ICOPE

INTEGRATED CARE FOR OLDER PEOPLE

Case studies

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Contents

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 helps trainers and facilitators lead sessions on developing personalized care plans for older people, focusing on collaboration, person-centred care, and integrated services. It guides understanding of how to address intrinsic capacity decline, manage health conditions, and ensure social support and care. The guide highlights the roles of different sectors and health and care workers, the use of appropriate assessments and interventions, and steps to design, implement, and monitor a personalized care plan. It also includes tips, challenges, and approaches for effective discussion and learning.

Session structure

This Facilitator Guide is organized around four core facilitation actions that you will use throughout the session. These actions are represented by icons 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.

Case studies

Do:

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

Show: Slide 1

Say:

In this session, we will embark on working group session that focuses on creating personalized care plans for older adults. As healthcare professionals, carers, and community workers, our goal is to holistically address the intrinsic capacity impairments, underlying conditions, and social care needs of older individuals.

This session will take a total of 55 minutes. You will be divided in different groups. After a short introduction of the activity with the explanation of the instructions, each group will interactively work on a case study. We will then have final moment for plenary reporting back and discussion.

Let us get started.

Development of a personalized care plan

Show: Slide 2

Say:

Our objective for this session is to simulate the development of personalized care plan for an older person.

You will be divided in small groups. Each group will work on a different case study to design, in a multidisciplinary way, a detailed care plan tailored to the specific needs and priorities of the older person depicted in the case.

In particular, you will need to address the following key questions:

- What are the person's priorities, preferences and needs? Define realistic goals in a person-centred way.
- Which assessment and interventions can best support integrated and person-centred care? Assess what is needed to achieve the goals and identify possible solutions that can be offered to address the person's needs and priorities.
- What are the critical roles of the different sectors and health and care workers in developing and implementing the plan? Who should be involved, when, and how?

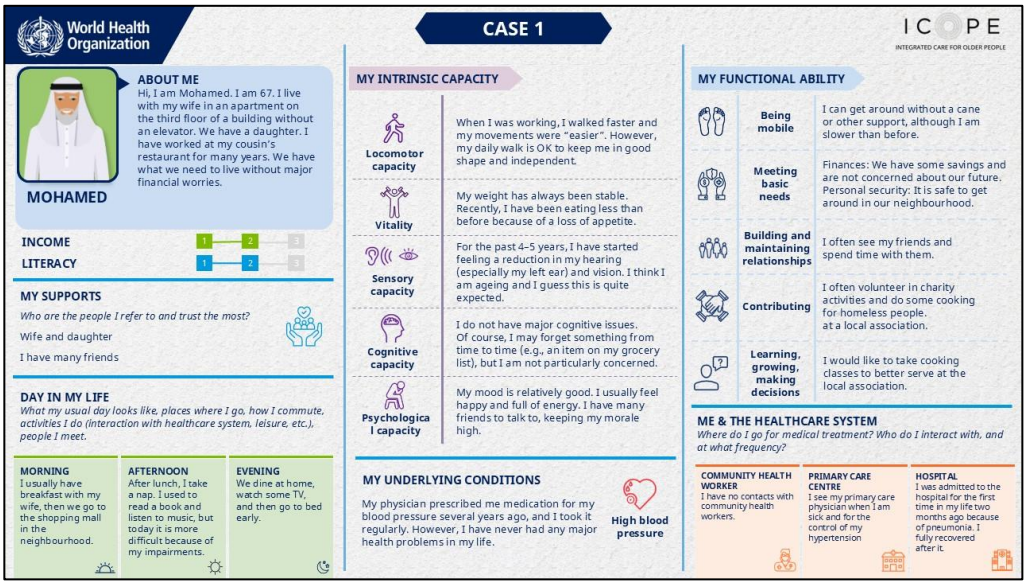
Do:

- Ask the participants to form small teams (maximum eight persons per team). It is recommended to create teams' characterized by heterogeneity in the professional background.
- Hand out one case study to each team.

- Each case study contains personal information, daily activities, intrinsic capacity, underlying conditions, functional ability, support, and interaction with the health care system of a fictional older person.

Example case study

Show: Slide 3



Say:

To show you how each group should work, here is an example of a case study, structured in a similar way to that your group has received.

In this case, Mohamed, a 67-year-old person, is described. It is reported that he lives with his wife on the third floor of a building without an elevator, and enjoys a relatively stable situation. You can see that they have a daughter. This information is important to know as it explains Mohamed's support network, an aspect that can eventually assist in his care.

In the form, you can also find information about Mohamed's daily life, which will help us understand his lifestyle and social interactions. These activities reflect his current level of engagement and any changes in his abilities or interests.

A specific section then covers Mohamed's intrinsic capacity, which includes physical and mental aspects. For example, we can see that he walks more slowly than before but remains independent. Could there be here an opportunity to improve mobility? He is also eating less due to a loss of appetite. Is this potentially suggesting a need for nutritional support?

Understanding Mohamed's underlying health conditions is also critical for creating a comprehensive care plan. In this case, Mohamed has high blood pressure and takes medication for it. We need to consider these aspects/needs when defining his care plan.

Another section assesses Mohamed's functional ability across different areas of his life. We can see that he may have limited mobility, although he remains substantially independent in meeting his basic needs. Is there anything we can do to improve his ability to function independently, for his family, and in the community?

Finally, one section outlines Mohamed's interactions with the healthcare system. He has no contact with community health workers. He sees his primary care physician when he is sick and for regular follow-up and control of his hypertension. Is this sufficient? Should we propose something different?

Now that we have gone through Mohamed's case study, we have all the information for designing a personalized care plan for him, considering his needs and priorities as well as the available care services and resources.

Now, here are the rules of the activity:

Each team will have a total of 30 minutes for the case study.

- First, identify in your group 1) a *rapporteur*, who will report back in the later session the results of the discussion, and 2) a notetaker, who will support them by recording the key points.
- Then, during the first 5 minutes, read and understand the case study of the older person assigned to your team.
- Subsequently, for 20 minutes, collaborate to 1) identify and define needs and priorities, and 2) develop a personalized care plan for the older person depicted in the handout.
- Finally, during the last 5 minutes, wrap up your discussions with the support of the notetaker and, with the *rapporteur*, prioritise the main messages to be presented.

In the following session, the *rapporteur*, together with or on behalf of the team, will present the results of the case study and share the hypothesized care plan with the other teams for discussion.

Be prepared to discuss your rationale and the thought process behind your solutions.

Let's start.

Do:

- During the work, remind trainees about the time, especially when it is needed for them to shift from one phase (e.g., reading of the case study) to the following one (e.g., collaborative work for definition of the care plan).
- Facilitate the presentation by each group.
- After each presentation, allow time for feedback and reflection.
- Encourage participants to share their key takeaways from working on the case study.

Say:

Thank you for your active participation. Through this activity, we have explored how the care needs of an older person are often diverse and extend beyond the health sector. To develop

a meaningful and effective personalized and integrated care plan, a multidisciplinary and comprehensive approach is recommended. Let us carry the insights and empathy gained today into our professional practice to enhance the quality of care for older people.

Please note:

Additional case examples are available at the end of the deck to facilitate contextualisation and for further reference and discussion.