integrated to ensure optimal coordination and efficiency.[1,6] Long-term care systems may include a range of paid and unpaid caregivers, so this needs to be considered in the implementation of the ICOPE approach.

WHO proposes the following three strategies to sustainably build long-term care systems.[7]

1. Develop and continually improve the system infrastructure through appropriate legislation and sustainable financing mechanisms that enable access to services.

2. Build capacity in the paid and unpaid workforce by providing training, support and career opportunities.

3. Ensure the quality of social care services.

Integrating at the levels of systems and services

Achieving integrated health and social care services and systems for older people needs transformation at the system (macro) level, service (meso) level and clinical (micro) level. This guidance for developing systems and services is designed to support the implementation of strategies to achieve ICOPE at the macro and meso levels. Other WHO resources have been developed to support change at the micro level, such as the *Guidelines on community level-interventions to manage declines in intrinsic capacity*[8] and *ICOPE: guidance on person-centred assessment and pathways in primary care.*[9]

Guiding principles of the ICOPE approach

The ICOPE approach is underpinned by four guiding principles.

1. Older people are afforded the same basic human rights as all people, including the right to the best possible health.

2. Older people should be given equal opportunity to achieve healthy ageing, regardless of social or economic status, place of birth or residence, or other social factors.

3. Care should be provided with equality and non-discrimination, particularly on gender, age and ethnicity.

4. Health and social care systems and services need to respond to the unique health and social care needs and goals of older people, which may vary over time, and should address the social determinants of health.

Details of the ICOPE approach

To support healthy ageing,[i] health and social care services and the systems that support them need to respond to the diverse needs of older people, including people with high and stable levels of intrinsic capacity,[ii] those experiencing declining intrinsic capacity, and people whose capacity has fallen to the point where they need the care and support of others.

WHO proposed the ICOPE approach to support these diverse needs. This involves health and social care being integrated, and supported by a long-term care system, to better address the needs of older people.[1,3]

The ICOPE approach enables health and long-term care systems – and the services within them – to respond optimally to the unique, varied and often complex needs of older people. The ultimate aim is to maximize people's intrinsic capacity and functional ability.[iii]

WHO generally considers older people to be in their second half of life, based on the median life expectancy of the population of interest. The ICOPE approach is focused mainly on older people who have declining intrinsic capacity, or who have significant loss in capacity and are care-dependent **(Figure 1)**.

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[i]   Healthy ageing is the process of developing and maintaining the functional ability that enables well-being in older age.
[ii] Intrinsic capacity is a person's total physical and mental reserves.
[iii] Functional ability comprises the health-related attributes that enable people to be and to do what they value.

FIGURE 1.
A public health framework for healthy ageing and the opportunities for public health

ICOPE APPROACH

High and stable capacity | Declining capacity | Significant loss of capacity

Functional ability

Intrinsic capacity

HEALTH SERVICES:

Prevent chronic conditions or ensure early detection and control

Reverse or slow declines in capacity

Manage advanced chronic conditions

LONG-TERM CARE:

Support capacity-enhancing behaviours

Ensure a dignified late life

ENVIRONMENTS:

Promote capacity-enhancing behaviours

Remove barriers to participants, compensate for loss of capacity

The ICOPE approach is underpinned by the principle that functional ability can be maximized when services and systems integrate health and social care for older people in a manner that responds to their unique needs – that is, in a person-centred manner. Integration does not mean that structures must merge but, rather, that a wide array of service providers should work together in a coordinated way within a system. ICOPE is a community-based approach that helps to reorient health services and build long-term care systems towards this more person-centred and coordinated model of care.

The evidence suggests service-delivery models need the following features for the ICOPE approach:[10,11]

- community-level and home-based interventions
- person-centred assessments and integrated care plans
- shared decision-making and goal-setting
- support for self-management
- multidisciplinary care teams
- unified information or data-sharing systems
- community engagement and caregiver support
- formal links with social care and support services.

Implementation

Development of the ICOPE implementation framework

The implementation of any health or social care reform is complex. Considerations and actions are needed at multiple levels for integrated care for older people (ICOPE) – from better individual clinical encounters to whole-system changes. While most interventions are targeted at the clinical level, there is a growing recognition for effort and resources to be invested at the service and system levels.[10,12,13]

Having confirmed the scope and components of the ICOPE approach,[10] the World Health Organization (WHO) now aims to support Member States to implement the key actions needed in health and social care services.

To inform this implementation, WHO undertook a systematic review of reviews of the evidence on integrated care. This was followed by a Delphi study in 2017–2018 to reach a global consensus on the key implementation actions that would be needed by health and long-term care systems and services to deliver the ICOPE approach.[10] Nineteen implementation actions were agreed in the consensus – nine at the system (macro) level and 10 at the service (meso) level.

Results are documented here:

- Elements of integrated care approaches for older people: a review of reviews. *BMJ Open* (https://bmjopen.bmj.com/content/bmjopen/8/4/e021194.full.pdf);[10]

- Global consultation on integrated care for older people (ICOPE) – the path to universal health coverage: report of consultation meeting 23–25 October 2017 in Berlin, Germany (http://apps.who.int/iris/bitstream/handle/10665/272863/WHO-FWC-ALC-18.3-eng.pdf);[14]

- Actions required to implement integrated care for older people in the community using the World Health Organization's ICOPE approach: a global Delphi consensus study. *PLOS One* (https://journals.plos.org/plosone/article?id=10.1371%2Fjournal.pone.0205533).[15]

Who should use the framework?

The 19 implementation actions in the ICOPE framework are presented here to support Member States in implementing the ICOPE approach. The macro-level components of the framework are intended to support policy-makers, and system-level planners, funders and decision-makers. The meso-level components are intended to support service and programme managers and decision-makers.

1. The framework offers guidance on how to implement the ICOPE approach, recognizing that the local social and cultural context and the level of health-system maturity will determine how these implementation recommendations are adopted.

2. The implementation actions should integrate existing health and social care services, and improve the capacity of supporting systems (workforce, infrastructure, financing). In some settings, this may include integrating community services with acute care services.

3. The ICOPE implementation scorecard supports self-assessment by countries of their capacity to deliver integrated care.

4. Local leadership, to drive implementation efforts that integrate services effectively, is needed at both system and service levels.

FIGURE 2.

Steps for creating integrated services for older people
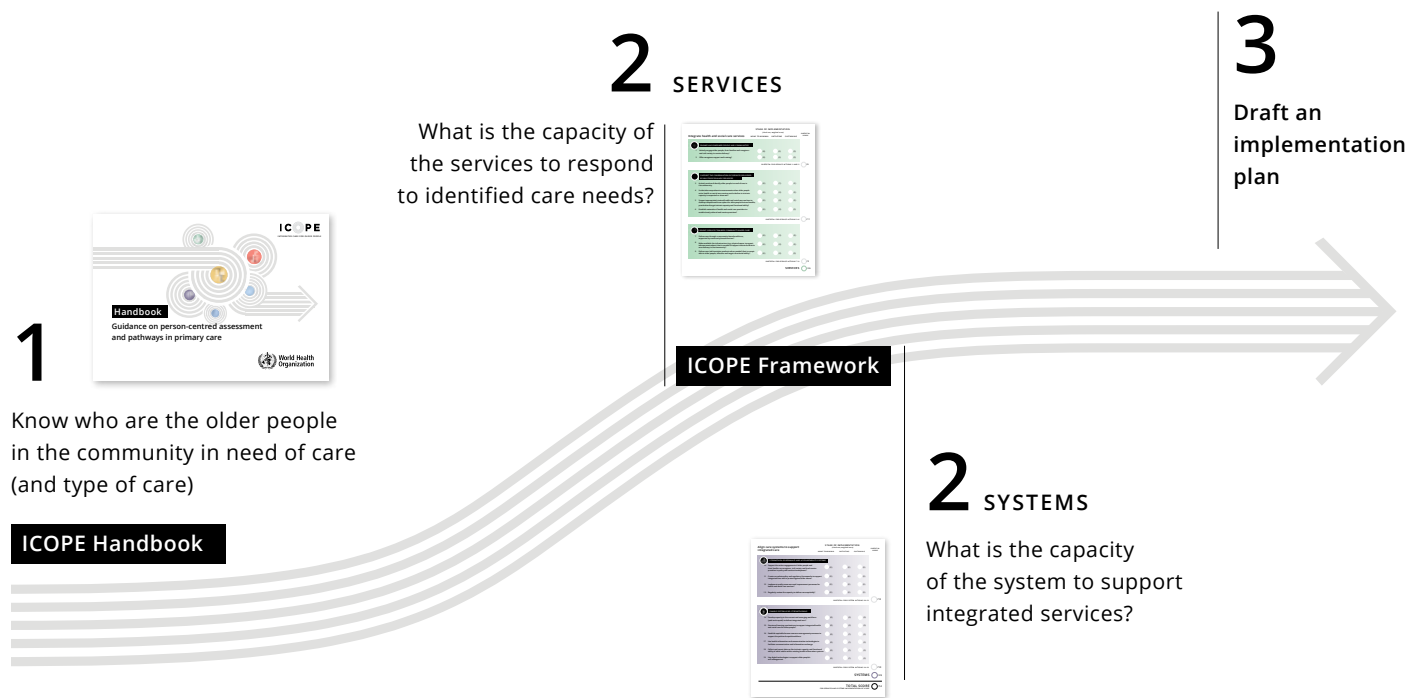
How to use the ICOPE implementation framework

The ICOPE implementation framework has two parts –
one for service managers and the other for system managers.
(see Figure 2). It may be used to:

1. identify older people in the community in need of
health and social care;

2. assess the capacity of services or systems to deliver
integrated care at the community level using the ICOPE
approach; and

3. initiate an ICOPE implementation plan according
to capacity.

Across the two parts of the framework, there are 19 actions
needed for implementing ICOPE in community settings. These
are grouped into the following themes **(see Figure 3)**.

Services (meso level):

- engage and empower people and communities
- support the coordination of services delivered by
  multidisciplinary providers
- orient services towards community-based care.

Systems (macro level):

- strengthen governance and accountability systems
- enable system-level strengthening.

Based on the international Delphi process, and as supported by the consultation meeting, 14 of the 19 actions have been identified as essential. The remaining five are important actions for implementing the ICOPE approach, but are not necessarily essential for all settings.

For the 19 actions, a description of each is followed by three indicators of the stage of implementation (starting at no to minimal implementation, through initiating implementation, to sustaining it). These three stages identify the current status of the system or service capacity for the ICOPE approach, and offer guidance for further action. By considering the stages described and actions needed, users will be able to score the current status under each action in the framework.

The ICOPE implementation scorecard produces totals that indicate the overall status of implementation, summarizing this for services, systems and for both overall. The scorecard is intended to help assess the overall capacity of health and social care services and systems to deliver integrated care in community settings, and so inform ICOPE implementation plans. The scoring will highlight areas of opportunity, and can be used to monitor the ongoing progress of implementation.

FIGURE 3.
ICOPE implementation framework
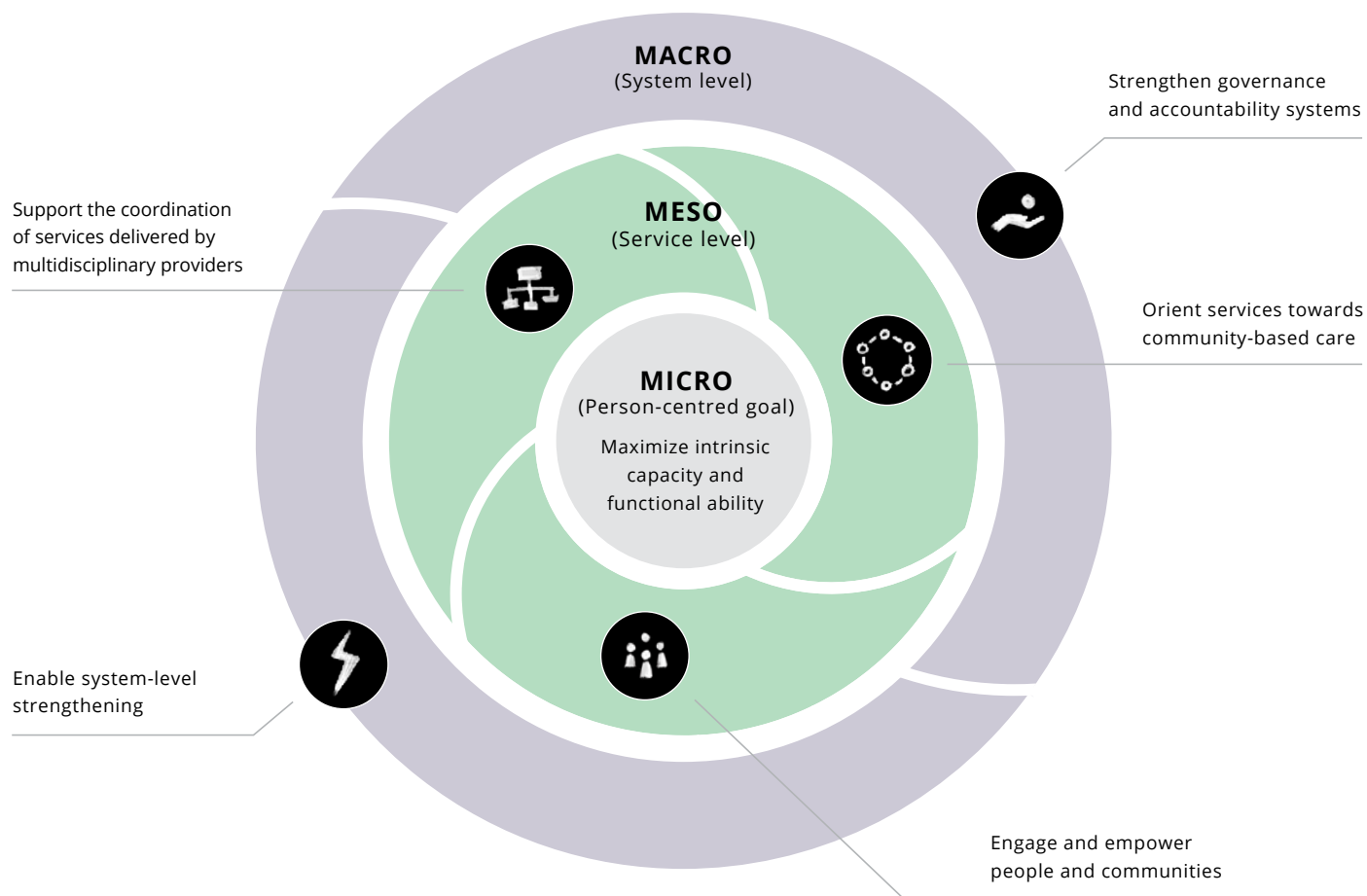
The following resources are recommended to support Member States in the implementation of the ICOPE approach.

- Framework on integrated, people-centred health services
(https://www.who.int/servicedeliverysafety/areas/people-centred-care).[16]

- Integrated care for older people. Guidelines on community-level interventions to manage declines in intrinsic capacity
(https://www.who.int/ageing/publications/guidelines-icope).[8]

- World report on ageing and health
(https://www.who.int/ageing/events/world-report-2015-launch).

- ICOPE evidence resource centre
(https://www.who.int/ageing/health-systems/icope/evidence-centre).[8]

- Global strategy and action plan on ageing and health
(https://www.who.int/ageing/global-strategy).[5]

- Global strategy on human resources for health: workforce 2030
(https://www.who.int/hrh/resources/globstrathrh-2030).[17]

- Rehabilitation in health systems
(https://www.who.int/rehabilitation/rehabilitation_health_systems).[18]

- Guidelines on transforming and scaling up health professionals' education and training
(https://www.who.int/hrh/resources/transf_scaling_hpet).[19]

- WHO guideline: recommendations on digital interventions for health system strengthening
(https://www.who.int/reproductivehealth/publications/digital-interventions-health-system-strengthening/).

- Organizing integrated health-care services to meet older people's needs
(https://www.who.int/bulletin/volumes/95/11/16-187617.pdf).[3]

- Be He@lthy, Be Mobile: a handbook on how to implement mAgeing
(https://www.who.int/ageing/publications/mageing).[20]

ICOPE implementation scorecard

Use this scorecard to produce a summary measure of the level of implementation achieved in integrated care for older people (ICOPE) across services and systems. Follow the ICOPE implementation framework for a full description and guidance on each action needed, and to see the levels of implementation that attract each weighted score. Completed scorecards can be used not only to gauge the present capacity to implement ICOPE, but also to monitor ongoing delivery as scores improve.

Integrate health and social care services

ENGAGE AND EMPOWER PEOPLE AND COMMUNITIES

		NONE TO MINIMAL	INITIATING	SUSTAINING
1	Actively engage older people, their families and caregivers and civil society in service delivery*	(0)	(2)	(3)
2	Offer caregivers support and training*	(0)	(2)	(3)

SUBTOTAL FOR SERVICE ACTIONS 1 AND 2 ◯ /6

SUPPORT THE COORDINATION OF SERVICES DELIVERED BY MULTIDISCIPLINARY PROVIDERS

		NONE TO MINIMAL	INITIATING	SUSTAINING
3	Actively seek and identify older people in need of care in the community	(0)	(1)	(2)
4	Undertake comprehensive assessments when older people enter health or social care services and a decline in intrinsic capacity is suspected or observed*	(0)	(2)	(3)
5	Support appropriately trained health and social care workers to develop comprehensive care plans for older people that are feasible, practical and target intrinsic capacity and functional ability*	(0)	(2)	(3)
6	Establish networks of health and social care providers to enable timely referral and service provision*	(0)	(2)	(3)

SUBTOTAL FOR SERVICE ACTIONS 3–6 ◯ /11

ORIENT SERVICES TOWARDS COMMUNITY-BASED CARE

		NONE TO MINIMAL	INITIATING	SUSTAINING
7	Deliver care through a community-based workforce, supported by community-based services*	(0)	(2)	(3)
8	Make available the infrastructure (e.g. physical space, transport, telecommunications) that is needed to support safe and effective care delivery in the community*	(0)	(2)	(3)
9	Deliver care (with assistive products when needed) that is acceptable to older people, effective and targets functional ability*	(0)	(2)	(3)

SUBTOTAL FOR SERVICE ACTIONS 7–9 ◯ /9

*Essential

SERVICES ◯ /26

Align care systems to support integrated care

STRENGTHEN GOVERNANCE AND ACCOUNTABILITY SYSTEMS

		NONE TO MINIMAL	INITIATING	SUSTAINING
10	Support the active engagement of older people and their families or caregivers, civil society and local service providers in policy and service development*	(0)	(2)	(3)
11	Create or update policy and regulatory frameworks to support integrated care and to protect against elder abuse*	(0)	(2)	(3)
12	Implement quality assurance and improvement processes for health and social care services*	(0)	(2)	(3)
13	Regularly review the capacity to deliver care equitably*	(0)	(2)	(3)

SUBTOTAL FOR SYSTEM ACTIONS 10–13 ◯ /12

ENABLE SYSTEM-LEVEL STRENGTHENING

		NONE TO MINIMAL	INITIATING	SUSTAINING
14	Develop capacity in the current and emerging workforce (paid and unpaid) to deliver integrated care*	(0)	(2)	(3)
15	Structure financing mechanisms to support integrated health and social care for older people*	(0)	(2)	(3)
16	Establish equitable human resource management processes to support the paid and unpaid workforce	(0)	(1)	(2)
17	Use health information and communication technologies to facilitate communication and information exchange	(0)	(1)	(2)
18	Collect and report data on the intrinsic capacity and functional ability of older adults within existing health information systems	(0)	(1)	(2)
19	Use digital technologies to support older people's self-management	(0)	(1)	(2)

SUBTOTAL FOR SYSTEM ACTIONS 14–19 ◯ /14

SYSTEMS ◯ /26

TOTAL SCORE ◯ /52
FOR SERVICES AND SYSTEMS IMPLEMENTATION OF ICOPE

Overall levels of implementation

	NO TO MINIMAL IMPLEMENTAION	INITIATING IMPLEMENTATION	SUSTAINING IMPLEMENTATION
SERVICES	0–10	11–18	19–26
SYSTEMS	0–10	11–18	19–26
OVERALL	0–20	22–36	38–52

Service (meso) level

Service actions one to nine in the framework are directed at supporting the implementation of the ICOPE approach in health and social care services.

The actions are intended to assist **service and programme managers**.

Service-level managers will vary according to service designs in each country, but may include roles such as service manager, district manager, programme manager and state health coordinator.

Community-based care is a blend of health and social services provided to an individual or their family or caregivers in their place of residence to promote, maintain or restore health, or to minimize the effects of illness and disability. These services are usually designed to help older people remain independent and in their own homes. They can include, for example, seniors' centres, transport, meal deliveries or sites for meal congregation, visiting nurses or carers, and adult day care services.[21]

The service actions are grouped into three areas of focus:

engage and empower people and communities

support the coordination of services delivered by multidisciplinary providers

orient services towards community-based care

ENGAGE AND EMPOWER PEOPLE AND COMMUNITIES

Service actions 1 and 2

1

Actively engage older people, their families and caregivers and civil society in service delivery

The engagement of community members and organizations in service delivery leverages untapped resources, helps to ensure healthy and facilitative environments for older people and helps to decrease caregiver burden. The community may include, for example, families and neighbours, other older people, employers, religious organizations and community organizations. Participation by individuals, families and civil society in health and social care delivery can help to fill care gaps, such as personal care, promote older people's health and well-being and create age-friendly environments. Non-governmental organizations, social enterprises and medical care funds can often provide services that health facilities are unable to offer, such as care coordination, peer support and support for self-management.

STAGE	IMPLEMENTATION STATUS	SCORE	ACTION(S) NEEDED
○	**No to minimal implementation** *There is no current or planned formal engagement with community members or organizations in the delivery of health or social care services for older people. Any community services provided are largely ad hoc or informal.*	0	❯ Identify the scope, nature and capacity of community services in the local area. ❯ Develop a strategy to formally engage the local community in health and social care service delivery.
◎	**Initiating implementation** *There is some formal engagement with community members or organizations in the delivery of health or social care services for older people.*	2	❯ Consult with community groups and other local services to identify opportunities for expanding engagement with the community. ❯ Formalize the relationship of health and social services with the community, for example by establishing weekly support and monitoring visits from care workers to community volunteers, registering volunteers in the health facility and providing incentives and training.
◉	**Sustaining implementation** *Processes have been implemented where community members or organizations are formally engaged in the delivery of health and social care services for older people.*	3	❯ Maintain engagement with community members, community groups and other services in the delivery of health and social care services. ❯ Sustain monitoring and support systems.

Offer caregivers support and training

2

Supporting the physical and mental well-being of caregivers and supporting their skills-based care competencies is essential to supporting the care of older people. Caregivers often form a critical component of the unpaid workforce. The mode of training and support for caregivers will differ by setting and should be flexible to suit local needs, capacity and available resources. Services should provide a combination of supports for caregivers, including for their:

- physical well-being
- mental well-being
- skills-based care competencies
- respite care where indicated.

STAGE	IMPLEMENTATION STATUS	SCORE	ACTION(S) NEEDED
	No to minimal implementation *There are limited services to support the physical or mental well-being of caregivers (e.g. day centres), and minimal formal training or respite care.*	0	Undertake a needs assessment to identify threats to, or impairments in, caregivers' mental and physical well-being, gaps in competencies, and respite care needs. Undertake a capacity assessment to determine the human, financial and infrastructure resources needed and available to provide caregiver support, respite care and training. Community day centres may be appropriate options, for example.
	Initiating implementation *Initiatives are being developed or piloted to offer support to caregivers in one or more of the following areas: physical well-being, mental well-being, skills-based care competencies or respite care. Some infrastructure is available to support caregivers, such as day centres or respite care.*	2	Consult within and across services and with caregivers to evaluate the acceptability of planned or piloted support or of training initiatives, and evaluate opportunities for scaling them up. Begin efforts to make psychological support available for responding to caregiver burden. Initiate plans for community-based respite care, such as community day centres or temporary home support.
	Sustaining implementation *Services are available to support caregivers in one or more of the following areas: physical well-being, mental well-being, skills-based care competencies or respite care. Infrastructure is in place to support caregivers, such as day centres or respite care.*	3	Continue to deliver support and training initiatives and implement a cycle of quality improvement to ensure the initiatives remain relevant and useful to caregivers. • For carers of people living with dementia, for example, the WHO iSupport tool (http://www.who.int/mental_health/neurology/dementia/isupport) can be a useful online training platform. It provides information, skills training and support, and uses problem-solving and cognitive behavioural therapy to address caregivers' needs.[22]

SUPPORT THE COORDINATION OF SERVICES DELIVERED BY MULTIDISCIPLINARY PROVIDERS

Service actions 3–6

Actively seek and identify older people in need of care in the community

3

Services can implement case-finding systems to identify older people in the community (or in a defined geographical area) who are in need of health and social care. For example, home visits within a defined geographical area by health and/or social care workers, or other members of a multidisciplinary team, may be appropriate in some settings. In most case-finding initiatives, some level of central coordination for a given geographical area is needed.

STAGE	IMPLEMENTATION STATUS	SCORE	ACTION(S) NEEDED
○	**No to minimal implementation** *There is currently no formal case finding in the community.*	0	Consult providers, community members and civil society to identify locally appropriate and acceptable case-finding strategies. Assess the capacity within and between services for implementing formal case-finding strategies.
◎	**Initiating implementation** *Some case finding is undertaken, but not through a structured mechanism or formalized process.* *or* *Structured case finding is planned or being piloted.*	1	Develop a clear case-finding strategy for the community and engage with providers, community members and civil society to consult them on developing implementation strategies. Consultations should include older people and caregivers, judge acceptability and feasibility and identify opportunities for scaling up case finding and its coordination between service providers.
◉	**Sustaining implementation** *Structured case finding is undertaken by services in the community.*	2	Continue case finding and implement a cycle of quality improvement to ensure processes remain effective and locally acceptable.

4

Undertake person-centred assessments when older people enter health or social care services and a decline in intrinsic capacity is suspected or observed

Person-centred assessments are an essential aspect of personalized care planning when an older person's intrinsic capacity (IC) has declined or is at risk of decline. Person-centred assessments consider the older person's:

- IC and functional ability (FA), and their trajectories
- specific health or social conditions, behaviours and risks that may influence IC and FA
- environmental context
- social care needs.[9]

Person-centred assessments provide the information needed to prioritize and tailor interventions that are aligned to the holistic, individual needs of the person. Assessments should be shared between multidisciplinary providers to inform a personalized care plan that includes a package of services (see the next service action in the framework, number 5).

STAGE	IMPLEMENTATION STATUS	SCORE	ACTION(S) NEEDED
○	**No to minimal implementation** *Standardized comprehensive assessments are not routinely performed when older people enter health or social care services and a decline in IC is noted.*	0	Assess the capacity of current services to perform comprehensive assessments, such as the competencies of health and social care workers, the current user admission/enrolment processes in health and social care services, the infrastructure needed to implement a standardized comprehensive assessment and the existence of strategies for case finding and community outreach.
◎	**Initiating implementation** *Some services perform structured or standardized comprehensive assessments that can be shared between providers when older people enter health or social care services and a decline in IC is noted.* *or* *Services are in the process of developing or implementing structured or standardized comprehensive assessments, supported by training for health care workers, for use when older people enter health or social care services and a decline in IC is noted.*	2	Explore the opportunities, capabilities and readiness to implement standardized comprehensive assessments by consulting within and between service providers. Offer training to health and/or social care workers to perform comprehensive assessments and to develop care plans.
◉	**Sustaining implementation** *Structured or standardized comprehensive assessments are routinely performed when older people enter health or social care services and a decline in IC is noted. The training of health and social care workers is embedded in this activity.*	3	Continue undertaking comprehensive assessments and implementing care pathways. Continue to implement a cycle of quality improvement to ensure assessment processes remain efficient and acceptable to health and social care workers and to older people, families and caregivers.

Support appropriately trained health and social care workers to develop personalized care plans

5

Services should support the development of personalized care plans for older people based on a person-centred assessment of their health (e.g. disease management) and social care needs as well as their goals and preferences. Where appropriate, care plans should also incorporate advance care planning and be revised as a person's health or social circumstances change.

The primary focus of a personalized care plan should be on improving intrinsic capacity and functional ability by directly addressing the older person's health and social care needs.

STAGE	IMPLEMENTATION STATUS	SCORE	ACTION(S) NEEDED
◯	**No to minimal implementation** *Comprehensive care plans that can be shared between providers or services are not routinely developed by appropriately trained health or social care workers.*	0	Undertake a capacity assessment on the competencies of health and/or social care workers to create personalized care plans. Assess the current user admission/enrolment processes in health and social care services. Assess the infrastructure needed to create and share personalized care plans.
◎	**Initiating implementation** *Appropriately trained health or social care workers sometimes develop comprehensive care plans that can be shared between providers.* *or* *Processes are being developed or implemented to enable appropriately trained health and/or social care workers to create comprehensive care plans that can be shared between providers.*	2	Consult within and between service providers to explore the opportunities, capabilities and readiness for creating personalized care plans. Offer training to health and social care workers to develop personalized care plans. Use normative guidance such as the WHO ICOPE guidance on person-centred assessments and pathways in primary care.[9]
◉	**Sustaining implementation** *Comprehensive care plans that can be shared between providers are routinely developed by appropriately trained health and/or social care workers. The training of health and/or social care workers is embedded in this activity.*	3	Continue developing comprehensive care planning and continue training health and/or social care workers to develop care plans. Implement a quality-improvement cycle to ensure care planning remains effective and acceptable to health and social care workers and to older people and their families or caregivers.

6

Establish networks of health and social care providers to enable timely referral and service provision

Networks of local health and social care service providers are needed to facilitate timely referral to appropriate sites and levels of care for older people. This development of networks should include pathways for:

- rapid access to acute care and specialist services when needed (e.g. to a geriatric medicine unit)
- rehabilitation
- palliative and end-of-life care.

These networks can build communities of practice to optimize care delivery and coordination. A referral network to accommodate respite services for caregivers and to maintain their physical and mental well-being is also an important component of service delivery.

STAGE	IMPLEMENTATION STATUS	SCORE	ACTION(S) NEEDED
◯	**No to minimal implementation** *There is no formal network of service providers to enable timely referral or rapid care escalation for older people and their caregivers.*	0	❯ Do a mapping assessment to identify and create a network of service providers for older people and caregiver respite. ❯ Engage with potential service providers to explore their capabilities and readiness to join a provider network for older people and caregivers.
◎	**Initiating implementation** *A service provider network for timely referral or rapid care escalation for older people and for caregiver respite is being developed and piloted.*	2	❯ Engage with potential service providers to explore their capabilities and readiness to join a provider network for older people and caregivers.
◉	**Sustaining implementation** *There is a formal network of service providers to enable timely referral or rapid care escalation for older people and for their caregivers.*	3	❯ Sustain and further develop the formal network of service providers that enables timely referral or rapid care escalation for older people and their caregivers by continuing to map services and consult service providers.
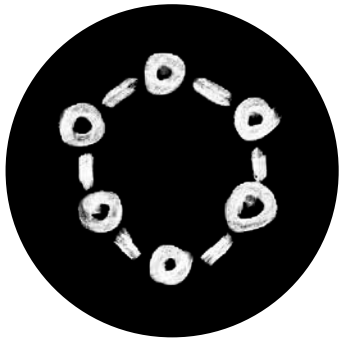
ORIENT SERVICES TOWARDS COMMUNITY-BASED CARE

Service actions 7–9

7

Deliver care through a community-based workforce, supported by community-based services

Care should be delivered through a community-based health and social care workforce, including paid and unpaid roles (e.g. family members), that is supported by infrastructure for the delivery of safe and effective, clinically appropriate and feasible care to older people in their home or community.

Workforce configurations to deliver such care will vary according to the setting and resources available. For example, it may include a mix of health and social care professionals (e.g. family doctors, dentists, nurses, allied health professionals, social workers), and community health workers and volunteers/peers/family members (i.e. paid and/or unpaid roles). Where unpaid carers are involved, adequate support (financial or in kind) is likely to be needed.

STAGE	IMPLEMENTATION STATUS	SCORE	ACTION(S) NEEDED
◯	**No to minimal implementation** *A community-based workforce has not been constructed, is not available and is not currently planned to deliver health and/or social care services to older people in their community or home.*	0	❯ Undertake a capacity assessment to create a community-based workforce based on local need (e.g. volumes of health and social care workers, the availability of an unpaid workforce, opportunities for new cadres) to deliver health and social care services to older people in their community or home. ❯ Do a mapping exercise to identify local community services capable of supporting a local workforce.
◎	**Initiating implementation** *A community-based workforce to deliver health and/or social care services to older people in their community or home is:* • *intermittently available* *or* • *planned or being trialled locally* *or* • *available but not supported by community services.*	2	❯ Explore opportunities to implement a permanent, community-based workforce through novel configurations that are suitable to the local context (e.g. unpaid roles, new work cadres). ❯ Do a mapping exercise to identify local community services capable of supporting a local workforce.
◉	**Sustaining implementation** *A community-based workforce to deliver health and/or social care services to older people in their community or home is established and supported by community services.*	3	❯ Continue to deliver care to older people in their community or home through a community-based health and social care workforce. ❯ Continue to engage with and support local community services and to map the availability and capabilities of these services to support the workforce. ❯ Continue to support the workforce (paid and unpaid) through local community services.
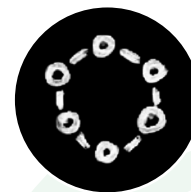
Make available the infrastructure (e.g. physical space, transport, telecommunications) that is needed to support safe and effective care delivery in the community

8

The physical infrastructure of many health care settings may not be well matched to older people's needs or abilities. This may include a lack of accessible toilets, long waiting lines, physical barriers to access (e.g. stairs) and communication barriers resulting from a lack of accessible information for people with hearing loss and/or visual impairment. Social care service infrastructure such as respite care, day care centres and nursing homes should be made available. Wherever possible, locally available infrastructure should be used, or local strategies devised to deliver care in the absence of such infrastructure, so as not to limit service initiation or the delivery of integrated care.

STAGE	IMPLEMENTATION STATUS	SCORE	ACTION(S) NEEDED
⬤	**No to minimal implementation** *The workforce has no or minimal access to the infrastructure needed to deliver safe and effective care to older people and their caregivers in the community.*	0	❯ Undertake an infrastructure needs assessment that considers the availability of current infrastructure in the community. ❯ Cost the infrastructure needed to support the workforce to deliver care, and develop a procurement plan. ❯ Consult with local stakeholders to identify how selected services could be delivered in the absence of supporting infrastructure.
⬤	**Initiating implementation** *Certain necessary infrastructure facilities are available and used to support the workforce to deliver care in the community.* *or* *A strategy to provide access to the necessary infrastructure is being developed or trialled, including the use of currently available resources.*	2	❯ Continue to use the available infrastructure. ❯ Develop and cost a strategy to acquire the additional infrastructure needed.
⬤	**Sustaining implementation** *The workforce has access to the infrastructure needed to deliver safe and effective care to older people and their caregivers in the community.*	3	❯ Continue to monitor infrastructure needs and provision capabilities as services expand or contract according to the health and social care needs of older people in the community.

9 Deliver care (with assistive products when needed) that is acceptable to older people and targets functional ability

Services should deliver safe and effective health and social care that targets functional ability (FA) and is aligned to older people's needs, preferences and cultural practices. In some settings, this may include traditional or complementary medicine. Where evidence exists to guide practice, care interventions should be aligned with it (including clinical guidelines such as the WHO *Guidelines on community-level interventions to manage declines in intrinsic capacity*[8]). In some circumstances, assistive devices and environmental adaptations will be needed, and where appropriate and feasible, services should provide assistive products that can accommodate losses in intrinsic capacity (IC) and so maintain FA. Examples include spectacles, hearing aids and mobility aids.

STAGE	IMPLEMENTATION STATUS	SCORE	ACTION(S) NEEDED
○	**No to minimal implementation** *Current care interventions for older people are not:* • *necessarily targeted at improving FA* • *aligned with best practice and evidence or older people's preferences* • *supported with assistive products that are included in essential medicines lists and available.*	0	❯ Modify care interventions in a phased manner to align them with recommended components of care. This may start with aligning to WHO guidelines,[8] for example, and orienting interventions towards improving IC and FA.
◎	**Initiating implementation** *Care is delivered with some but not all of the following components:* • *systematic targeting to the improvement of FA* • *alignment with best practice and evidence* • *alignment with older people's preferences and cultural practices* • *inclusion and availability of assistive products in essential medicines lists.*	2	❯ Audit care interventions to evaluate the extent to which they align with the recommended components of care. ❯ Through consultation and reviewing best practice (e.g. WHO guidelines[8]), modify care interventions to align more closely with recommended components of care.
◉	**Sustaining implementation** *Care is delivered consistently with the following components:* • *systematic targeting to the improvement of FA* • *alignment with best practice and evidence* • *alignment with older people's preferences and cultural practices* • *inclusion and availability of assistive products in essential medicines lists.*	3	❯ Continue to deliver services that are consistent with the recommended components of care, including buying assistive products and ensuring they are available.

System (macro) level

System actions 10 to 19 in the framework are directed at supporting the implementation of the ICOPE approach in health and long-term care systems (collectively referred to as systems).

The actions are intended to assist **system managers**.

The system actions are grouped into two areas of focus:

strengthen governance and accountability systems

enable system-level strengthening

STRENGTHEN GOVERNANCE AND ACCOUNTABILITY SYSTEMS

System actions 10–13

Support the active engagement of older people and their families or caregivers, civil society and local service providers in policy and service development

10

Implement processes to actively engage and empower older people and their families or caregivers, civil society (e.g. non-governmental organizations) and local service providers to participate in the development of health and social care policies. These policies may include long-term care systems, and services for older people.

Providing opportunities to all older people to share their views and wishes, without excluding any level of capacity, is an important component of participatory governance. Examples of strategies to achieve active community participation in policy or service development and its evaluation include:

- community forums (e.g. face-to-face meetings, online discussion boards)
- community representation on the boards of health care facilities
- active participation of civil society in policy and service development by government agencies.

STAGE	IMPLEMENTATION STATUS	SCORE	ACTION(S) NEEDED
◯	**No to minimal implementation** *There are no policies or participatory governance frameworks in place to support and encourage the engagement and participation of the community and older people in policy and service development. Any participation is ad hoc.*	0	❯ Develop policies or participatory governance frameworks in consultation with the community, older people and caregivers to formally support community engagement (inclusive of all older people and caregivers) in policy and service development.
◎	**Initiating implementation** *Informal mechanisms are in place to support and encourage community engagement and participation in policy and service development.* *or* *Systems are developing policies or participatory governance frameworks to support community engagement.*	2	❯ Review informal processes for their ability to be formalized and adopted at greater scale to support community engagement. ❯ Implement policies or participatory governance frameworks.
◉	**Sustaining implementation** *Systems have policies or participatory governance frameworks in place to support and encourage community engagement and participation in policy and service development.*	3	❯ Continue to support community engagement and participation in policy and service development through policies or participatory governance frameworks.

11

Create or update policy and regulatory frameworks to support integrated care and to protect against elder abuse

Elder abuse is an intentional act, or failure to act, by a person such as a caregiver in a relationship of trust with an older person that causes harm or creates a risk of harm to the older person. Regulatory frameworks to protect against elder abuse are important given the vulnerability of many older people. Policies, plans and regulatory frameworks should be created or updated to support the integration of care and activities against elder abuse at several levels, including:

- the clinical (micro) level between care teams
- the organization/service (meso) level (e.g. primary health care, residential care facilities and hospital-based services)
- the system (macro) level targeting health and social care systems.

Strong political support from senior leadership can catalyse integrated action against elder abuse at these levels. Support such as this is often needed for more detailed jurisdictional or national-level planning.

STAGE	IMPLEMENTATION STATUS	SCORE	ACTION(S) NEEDED
◯	**No to minimal implementation** *There are no policies or frameworks in place that promote integrated care and protection for older people.* *or* *Policies or frameworks that promote integrated care and protection for older people have been created but not implemented.*	0	❯ Create policies or frameworks to support integrated care and protection for older people. These should align with local need, be supported by a case for change against elder abuse and co-created with local champions or leaders. ❯ Identify and engage local champions or leaders to support the implementation of policies or frameworks.
◎	**Initiating implementation** *Policies or frameworks are being created, updated or implemented to promote integrated care and protection for older people.*	2	❯ Continue to create or update policies or frameworks through participatory governance. ❯ Support local champions or leaders to drive implementation efforts.
◉	**Sustaining implementation** *Contemporary policies or frameworks are in place to promote integrated care and protection for older people, and have been implemented and supported by champions or leaders across the sector.*	3	❯ Maintain contemporary policies or frameworks to provide integrated care and protection for older people, supported by a contemporary case for change against elder abuse. ❯ Continue to identify local champions or leaders and support them to disseminate policies and drive implementation.
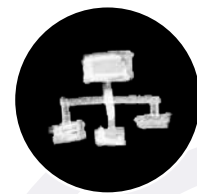
Implement quality assurance and improvement processes for health and social care services

12

Quality assurance and improvement are important components of service development and sustainability. Valuable data on the person-centredness and effectiveness of services are provided by the experiences of people, both consumers and providers, in accessing and interacting with services, and by patient- or person-reported outcome measures (PROMs) and patient- or person-reported experience measures (PREMs). PROMs reveal information about a person's self-perception of their health and may include quality of life, functioning (e.g. intrinsic capacity and functional ability) and self-efficacy. PREMs reveal a person's perception of their experience with a health or social care service. This may include experience with access, waiting times and the ability to participate in shared decision-making. Quality-improvement initiatives using measures such as these should use a culturally sensitive format.

STAGE	IMPLEMENTATION STATUS	SCORE	ACTION(S) NEEDED
	No to minimal implementation *There are no quality-assurance processes in place to measure person-centred or provider outcomes.* *or* *Some services measure quality outcomes but these are not systematically measured across the system.*	0	Identify the critical areas in service delivery where quality assurance is needed. Select the appropriate tools (PROMs, PREMs, person-centred outcomes). Develop a process to implement measurement tools.
	Initiating implementation *Some quality-assurance processes are in place to measure person-centred or provider outcomes, but these are not linked to service-improvement initiatives.* *or* *System-level quality-measurement processes are being developed or trialled.*	2	Develop processes for the use of quality outcomes data for service improvement. Expand system-level quality measures to include person-centred and provider outcomes across services.
	Sustaining implementation *Person-centred and provider outcomes are systematically measured across services and are used to improve the quality of care delivered.*	3	Continue to measure person-centred and provider outcomes across services and use these data to inform service improvement. Implement valid and reliable contemporary outcome measures.

13 Regularly review the capacity to deliver care equitably

System-level capacity assessments provide important information to a country or region on the gaps and opportunities for delivering integrated health and social care services to all older people, including disadvantaged groups. Assessments of this capacity may be far-reaching, including capabilities in policy, financing systems, infrastructure, workforce and local services. These data are useful for planning and review at the subnational level.

This integrated care for older people (ICOPE) implementation framework and scorecard as a whole guide the essential and important actions needed within systems and services to implement the ICOPE approach. The present component of the framework evaluates whether systems routinely assess the overall capacity for equitable delivery, while each of the other components prompts users to judge the capacity within services or systems to implement specific elements of ICOPE.

STAGE	IMPLEMENTATION STATUS	SCORE	ACTION(S) NEEDED
◯	**No to minimal implementation** *The capacity to deliver ICOPE is not routinely assessed.*	0	❯ Adopt the actions recommended by this framework as the criteria for assessing the capacity to deliver equitable ICOPE. ❯ Develop processes within systems to evaluate the capacity based on these criteria.
◎	**Initiating implementation** *The capacity to deliver ICOPE has been assessed but not routinely, nor with disadvantaged groups considered.*	2	❯ Implement routine capacity and performance assessments for integrated care (e.g. every five years), ensuring that assessments include disadvantaged groups and that outcomes are meaningful to system managers.
◉	**Sustaining implementation** *The capacity to deliver integrated care is routinely assessed, with disadvantaged groups included. Updated population-level health data are used, for example.*	3	❯ Routinely continue to assess the capacity to deliver ICOPE, and to evaluate the performance of the system in delivering this care. ❯ Routinely review assessment outcomes to ensure they remain meaningful to system managers.

ENABLE SYSTEM-LEVEL STRENGTHENING

System actions 14–19

14 Develop capacity in the current and emerging workforce (paid and unpaid) to deliver integrated care

Workforce capacity-building means supporting the development of knowledge and skills in the workforce to undertake person-centred assessments, develop personalized care plans and deliver services that target functional ability (FA), both in the current health and social care workforce and the emerging one (students, trainees and new roles, or roles with extended scope).

Capacity-building may be achieved by providing regular training opportunities to develop competency-based skills and continuing professional development across the workforce. Initiatives such as education to develop knowledge and skills in integrated care for older people (ICOPE) and intersectoral collaboration should be undertaken across providers. This gives cross-discipline relevance and supports team-based (i.e. interdisciplinary) collaborative care. It is important to recognize that the workforce may involve both paid and unpaid caregivers and providers, such as family members, so capacity-building initiatives should accommodate both.

STAGE	IMPLEMENTATION STATUS	SCORE	ACTION(S) NEEDED

No to minimal implementation   **0**

There are no processes in place to develop the knowledge or skills of the current or emerging workforce across the whole system.

Evaluate the current capacity of the workforce, specifically the knowledge and skills to deliver the right care. Key competencies include:[8]

- basic screening to assess intrinsic capacity (IC) and FA and the need for social care (mobility, vision, hearing, cognition, mood, psychological);
- basic skills in the management of health conditions that affect older people (e.g. frailty, urinary incontinence, risk of falls);
- basic understanding of how depression, dementia and alcohol use manifest in older people;
- ability to identify neglect or abuse of older people;
- ability to conduct person-centred assessments (service action 4) and to develop care plans (service action 5);[9] and
- basic competencies in communication, multidisciplinary teamwork, information technology and public health.

Develop workforce capacity-building initiatives to target the current and emerging workforce and both paid and unpaid roles. For the emerging workforce, capacity-building initiatives might include:

- transitioning to competency-based curricula;
- adopting inter-professional education models; and
- expanding training into primary care and community-based centres.

Initiating implementation

There are processes in place to develop the knowledge and skills for a limited sector of the workforce – for one or more of these examples:

- *paid health care practitioners*
- *unpaid care providers*
- *trainees*
- *new workforce roles.*

or

There are initiatives to develop workforce capacity but these are not interdisciplinary or do not comprehensively focus on the recommended components of ICOPE.

2 ❯ Expand existing capacity-building processes and initiatives to include all workforce roles, reflect interdisciplinary care and address the recommended components of care for the ICOPE approach. Follow the same key competencies outlined above for systems at the stage of minimal implementation.

Sustaining implementation

System-wide processes are in place to develop knowledge and skills across the paid and unpaid workforce. Initiatives to build workforce competencies for working in integrated models of service delivery include current and emerging workforce roles and have interdisciplinary relevance.

3 ❯ Continue the system-wide workforce capacity-building initiatives and update them as new evidence or resources emerge. Key strategies include:

- providing in-service training aligned to the same competencies outlined above for systems at the stage of minimal implementation;
- enabling ongoing supervision of service providers by senior staff;
- supporting joint consultations between generalists and specialists (e.g. geriatric specialists);
- supporting meetings of multidisciplinary team members;
- transitioning to competency-based curricula for trainees;
- adopting inter-professional education models; and
- expanding training into primary care and community-based centres.

❯ Monitor the capacity of the workforce so that capacity-building initiatives are responsive to need.

15 Structure financing mechanisms to support integrated health and social care for older people

Financing policies and mechanisms to support the integration of health and social care for older people can be established through:

- joint or pooled funding of health and social sectors, managed at the system level
- incentives for effective care coordination at the service level.

In some cases, contractual incentives or joint reimbursement models have been used to motivate health and social care workers to incorporate new practices to promote the coordination of care, such as joint care planning or joint support for self-management.

STAGE	IMPLEMENTATION STATUS	SCORE	ACTION(S) NEEDED
○	**No to minimal implementation** *Financing mechanisms for health and social care services across the system are not based on joint, pooled or shared funding models.* *and* *There are no financial incentive mechanisms to support coordinated or shared care between providers at the service level.*	0	Modify policies and processes to structure financing for health and social care services around a shared or pooled funding model that includes financial incentives for appropriate care coordination at the service level and includes the cost of interventions and essential medicines and devices to maintain intrinsic capacity (IC) and functional ability (FA).
◎	**Initiating implementation** *Financing models are in the process of being changed to support shared funding for health and social care services.* *or* *Financial incentives are planned or being trialled to promote care coordination at the service level and reduce the cost of interventions and essential medicines and devices to maintain IC and FA.*	2	Implement modified financing models that support shared or pooled funding approaches for health and social care services, which include financial incentives for appropriate care coordination at the service level. Evaluate the effectiveness of financial incentive initiatives in supporting sustained and meaningful care coordination at the service level.
◉	**Sustaining implementation** *The system currently supports both:* - *joint or pooled health and social sector funding* *and* - *incentives for effective care coordination at the service level.*	3	Continue to fund health and social care services in a joint funding mechanism. Continue to offer financial incentives to support care coordination at the service level, based on an evaluation of effectiveness.

Establish equitable human resource management processes to support the paid and unpaid workforce

16

Human resource (HR) processes and systems are needed to ensure the paid and unpaid workforce is managed in a fair, transparent and equitable manner. HR systems ensure that the workforce is supported by appropriate processes and procedures (e.g. for promotions, personal development, grievances, professional advice). Ideally, HR processes should be reasonably standardized across services to ensure equitable approaches to the management of human capital. HR processes should be aligned across services such that there is consistency in, for example, performance-management practices, in the establishment of supervision and advisory roles, and in processes to provide timely feedback on performance.

This system action does not necessarily mean that HR processes should be the same for paid and unpaid workers, but both areas of the workforce should be supported and managed by processes that are appropriate to their context.

WHO has produced the *Global strategy on human resources for health: workforce 2030.*[17] This provides policy direction for capacity-building in HR processes.

STAGE	IMPLEMENTATION STATUS	SCORE	ACTION(S) NEEDED
○	**No to minimal implementation** *There are no semi-standardized HR processes in place to support the paid workforce across health and social care services.*	0	❯ Develop system-level, semi-structured HR processes to support the equitable management of the workforce, including paid and unpaid workers, across services, consistent with the principles of the WHO *Global strategy on human resources for health: workforce 2030.*[17] ❯ Consult workers and service managers in developing HR processes.
◎	**Initiating implementation** *HR processes are being reformed for semi-standardization across health and social care services to support the paid workforce.*	2	❯ Implement semi-structured HR processes to support the equitable management of the workforce, including paid and unpaid workers, across services, consistent with the principles of the WHO *Global strategy on human resources for health: workforce 2030.*[17]
◉	**Sustaining implementation** *There are semi-standardized HR processes in place to support both the paid and unpaid workforce across health and social care services.*	3	❯ Continue to adopt HR processes that support the paid and unpaid workforce in a semi-structured and equitable manner. ❯ Review HR processes periodically (e.g. every five years) to reflect changes in work cadres and respond to service quality-improvement initiatives.

17

Use health information and communications technology to facilitate communication and information exchange

Where locally acceptable and feasible, systems should implement health information and communications technology (ICT) and processes to facilitate the storage, sharing and communication of information (e.g. health records, prescriptions, consultations) between health and social care services and providers.

Examples of this may include e-health records, home monitoring systems, integrated prescription systems and telehealth.[20] Such systems may also facilitate data collection and auditing – e-health records, for example, can organize information about individuals and entire clinical populations of older people to help identify needs, plan care over time, monitor responses to treatment and assess health outcomes.

Many health systems do not have the capability to support e-health systems, although being unable to perform this system action should not prevent integrated care advances in other areas. In the absence of ICT, relatively low-tech options such as telephone and fax can be used to ensure that information is shared appropriately among providers.

STAGE	IMPLEMENTATION STATUS	SCORE	ACTION(S) NEEDED
	No to minimal implementation *Secure digital technologies are not supported for health information storage and sharing or communication between services or providers.*	0	❯ Identify where health information storage and sharing and communication between services or providers could be enhanced by secure digital technologies. ❯ Develop a strategy to guide the phased procurement and implementation of digital technologies, supported by a policy for appropriate privacy and security. ❯ Continue to use existing low-tech systems to support information exchange and care coordination among services or providers.
	Initiating implementation *Secure digital technologies to support health information storage and sharing and communication between services or providers are being trialled or implemented.*	1	❯ Develop a strategy to guide the phased procurement and implementation of digital technologies, supported by a policy for appropriate privacy and security. ❯ Implement digital technologies in a phased approach in consultation with service managers and providers to ensure acceptability and feasibility.
	Sustaining implementation *Secure digital technologies are used across the system to support health information storage and sharing and communication between services or providers.*	2	❯ Continue to review the needs for digital health technology. ❯ Continue to review the policy for data privacy and security and the latest developments to support digital health technologies.

Collect and report data on the intrinsic capacity and functional ability of older adults within existing health information systems

18

Declines in intrinsic capacity (IC) and losses in functional ability (FA) – such as limitations in locomotor capacity, cognitive capacity, psychological capacity, vision, hearing and nutritional status – should be routinely assessed in older age groups within existing health information or surveillance systems; see WHO ICOPE guidance on person-centred assessments and pathways in primary care for further implementation support.[9] Various instruments for measuring IC, including those being developed by WHO,[9] may provide useful starting points for responding to health needs at a primary care level. At the service level, collecting data on IC will facilitate timely responses to declines, and better resource allocation. At a system level, collecting these health data offers the opportunity to monitor population health and to evaluate initiatives designed to improve system performance in care integration, quality and safety.

Evidence for the proposed domains of IC that are of clinical relevance has been published.[24]

STAGE	IMPLEMENTATION STATUS	SCORE	ACTION(S) NEEDED
○	**No to minimal implementation** *Data on the IC and/or FA of older people are not collected as part of existing health information systems.*	0	Evaluate the capacity to integrate measures of IC and FA into health information systems. Develop a phased implementation plan to integrate IC and FA measures into health information systems.
◎	**Initiating implementation** *Tools to measure IC or FA are being integrated into existing health information systems.* *or* *Some services measure IC or FA in older adults, but these data are not integrated into system-level health information systems.*	1	Implement tools across services to measure the IC and FA of older people as part of system-level health information or surveillance. Use the experiences of services already using or trialling tools to inform implementation. Develop a reporting plan for IC and FA data.
◉	**Sustaining implementation** *IC and FA in older adults are measured within existing health information systems and reports on the data are used to evaluate the population needs of older people over time.*	2	Continue to measure IC and FA within existing health information systems. Update the measurement tools, under guidance from WHO.[9] Prospectively report on IC and FA data to evaluate population health needs and changes over time.

19

Use digital technologies to support older people's self-management

Where locally acceptable and feasible, implement digital technologies to support self-management by older people.

Where settings have the resources, infrastructure and policy to support them, digital technologies should be deployed to support older people to self-manage, for example through self-monitoring using mHealth (mobile technologies) or web-based tools.[20,23] The implementation of such technologies may be easier as technologies evolve and the evidence for their effectiveness and acceptability emerges.

STAGE	IMPLEMENTATION STATUS	SCORE	ACTION(S) NEEDED
	No to minimal implementation *Digital technologies are not provided or are not supported for the purpose of assisting older people with self-management.*	0	Undertake a needs and capacity assessment to provide or support digital technologies. Evaluate available digital technologies to determine effectiveness, acceptability and fit within the existing system.
	Initiating implementation *Some services use digital technologies to support older people to self-manage but these are not implemented across the system.* *or* *Digital technologies to support self-management by older people are being trialled across services with a view to system-level implementation.*	1	Review evaluation outcomes of trials of digital technologies across services. Develop a system-level implementation plan for digital technologies identified as appropriate and acceptable to the local setting.
	Sustaining implementation *Digital technologies to assist self-management by older people are provided and supported.*	2	Continue to provide or support digital technologies to assist older people with self-management. Evaluate the impact of digital technologies on self-management capabilities and health service use.

Glossary

Capacity assessment

The analysis of a person's desired capacities against their existing capacities. This assessment of the person's assets and needs can inform a response that aims to develop their intrinsic capacity.

Delphi

A research design that facilities the development and refinement of a concept or issue based on expert feedback gathered to develop a consensus.

Elder abuse

An intentional act, or failure to act, by a person such as a caregiver in a relationship of trust with an older person that causes harm or creates a risk of harm to the older person.

Functional ability

The health-related attributes that enable people to be and to do what they value. Functional ability is made up of the intrinsic capacity of the individual, the relevant environmental characteristics and the interactions between the individual and these characteristics.[1]

Healthy ageing

The process of developing and maintaining the functional ability that enables well-being in older age.[1]

Integrated care

A system and process in which services are managed and delivered so that people receive a continuum of health promotion, disease prevention, diagnosis, treatment, disease management, rehabilitation and palliative care, coordinated across the different levels and sites of care within and beyond the health sector, and according to their needs throughout the life course.[16]

Interdisciplinary care

Care delivered by professionals from a diverse range of disciplines in a coordinated manner towards a common goal such as improving functional ability.

Intrinsic capacity

The composite of a person's total physical and mental reserves that they may draw on.[1,24]

Long-term care

The activities undertaken by others to ensure that people with a significant ongoing loss of intrinsic capacity can maintain a level of functional ability that is consistent with their basic rights, fundamental freedoms and human dignity.[1]

Needs assessment

A process for determining and addressing needs by identifying gaps or wants between current conditions and desired conditions (of knowledge and skills, for example). The discrepancy between the current condition and the wanted condition should be measured to identify the need.

Participatory governance

Processes to involve diverse stakeholders and institutions in public decision-making.

PREMs

Patient-reported experience measures are questionnaires that patients complete to provide their perceptions of their experiences while receiving care.[25]

PROMs

Patient-reported outcome measures are questionnaires that patients complete to provide self-rated assessment of health or social outcomes, for example pain, quality of life, physical function.[25]
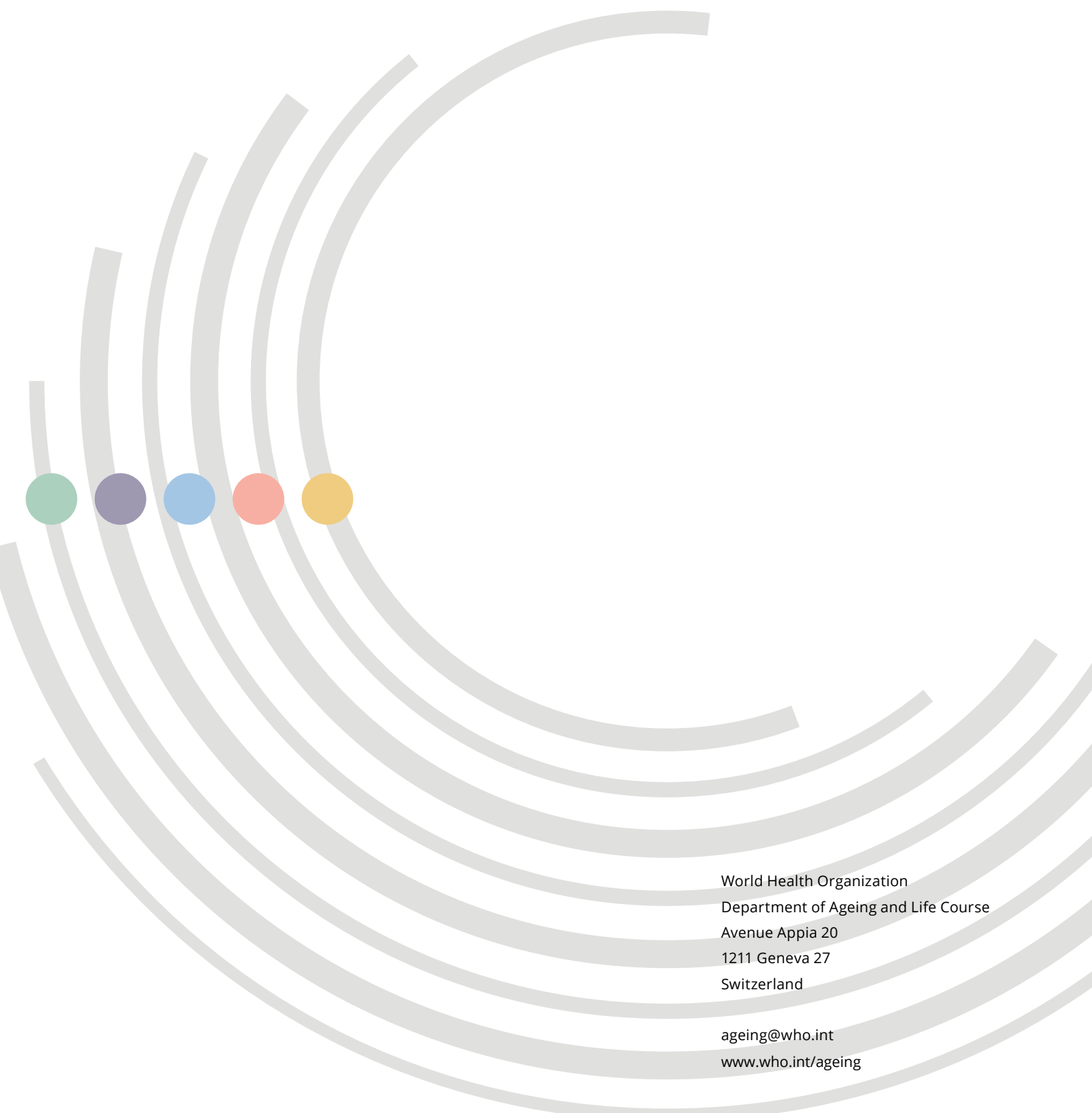
Universal health coverage

"All people and communities can use the promotive, preventive, curative, rehabilitative and palliative health services they need, of sufficient quality to be effective, while also ensuring that the use of these services does not expose the user to financial hardship."[26]

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