ICOPE

INTEGRATED CARE FOR OLDER PEOPLE

Personalized care plan

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Introduction to the Guide

This Facilitator Guide is part of the material developed to support training programmes on the WHO Integrated Care for Older People (ICOPE) approach. This guide serves as a roadmap for training and facilitators, helping them navigate through the session on developing personalized care plans for older people, while ensuring that key topics are covered and participants are actively engaged. It includes practical tips, potential challenges, and suggested ways to handle different situations that may arise during the session.

Session structure

This Facilitator Guide is organized around four core facilitation actions that you will use throughout the session. Icons represent these actions and indicate how you should guide participants through the content.

You will see these actions repeated across all slides and modules, providing a consistent structure for facilitation.

Show: The slides

This indicates the slide you should present from the slide deck. When you see the Show, display the corresponding slide to participants.

Say: What you explain

This provides a suggested narrative outline for you to explain the slide content. The text is intended as guidance rather than a fixed script. You may adapt the wording to suit your facilitation style, experience and the needs of your participants, while keeping the key messages intact.

Ask: Questions to prompt dialogue

This prompts you to ask questions and encourage dialogue with and among participants.

The discussion associated with these questions should generally take 2 to 5 minutes. However, you should use your best judgment to decide how much time to dedicate to such interactions, considering factors such as participant engagement, availability of time, and/or relevance of the topic.

Do: Actions to facilitate learning

This prompts you to conduct an action, such as guiding an activity, managing group interaction or providing instructions to participants.

Keep in mind that this Facilitator Guide is only a roadmap. You are expected to apply your voice and experience to make this tool work for you. As explained, the 'Say' sections are simply indications; you can use them as a script when you feel the need to, but you can and

should adapt them to suit your natural training style. Add your personal touch and personality to every training, while being careful to stick to the session objectives.

A key component of successful face-to-face training is establishing trust and rapport with your learners. Use your good judgement to assess the attitude and cultural sensitivities of the people in your workshop. Adapt your training techniques and approach accordingly.

You are going to be great at conducting this training.

Personalized care plan

Do:

- *Formal welcome*
- *Introduction of the facilitator*

Show: Slide 1

Say:

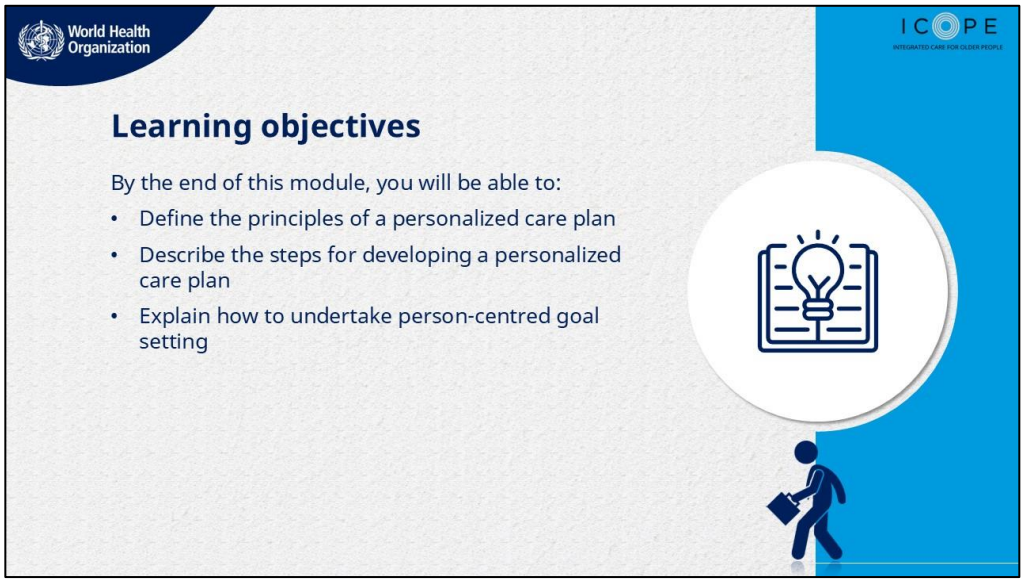
Welcome to the module on personalized care plans for older people. In this session, we will discuss the personalization of a care plan for an older person.

This session will take about 10 minutes.

Let us get started.

Learning objectives

Show: Slide 2



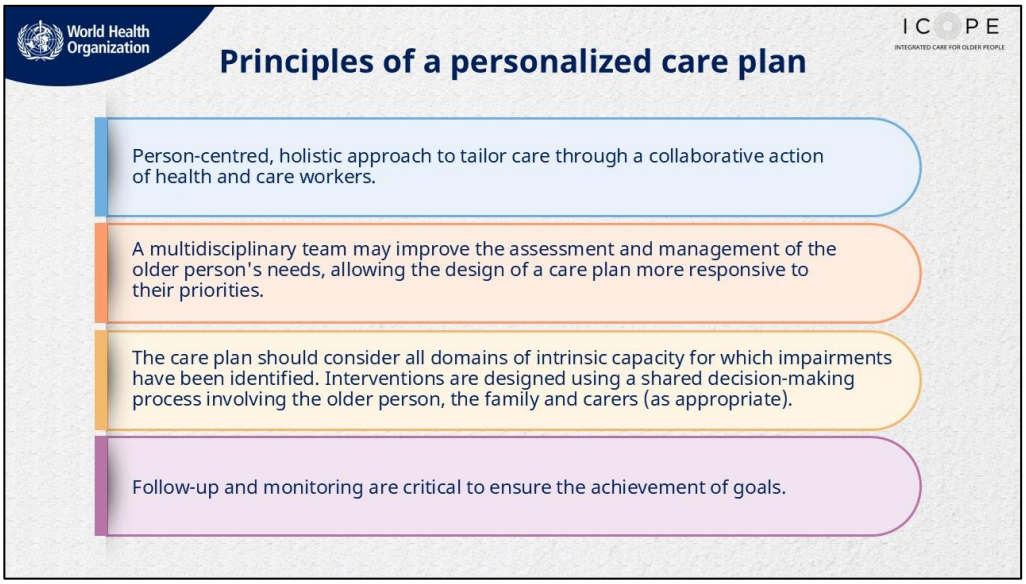
Say:

By the end of this module, you will have a solid grasp of essential components for effective and meaningful care of older people. We will cover:

1. **Principles of a personalized care plan:** You will understand how these plans are tailored to meet older people's needs, incorporating personal goals, preferences, and values.
2. **Steps to develop a personalized care plan:** It starts with a comprehensive assessment of the older person's needs and goals, setting realistic and achievable goals, identifying necessary resources and support, and regularly reviewing and adjusting the care plan.
3. **Undertake person-centred goal setting:** This empowers patients to actively participate in their care by setting goals.

Principles of a personalized care plan

Show: Slide 3



Say:

A personalized care plan is based on a few basic principles.

1. Person-centred, holistic approach

A person-centred, holistic approach tailors care through collaborative action among health and care workers, with active involvement from the older person, their family, and carers. This ensures that the care provided is truly aligned with the older person's needs and preferences.

2. Multidisciplinary teams

Multidisciplinary teams can enhance the assessment and management of an older person's needs, allowing for a care plan that is more responsive to their priorities. By combining the expertise of various professionals, we can create a comprehensive and effective care strategy.

3. Shared decision-making

The care plan should consider all domains of intrinsic capacity for which impairments have been identified. Interventions are designed using a shared decision-making process that involves the older person, their family and carers. This collaborative approach ensures that all perspectives are considered, making the care plan more personalized and sustainable, and increasing adherence to it.

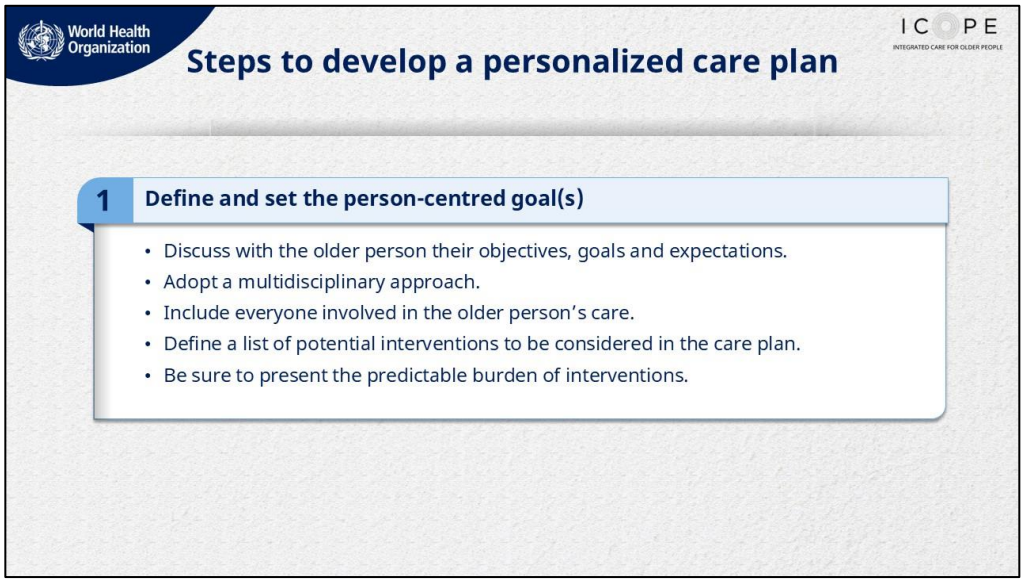
4. Follow-up and monitoring

Regular follow-up and monitoring are critical to ensure the achievement of goals. By continuously assessing progress and making necessary adjustments, we can maintain the relevance and effectiveness of the care plan over time. This also allows us to intervene in a

timely and preventive manner to modify the plan according to the evolution of the person's condition.

Steps to develop a personalized care plan - 1

Show: Slide 4



Say:

The starting point for developing a personalized care plan should be the older person's goals, identified through discussion with a health worker, ideally a doctor or nurse, led by a case manager or care coordinator. A doctor or nurse can fulfil the role of case manager/care coordinator. Health workers must involve the older person (and their carer(s), where appropriate) in decision-making about their own care, and respect their needs, values, preferences and priorities.

Generate a list of possible interventions to propose and potentially include in the care plan. These should be tailored to the older person's specific needs and preferences based on the initial assessment. At the same time, be sure to present the predictable burden of interventions to avoid a loss of adherence to the plan because of deviating from expectations.

How to set person-centred goals

Show: Slide 5

Say:

Let us discuss how to undertake person-centred goal setting when working with older people. This process involves three key parts: identifying goals, setting goals and prioritizing goals.

Identify Goals

Firstly, we must identify the goals in collaboration with the older person, their family members, and carers. This step is crucial as it ensures that the goals reflect the older person's values and aspirations. Here are some example questions you may want to consider, eventually to be adapted, to facilitate this discussion:

- *'Please explain the things that matter to you most in all parts of your life.'*
  - This question helps us understand what is truly important to the person in various aspects of their life.
- *'What are some specific goals that you have in your life?'*
  - Here, we encourage the person to articulate their broader life goals.
- *'What are some specific goals that you have for your health?'*
  - This question narrows the focus to health-related goals, which are often a priority for older people.
- *'Based on the list of both life and health goals we just discussed, can you pick three that you would like to focus on in the next three months? What about in the next six to 12 months?'*
  - We ask this to help prioritize immediate and longer-term goals.

Set Goals

Once we have identified the goals, the next step is to set them. It is important to adapt these goals to the older person's needs and their definition of problems. Here are some guiding questions, eventually to be adapted:

- *'What specifically about goal one, two, or three would you like to work on over the next three months? What about over the next six to 12 months?'*
  - This question helps to break down the goals into actionable steps over specific time frames.
- *'What are you currently doing about [goal area]?'*
  - This helps us understand the current efforts and any ongoing actions related to the goals.
- *'What would be an ideal yet possible target for you in achieving this goal?'*
  - Here, we set realistic and achievable targets to work towards.

Prioritize Goals

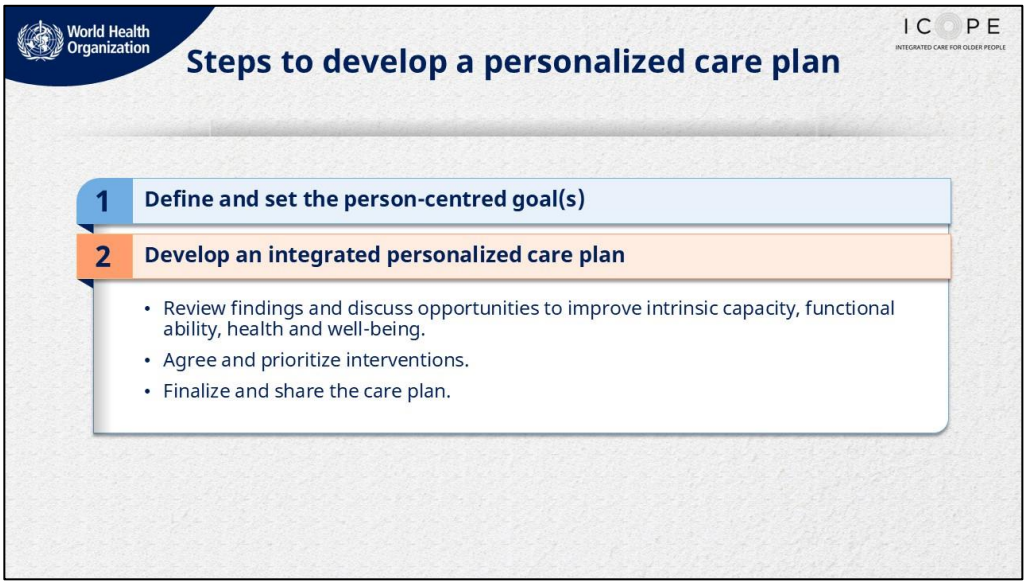
Finally, we need to prioritize the goals. Agreement on the prioritized care goals between older people and providers is essential for demonstrating improved outcomes. Some example questions to ask may be:

- *'Of these goals, which one are you most willing to work on over the next three months—either by yourself or with support from [Dr XX and their team]? What about over the next six to 12 months?'*
  - This helps in identifying the most immediate and actionable goals and ensures that the older person is engaged and motivated to work towards them.

By following these steps, we can ensure that the goals are person-centred, realistic, and prioritized according to the older person's values and needs. This collaborative approach helps to achieve better outcomes and enhances the overall well-being of the older person.

Steps to develop a personalized care plan - 2

Show: Slide 6



Say:

Three main steps should then be considered in the development of a personalized care plan:

1. Review findings and discuss opportunities: During goal-setting discussions, it is important to review the results of assessments and suggested interventions for various intrinsic capacity losses. Interventions should be prioritized based on clinical urgency, likelihood of success, broader impacts, predictable burdens, and the older person's preferences. Prioritization can be guided by the urgency of an issue from a clinical perspective; the likelihood of success; the broader impact of addressing a specific issue (including how resolving one loss may help address another); the predictable burden of interventions; and what the older person feels is most important.

2. Agree on interventions to prioritize: This agreement requires the older person's informed consent and alignment with their goals and preferences. It should include self-care components, accommodate their physical and social environments, and support carers where needed. Each intervention must be discussed individually with the older person. A partnership among the older person, their carers, and the multidisciplinary team is essential for sustaining their well-being.

3. Finalize and share the care plan: The case manager or care coordinator should document agreed interventions in the care plan and share it with the older person, their family and carers, and the multidisciplinary team, with the person's consent. If referrals are needed, the older person should receive guidance on making appointments and how health workers can assist.

Steps to develop a personalized care plan - 3

Show: Slide 7

Say:

Let us move on to our third step: implement and monitor the personalized care plan.

A collaborative work by the multidisciplinary team led by a care coordinator is crucial for implementing personalized care plans. This approach allows the early detection of complications, addresses challenges from acute events, and identifies critical changes in social roles or intrinsic capacity.

This recommendation implies the need to:

- Monitor progress and detect any new or worsening issues.
- Adapt the plan as needed to respond to changes in health or circumstances.
- Ensure implementation through coordinated action by the care team.
- Reassess and re-evaluate regularly to keep the plan relevant and effective.
- Update the plan based on documented changes and evolving priorities.

Summary

Show: Slide 8

Do:

Go through the slides and recap the points discussed during the session.

Say:

To summarize this session, we have focused on the development of personalized care plans for older people as a core component of person-centred and integrated care.

We discussed the importance of collaboration across a multidisciplinary team to ensure that care plans are comprehensive, coordinated, and responsive to individual needs.

We have seen that effective personalized care planning begins with defining clear, person-centred goals based on the older person's priorities. This is followed by reviewing assessment findings, discussing available options, and jointly agreeing on appropriate interventions. Finally, we emphasized that personalized care plans must be shared, implemented, and regularly monitored, with follow-up to ensure that interventions remain aligned with the person's goals and changing needs over time.