

Integrated care for older people (ICOPE)
implementation pilot programme:

findings from the 'ready' phase



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Organization

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ISBN 978-92-4-004835-5 (electronic version)

ISBN 978-92-4-004836-2 (print version)

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Design and layout by Erica Lefstad

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ACKNOWLEDGEMENTS

This ready phase ICOPE pilot programme report was produced under the overall technical oversight of Yuka Sumi, Medical Officer, Ageing and Health Unit (AAH), with the direction of Anshu Banerjee, Director, Maternal, Newborn, Child and Adolescent Health and Ageing Department, within the Division of Universal Health Coverage, Life Course at the World Health Organization (WHO) headquarters in Geneva. The pilot programme ready phase was designed and developed by Yuka Sumi, Michael Valenzuela (consultant, AAH), Eric Ohuma (consultant, AAH). The principal report writers were Rachel Albone (consultant, AAH), Michael Valenzuela and Andrew Briggs (consultant, AAH) with the supervision of Yuka Sumi.

The steering group for the development of the ready phase of the ICOPE pilot programme report consisted of the following WHO regional advisers: Françoise Bigirimana, Innocent Bright Nuwagira, Saliyou Sanni, Fatim Tall (Regional Office for Africa); Patricia Morsch, Enrique Vega (Regional Office for the Americas); Samar Elfesky (Regional Office for the Eastern Mediterranean); Manfred Huber, Stefania Ilinca, Satish Mishra (Regional Office for Europe); Neena Raina (Regional Office for South-East Asia); Hiromasa Okayasu (Regional Office for the Western Pacific); and colleagues from WHO technical departments at the headquarters (Shelly Chadha, Alarcos Cieza, Tarun Dua, Silvio Paolo Mariotti, Maria Nieves Garcia-casal).

The principal investigators contributing country case studies were Eva Heras Muxella (Servei Andorrà d'Atenció Sanitària, Andorra); Amy Song, Ninie Wang (Pinetree Care Group, China); Philippe de Souto Barreto, Neda Tavassoli, Bruno Vellas (WHO Collaborating Centre for Frailty, Clinical Research and Geriatric Training, Toulouse University Hospital, France); Arvind Mathur (Asian Centre for Medical Education, Research and Innovation, India).

For support on facilitating surveys, we thank Edith Pereira (WHO Cabo Verde office, Cabo Verde); Mario Cruz Penate (WHO Chile office, Chile); Tuohong Zhang (WHO China Office, China); Eliane Vanhecke (Ministry of Health, France); Itsnaeni Abbas, Tara Mona Kessaram (WHO Indonesian office, Indonesia); Marco Canevelli, Nicola Vanacore (National Institute of Health, Italy); Muthoni Gichu (Ministry of Health, Kenya); Sandra Pais (University of Algarve, Portugal); Chang Won

(Kyung-Hee University, Republic of Korea); Olga Manukhina (WHO Russia office, Russian Federation); Sergi Blancafort Alias (Health and Ageing Foundation, Autonomous University of Barcelona, Spain); Leon Geffen (Samson Institute for Ageing Research, South Africa); Adrian Hayter (NHS England and NHS Improvement, United Kingdom of Great Britain and Northern Ireland); Ian Philp (Age Care Technologies, United Kingdom); Thi Kim Phuong Nguyen, Linh Diew Pham (WHO Viet Nam office, Viet Nam).

For their careful review of the report, WHO would like to thank Luis Bautzer (Olyst Integrated Care Management, France), AB Dey (Venu Charitable Society Sheikh Sarai, India), Pauline Kleinitz (WHO headquarters), Angela Leung (Hong Kong Polytechnic University, China), Kafi Lubis (WHO Indonesia office, Indonesia), Leocadio Rodríguez Mañas (Hospital Universitario de Getafe, Spain), Finbarr Martin (King's College London, United Kingdom), Chris Mikton (WHO headquarters), Jean Yves Reginster (WHO Collaborating Center for Public Health Aspects of Musculoskeletal Health and Aging, University of Liege, Belgium), Saniya Sabzwari (Aga Khan University, Pakistan) and Jean Woo (Chinese University of Hong Kong, China).

Appreciation for their insightful comments goes to AAH team members: Hyobum Jang, Jothees Amuthavalli Thiyagarajan, Matteo Cesari (consultant, AAH) and Ritu Sadana with support to analyse the survey data from Ming Ong (consultant, AAH).

We also benefitted from the inputs of participants at the annual meetings of the WHO Clinical Consortium on Healthy Ageing, 2020 and 2021.

None of the experts involved in the development of this document declared any conflict of interest.

The WHO AAH unit acknowledges the financial support of the Government of Germany, the Kanagawa prefectural government in Japan and the [Universal Health Coverage Partnership](#) (Belgium, Canada, European Union, Germany, Luxembourg, Ireland, France, Japan, United Kingdom and WHO).

EXECUTIVE SUMMARY

Integrated care for older people (ICOPE) reflects a continuum of care that helps to reorient health and social services towards a more person-centred and coordinated model of care that helps optimise older people's intrinsic capacity (physical and mental capacities) and functional ability. Successful implementation of WHO's ICOPE approach requires coordination between multiple parts of the health and social care systems, through a multidisciplinary team that includes older people and their families, health and care workers, communities and civil society organizations.

In order to support Member States to implement ICOPE, WHO is conducting a three-phase research project, the 'ICOPE implementation pilot programme', comprising ready, set and go phases. The objective of the ready phase is to evaluate readiness and feasibility to implement ICOPE at the service and systems levels. Three sub-studies have been undertaken, two addressing the clinical (micro) and service (meso) levels, and a third focused on service and system (macro) levels. At the clinical and service levels, the studies focused primarily on the views and experiences of health and care workers through an online micro survey, and four country case studies (Canillo in Andorra, Chaoyang in Beijing, China, Occitanie in France and Rajasthan in India). At the service and system levels, the study utilised the ICOPE implementation framework through an online implementation scorecard survey to assess capacity to deliver integrated care.

This report summarizes the findings of the ready phase from the implementation experiences across nominated Member States, including enablers, barriers and strengths for the implementation of the ICOPE approach, and learning on the preparation and adaptation needed to implement ICOPE. The findings will inform the further scale up of the approach.

The majority of respondents of the micro survey expressed positive attitudes towards the ICOPE approach, agreeing that integrated care is important to promoting the maintenance of, and preventing declines in, intrinsic capacity and functional ability. Most also stated the need to change current practice to the provision of person-centred integrated care. Health and care workers consistently identified the proactive engagement of older people as a key enabler across all steps of the ICOPE care pathway.

Respondents identified that integrated care was more time-consuming, complex and challenging than the current practice and highlighted human resource capacity as a barrier. The need to increase local workforces and for training was identified, particularly for screening and assessment of declines in intrinsic capacity. In lower-middle-income

The studies suggested a good level of buy-in and enthusiasm for ICOPE, with positive feedback received from older participants.

countries, additional training was also highlighted as important for the assessment and management of the environment as well as the development of personalized care plans. A lack of infrastructure and of systems integration were found to be potential barriers to the development of personalized care plans. Respondents from lower-middle-income countries also identified a lack of digital integration of health information as a barrier and welcomed the mobile ICOPE handbook app and data dashboard as enabling tools.

The four country case studies focused primarily on piloting ICOPE within existing clinical and community (micro) settings and services (meso). They have shown the usability and feasibility of ICOPE and highlighted the preparation and adaptation necessary to implement the approach in different contexts

Although the scale of studies varied, all older participants were assessed through an ICOPE screening. Identifying potential declines in intrinsic capacity through screening enables opportunities to provide the interventions to prevent and slow decline and prevent care dependency. The studies suggested a good level of buy-in and enthusiasm for ICOPE, with positive feedback received from older participants. The four research teams also stressed the importance of older people's participation as a crucial enabler for ICOPE implementation and its role in promoting empowerment and increasing knowledge on health and well-being.

Aligned with the micro level survey, human resource constraints were a common barrier highlighted by all four studies, both in terms of the number of health and care workers, and the time they were able to give to implement the ICOPE approach. Financial barriers to implementation, including health insurance coverage and staff time, were also highlighted.

The studies demonstrated the role ICOPE can play in encouraging coordination and collaboration among health and care workers and among different stakeholders in the health and social care systems, including local and national government.

The studies demonstrated the role ICOPE can play in encouraging coordination and collaboration among health and care workers



KEY OPPORTUNITIES FOR ICOPE IMPLEMENTATION:

- 1** Positive attitudes from health and care workers towards the principles of integrated care and high levels of commitment to adopt and implement ICOPE. With appropriate workforce capacity-building and creating enabling service delivery environments, care and service delivery can change;
- 2** Proactive engagement of older people and their communities is crucial across all steps of the ICOPE care pathway. This was highlighted in feedback from both older participants, and health and care workers;
- 3** ICOPE is feasible to implement in different contexts, as shown by case studies from different countries, which also demonstrated the value of local co-design and adaptation to suit local context.

The service- and system-level (implementation scorecard) survey showed a large range of scores across countries, suggesting that implementation readiness is context-specific. Irrespective of economic development, implementation readiness was higher on average for services than for systems. The greatest implementation readiness was associated with the service action to “actively engage older people, their families and caregivers and civil society”, while the least was with “deliver care that is acceptable to older people, effective and targets functional ability”. At the systems level, readiness was most commonly associated with the action to “develop capacity in the current and emerging workforce to deliver integrated care”, while “digital technologies to support older people’s self-management” were rarely in place.

The United Nations Decade of Healthy Ageing (2021–2030) is an important opportunity for stakeholders to come together to deliver its vision for “a world in which all people can live longer and healthier lives”. The implementation of ICOPE will play an important role in this effort. By focusing on the promotion of intrinsic capacity and the prevention of declines through the provision of integrated, person-centred care, ICOPE will facilitate ‘Healthy Ageing’.

The findings in this report can support governments to recognize the value of responding to the additional resource needs of implementing ICOPE as part of efforts towards universal health coverage. With the successful implementation of ICOPE, supported by high levels of grassroots support and stakeholder engagement, we can expect a brighter future for older people around the world.

The findings in this report can support governments to recognize the value of responding to the additional resource needs of implementing ICOPE as part of efforts towards universal health coverage





Public health students provide health and lifestyle advice following ICOPE screening. Pilot site in Jodhpur District, Rajasthan, India.

Photocredit: School of Public Health, All India Institute of Medical Sciences, India.

The United Nations Decade of Healthy Ageing is focused on four action areas: changing how we think, feel and act towards age and ageing; ensuring that communities foster the abilities of older people; delivering person-centred, integrated care and primary health services responsive to older people; and providing access to long-term care for older people who need it.



BACKGROUND

Over the last 50 years, countries around the world have experienced a rapid decline in fertility rates alongside significant increases in life expectancy, leading to the global demographic trend of population ageing. While increasing life expectancy is an important goal, improving healthy life expectancy is crucial to ensuring that, as populations age, individuals are not living their later lives in poorer health and with significant loss of intrinsic capacity and functional ability.

intrinsic capacity: *the composite of all the physical and mental capacities of the individual*

Although there is no single common experience of ageing, physiological changes do occur with increasing age. As we age, we are at risk of experiencing a decline in our intrinsic capacity and, without support, also deteriorations in our functional ability. Older people often face increased risks for chronic diseases and care dependency (1).

functional ability: *the combination of the intrinsic capacity of the individual, the environment a person lives in, and how people interact with their environment*

To address these challenges, efforts are needed to support healthy ageing.

healthy ageing: *the process of developing and maintaining the functional ability that enables well-being in older age (2)*

In response to rapid population ageing, the World Health Organization (WHO) developed the *World report on ageing and health* in 2015 (2), followed by the *Global strategy and action plan on ageing and health* in 2016 (3). A proposal for a Decade of Healthy Ageing was endorsed by the World Health Assembly in 2020 and adopted by the United Nations General Assembly in December 2020 (4), leading to the proclamation of a United Nations Decade of Healthy Ageing (2021–2030). The Decade is focused on four action areas (5): changing how we think, feel and act towards age and ageing; ensuring that communities foster the abilities of older people; delivering person-centred, integrated care and primary health services responsive to older people; and providing access to long-term care for older people who need it.



FIGURE 1.

The six conditions associated with declines in intrinsic capacity



THE ICOPE APPROACH AND ITS IMPLEMENTATION

WHO developed the integrated care for older people (ICOPE) approach in recognition of the need for a transformation of health and social care systems to deliver integrated and person-centred care for older people (6). Through a process of consultation with leading experts in the WHO Clinical Consortium on Healthy Ageing (CCHA), WHO published the evidence-based *ICOPE guidelines to manage declines in intrinsic capacity in the community* in 2017 (7) and a package of supporting tools, including the *ICOPE implementation framework for policy-makers and programme managers* (8), *ICOPE handbook for health and care workers* (9) and an ICOPE handbook mobile app.



The app is available from [Apple](#) or [Google](#)

Many older people lack knowledge about their health and may consider declines to be a 'natural part of ageing'. Health-seeking behaviour often declines when older people do not believe interventions or support are available. Furthermore, early markers of decline in intrinsic capacity, such as decreased gait speed or reduced muscle strength, are often not identified by health and care workers due to a lack of training in older people's health. This can result in missed opportunities to reverse or delay declines through appropriate monitoring and care.

The ICOPE approach therefore aims to support health and care workers to detect declines in older people's intrinsic capacity in community and primary care settings by conducting person-centred assessments and developing personalized care plans with older people. The approach also provides an opportunity to empower and engage older people in their health and care. The six priority conditions associated with declines in intrinsic capacity are given in **FIGURE 1**. Assessment and management of each of these conditions as well as social care needs are included in the ICOPE approach (**FIGURE 2**).



The ICOPE approach provides an opportunity to empower and engage older people in their health and care



Implementing the ICOPE approach in clinical settings involves a five-step pathway (FIGURE 2) to address the health and social care needs of older people. This includes screening, assessment, the development of personalized care plans based on individuals' goals and preferences, the management of declines in intrinsic capacity and underlying conditions, and taking into account the environments to support functional ability. The pathway involves tracking progress through management, referral and monitoring, and having linkages to community and carer support.

Successful implementation of ICOPE involves all steps of the pathway being provided for older people, so that people at potential risk of declining intrinsic capacity – as demonstrated by the initial screening and a person-centred assessment – receive the care and support they need through the development of a care plan and follow up. The approach requires coordination between multiple parts of the health and social care systems, through a multidisciplinary team that includes health and care workers, family, support groups and civil society organizations.

The implementation and scale-up of the ICOPE approach requires support from multiple levels of health and social care systems and, in some cases, transformational change. Three levels of realignment are relevant:

- changes in clinical practices and attitudes of health and care workers, including to older people's participation in their care (at the micro level);
- changes in how health and social care services operate and integrate (at the meso level);
- strengthening of health and social care systems with a focus on governance, financing and strategic direction (macro level).

The implementation and scale-up of the ICOPE approach requires support from multiple levels of health and social care systems and, in some cases, transformational change

Most reform efforts in the context of ICOPE have centred on the micro level, with comparatively less attention given to the meso and macro levels (10). WHO responded to this gap by empirically deriving a framework of actions to support Member States in the implementation of the ICOPE approach (11).

The ICOPE implementation framework (FIGURE 3) proposes 19 actions across five domains: three that comprise nine actions targeting the service (meso) level and two domains comprising 10 actions targeting the system (macro) level. Along with the listing of these actions for health and social care services and systems, the framework (11) also provides an implementation scorecard, which has been used in this pilot programme. This prompts policy-makers, system and programme managers to consider and assess the implementation readiness, nationally and sub-nationally, to deliver ICOPE across health and social care systems and services.

FIGURE 2.
The ICOPE approach: a five-step person-centred assessment and care pathway

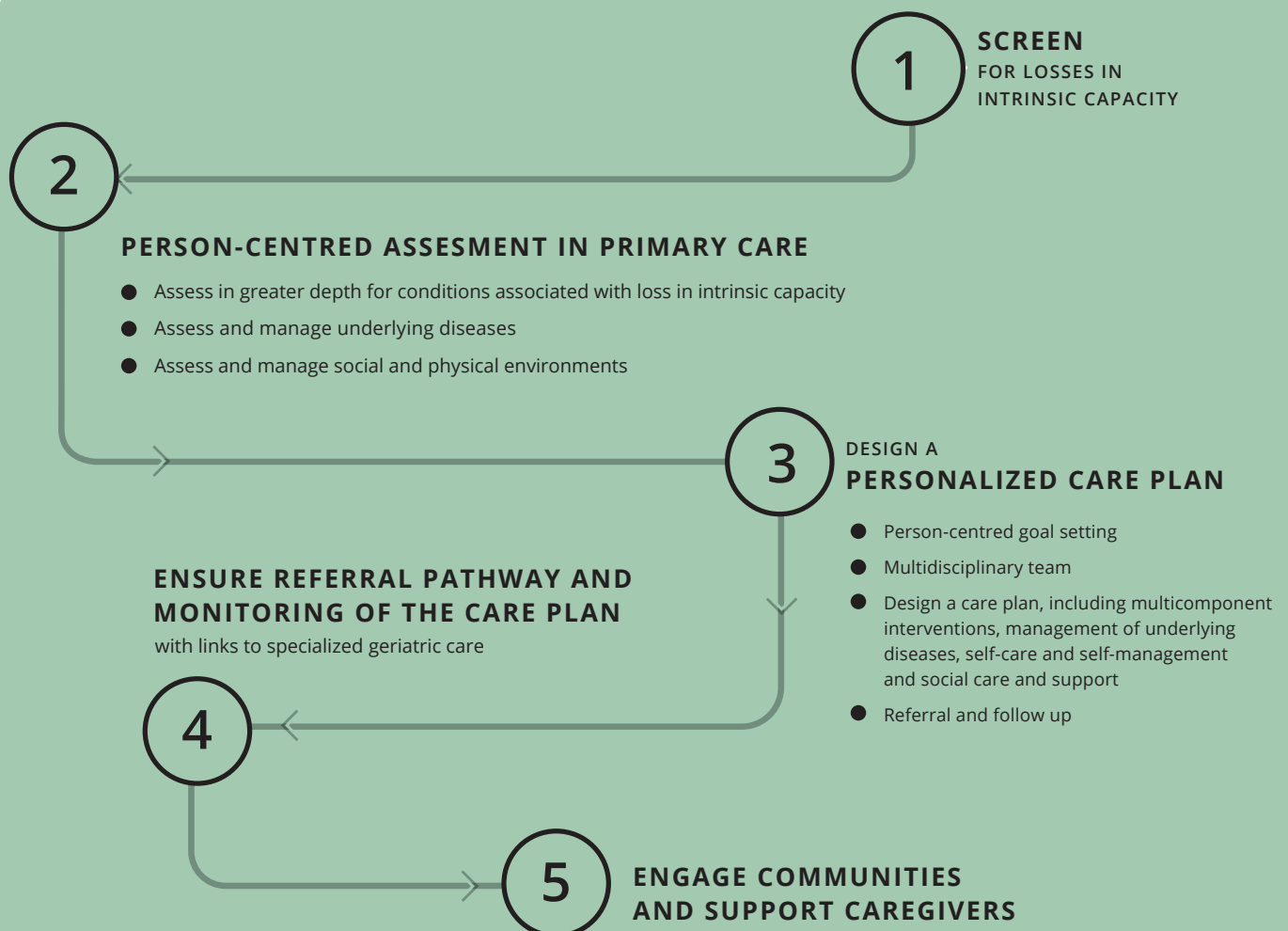
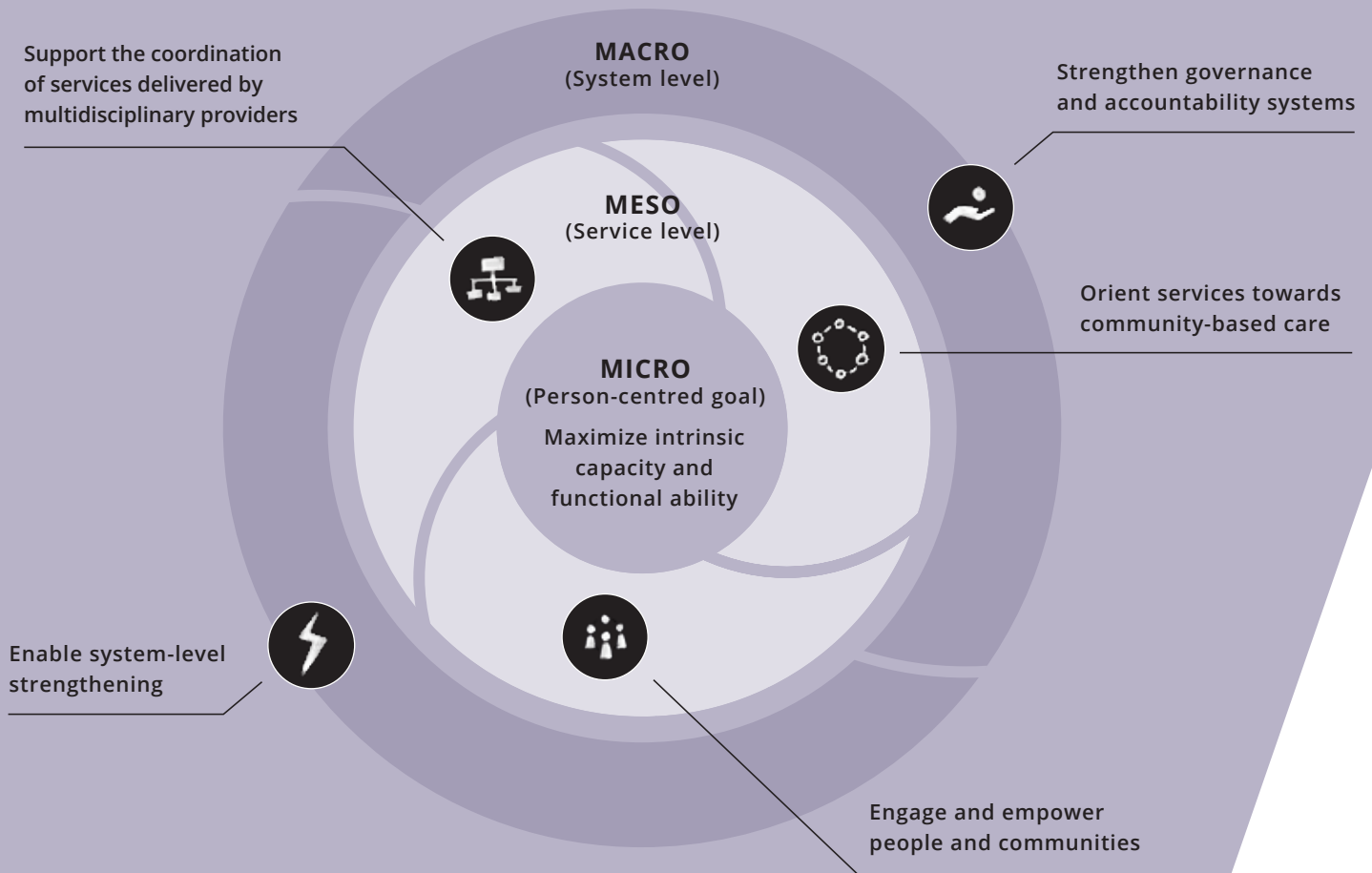


FIGURE 3.
The ICOPE implementation framework



The objective of this ready phase pilot is to evaluate the readiness and feasibility to implement ICOPE, focusing on all three levels of implementation readiness

DESIGN OF THE THREE-STEP ICOPE IMPLEMENTATION PILOT PROGRAMME

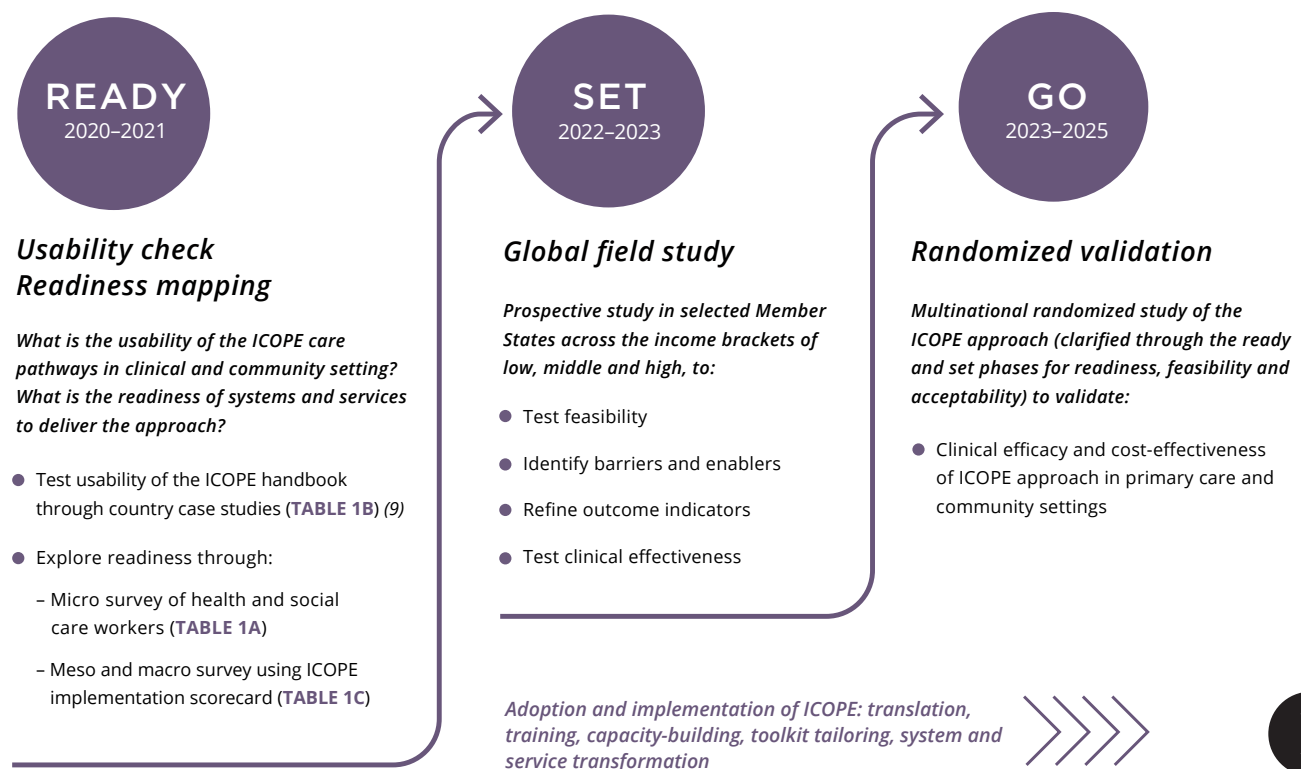
Following the development of the ICOPE approach, WHO launched an implementation pilot programme in collaboration with experts from the CCHA (12), consisting of three phases – ready, set and go. The objective of this ready phase pilot is to evaluate the readiness and feasibility to implement ICOPE, focusing on the following three levels:

- **Clinical (micro) level:** determining the acceptability and feasibility of the approach, by learning how integrated care is provided in clinical and community setting;
- **Service (meso) level:** assessing the capacity of available services to respond to care needs, identifying challenges and enablers;
- **System (macro) level:** measuring the capacity of systems to support ICOPE.

Focusing on these three levels of implementation readiness for ICOPE, this report is targeted to policy-makers at the system level (nationally, regionally and locally), programme managers at the service level, and health and care workers at the clinical level. Its main objective is to highlight the results and learning from the ready phase. These have been informed by focused interviews on the usability of the ICOPE care pathway in clinical and community settings and by surveys examining readiness in nominated Member States.

As summarized in **FIGURE 4**, a further two phases will complete the sequence of interlinked projects in this three-step programme to comprehensively pilot the ICOPE approach.

FIGURE 4.
Phases of the ICOPE piloting programme



READY-PHASE METHODS TO ASSESS ICOPE IMPLEMENTATION READINESS

Three sub-studies, two addressing the clinical (micro) and service (meso) level, and a third focused on services and systems (macro), were undertaken across Member States. At the clinical and service levels, the studies focused primarily on the views and experiences of health and care workers to determine the nature of the support needed for the implementation of ICOPE, including through surveys and individual country case studies. The methods for each study are summarized in **TABLES 1A to 1C**.

Methodological limitations

The findings in this report are intended to provide a snapshot of implementation experiences for the WHO ICOPE approach across nominated Member States. Due to the convenience sample used across the sub-studies and the recognized potential for responder bias, and for other biases inherent in the study designs, the results should not be interpreted as representative of a particular region or Member State (including, for example, because no low-income countries have been studied in the the service delivery and clinical care survey). Rather, they should be considered part of a formative evaluation of the implementation of the ICOPE approach, derived from pilot studies that will need further validation in larger studies with representative sampling. The scope of the studies was largely restricted to implementation readiness and attitudes of the formal health and care workforce, without the systematic engagement of informal workers, who play an important role in the provision of person-centred, integrated care for older people.



TABLE 1A.

Survey of readiness at the level of service delivery and clinical care (micro survey)

➤ Aim	To provide an evaluation of health and care workers' expectations about the feasibility of implementing integrated care for older people (ICOPE) in their service delivery and clinical care.
➤ Objectives	<ol style="list-style-type: none"> 1. Sample a multidisciplinary group of health and care workers to evaluate the feasibility of implementing the ICOPE approach. 2. Identify unique contextual considerations in implementing ICOPE according to economic development.
➤ Design	<ul style="list-style-type: none"> • Cross-sectional electronic survey of health and care workers across a selection of Member States. • Those Member States with a strong interest in implementing the ICOPE approach were identified and nominated by WHO regional colleagues from all six regions and/or by members of the WHO Clinical Consortium on Healthy Ageing (CCHA).
➤ Sampling and recruitment	<ul style="list-style-type: none"> • Convenience sample of multidisciplinary health and care workers with at least two years' experience providing care to older people in any care setting. • Recruitment was enabled through networks across WHO offices (including headquarters, regional offices and country offices) and the CCHA.
➤ Data collection	<p>A custom survey tool was developed with input from the CCHA. (See ANNEX 1 for the English version; eight translations were made, to Chinese, French, Indonesian, Italian, Portuguese, Russian, Spanish and Vietnamese). The electronic survey, run between February and June 2021, had two parts.</p> <p>PART 1</p> <p>The first part presented a clinical case study that progressed respondents through all five steps of ICOPE pathway (FIGURE 2 on page 7), to introduce it to respondents unfamiliar with ICOPE, before asking them to make evaluations. At each of the following critical steps of the pathway, standard items were presented, directed at the setting, resources, enablers and barriers:</p> <ul style="list-style-type: none"> • ICOPE screening (step 1) • assessment of declines in intrinsic capacity (step 2.1) • assessment and management of diseases and associated conditions (step 2.2) • assessment and management of social and physical environments, social care and support (step 2.3) • develop a personalized care plan (step 3) • referral pathway and monitoring of care plan (step 4) • engage communities and support caregivers (step 5). <p>PART 2</p> <p>The second part had 15 items intended to assess respondents' readiness to change clinical practice towards ICOPE implementation. The items were structured along the COM-B model of behavioural change (13), with four items targeting capability/capacity, six targeting opportunity and five targeting motivation. Each item was answered along a five-point Likert scale ranging from strongly disagree to strongly agree.</p>
➤ Data analysis	<p>Data were disaggregated by country income groupings and WHO regions (ANNEX 2). Data provided by WHO staff or respondents from non-nominated Member States were excluded, as were those where no identification of the country was given.</p>



TABLE 1B.

Country case studies of readiness at the level of service delivery and clinical care

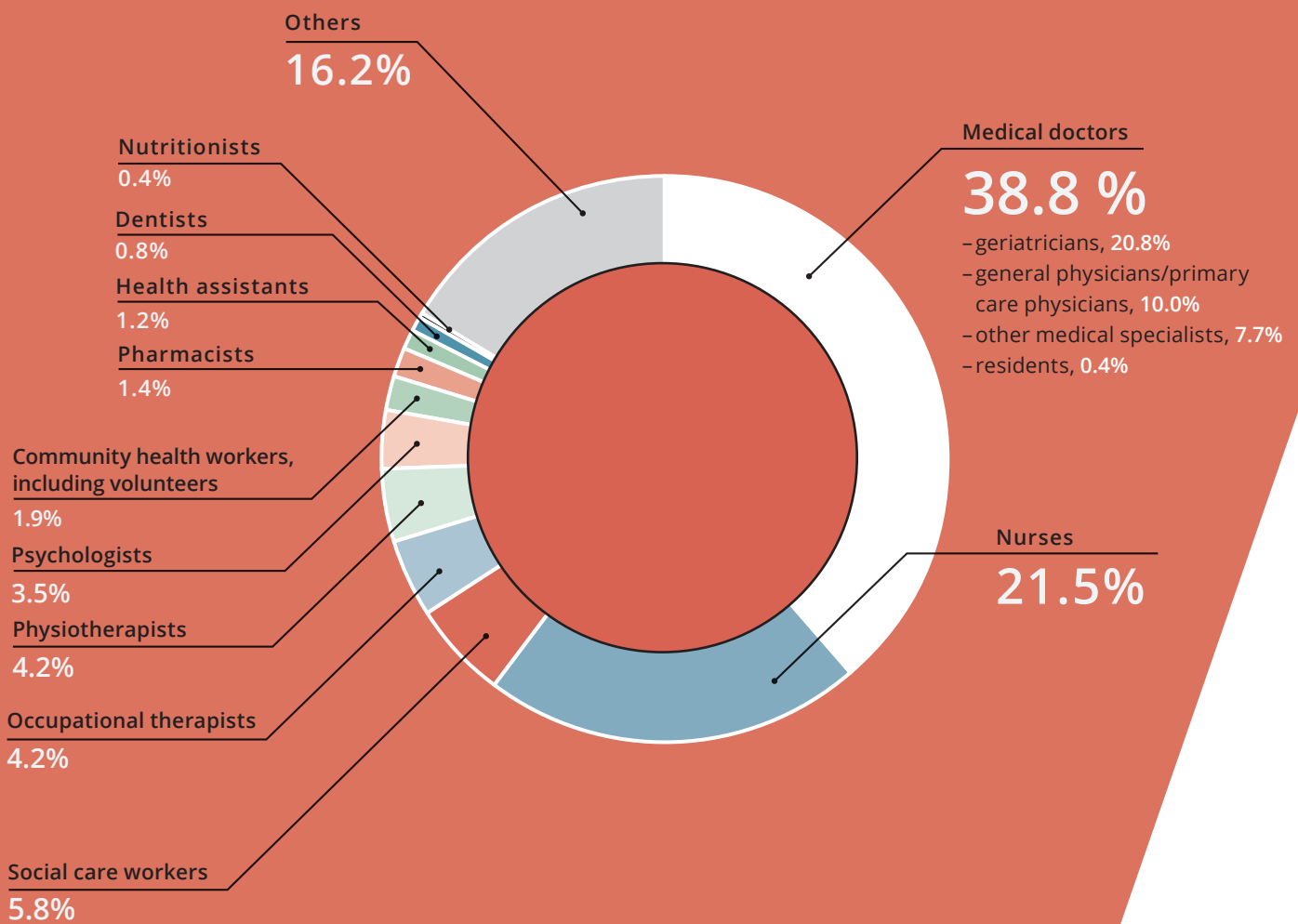
➤ Aim	To assess the usability of the ICOPE handbook by reviewing data and experience from sites implementing the ICOPE approach in different health-care delivery settings.
➤ Objectives	<ol style="list-style-type: none"> 1. Assess implementation readiness at the services and clinical levels in different contexts. 2. Understand barriers and enablers to implementation, and the need for change at these levels to support implementation. 3. Gain some understanding of potential declines in intrinsic capacity among older people, using ICOPE tools.
➤ Design	<ul style="list-style-type: none"> • Focused interviews with research teams in four pilot sites (Andorra, China, France and India) to gather and document experiences and learning from the implementation of the ICOPE approach.
➤ Sampling and recruitment	<p>A convenience sample of research teams with experience in piloting the ICOPE approach was gathered using these sampling criteria:</p> <ul style="list-style-type: none"> • teams that had proactively implemented the ICOPE approach in diverse clinical and community settings • teams willing to share learning from their implementation experience • studies with local ethics committee approval. <p>Recruitment was enabled through the CCHA, with which all team members engaged.</p>
➤ Data collection	<ul style="list-style-type: none"> • Data and information were collected through interviews and in correspondence with the primary investigators and their teams to capture their experience and learning. • Qualitative information included the preparation for studies, the implementation process, findings and learning. • Quantitative process and outcomes data were included for the ICOPE screening and assessment steps while data on the later steps of the ICOPE pathway varied depending on the unique nature and extent of each implementation pilot.
➤ Data analysis	<ul style="list-style-type: none"> • Data were thematically analysed and summarized using a structure developed for this report - preparation, implementation, findings and learning - focusing primarily on barriers, enablers, strengths and areas for improvement.

TABLE 1C.

Survey of readiness at the services and systems level (Implementation scorecard survey)

➤ Aim	To evaluate the readiness of national health and social care services and systems to implement the ICOPE approach.
➤ Objectives	<ol style="list-style-type: none"> 1. Sample service- and system-level stakeholders to derive a snapshot of the capacity of health and social care services and systems to implement the ICOPE approach. 2. Determine trends in implementation readiness of the ICOPE approach based on levels of country income.
➤ Design	A cross-sectional electronic survey of service-level and system-level stakeholders using the ICOPE implementation scorecard (8).
➤ Sampling and recruitment	<p>A convenience sample was gathered of stakeholders, across nominated Member States, whose scope of work was relevant to ICOPE at the service and/or system level. Relevant stakeholders included personnel from:</p> <ul style="list-style-type: none"> • national-level ministries with a portfolio relevant to health or social care for older people; • national or subnational health or social care policy-makers, service managers or system managers; • national or subnational civil society organizations relevant to older people; • international, national or subnational academic associations with an interest in supporting the implementation of ICOPE; • WHO country offices. <p>Recruitment was enabled through networks across WHO offices (including headquarters, regional offices and country offices) and the CCHA.</p>
➤ Data collection	<ul style="list-style-type: none"> • The electronic survey, running from February to June 2021, was in English, Chinese, French, Indonesian, Portuguese, Russian, Spanish and Vietnamese. • The scorecard required respondents to rate the stage of implementation readiness in their setting for nine actions at the service (meso) level and 10 at the system (macro) level, on a three-point Likert scale from none to minimal implementation, through initiating implementation, to sustaining it.
➤ Data analysis	<ul style="list-style-type: none"> • The scorecard data were analysed to derive subscale scores for implementation at the two levels and a total score. Arbitrary thresholds have guided interpretation. Data were disaggregated by country income levels and WHO regions (ANNEXES 6 AND 7).

FIGURE 5.
Health and care worker disciplines represented
by respondents to micro survey (n=260)



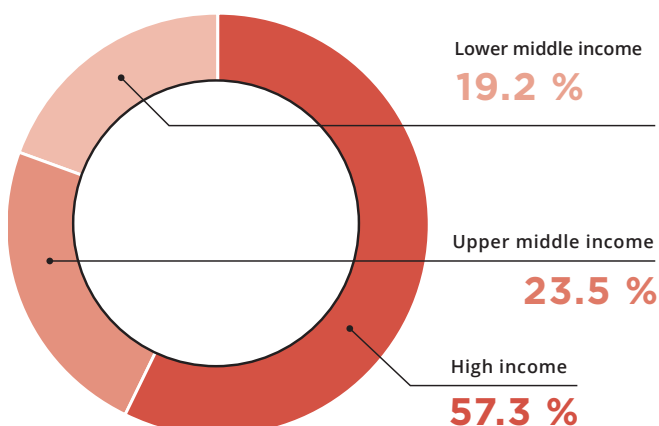
FINDINGS FROM THE READY PHASE

SURVEY RESULTS:

Readiness at level of service delivery and clinical care

The micro survey had 260 complete valid responses by health and care workers from 29 nominated Member States (10 lower-middle-income, eight upper-middle-income, and 11 high-income countries; see **ANNEX 2, TABLE A2.1**, which also shows a good spread across the WHO regions). The proportions representing the country income levels across the total number of individual respondents are shown in **FIGURE 6**; there were higher numbers of responses from high-income countries, representing over 57% of the total. The respondents worked across a range of disciplines, most frequently from the medical and nursing professions (**FIGURE 5**). They also practised across a range of settings, with a balanced distribution in primary, community and hospital care, long-term care facilities, and home care settings (see **ANNEX 2, FIGURE A2.1**).

FIGURE 6.
Distribution by country income level of respondents to micro survey



Local capacity, enablers and barriers to adopting ICOPE in clinical settings

The capacity of local health services to adopt the five steps of the ICOPE pathway, and the enablers and barriers to adoption, are summarized in **TABLES 2** and **3**. (Disaggregated data by income band and region are provided in **ANNEX 4**.)

Respondents consistently identified the proactive engagement of older people as a key enabler across all steps of the pathway, highlighting the importance of prioritizing co-design in services and shared decision-making as key principles of the ICOPE approach. Another consistent theme was related to human resource capacity. First, across the steps of the pathway, respondents identified the need for increasing local workforce capacity to be able to deliver person-centred, integrated care. Second, training was highlighted as particularly crucial for screening and assessment of declines in intrinsic capacity and, for lower-middle-income countries, for the assessment and management of environment as well as the development of personalized care plans. Third, around half of respondents did not have access to administrative support for referral and follow-up. A range of human resource constraints, including financial capacity and the lack of a mechanism to incorporate integrated care within health and care systems and services, enabling appropriate remuneration of the workforce, was more common than any single notable issue for respondents in lower-middle-income countries. A range of changes and adaptations will be needed at both the systems (macro) and services (meso) levels to address these barriers.



A number of themes emerged from responses in relation to tools and infrastructure – both as barriers and enablers. A lack of infrastructure and of systems integration were highlighted as potential barriers to the development of personalized care plans, and respondents from lower-middle-income countries also highlighted a lack of digital integration of health information as a barrier. Respondents

from upper-middle-income countries pointed to the availability of the ICOPE screening and assessment tools in local languages as an important enabler to screening, while respondents from lower-middle-income countries identified the mobile ICOPE handbook app and data dashboard as important enablers to steps 1 to 3 of the ICOPE pathway.

TABLE 2.
Local needs and enablers for steps in the ICOPE care pathway in clinical and community settings

Data shown for 260 complete and valid responses, pooled across regions and income bands

	STEPS	①	②.1	②.2	②.3	③	④	⑤
Local needs to implement ICOPE								
Need staff		34%	65%	70%	75%	72%	61%	78%
Need training		75%	70%	70%	70%	75%	64%	NA
Need space		30%	40%	37%	47%	39%	NA	NA
Need administrative support		NA	NA	NA	NA	NA	44%	NA
Enablers								
Support from local government		41%	35%	30%	45%	42%	30%	65%
Support from civil society organizations		31%	25%	23%	35%	35%	26%	56%
Support from academic associations such as medical associations		32%	29%	32%	37%	33%	32%	38%
Local mechanism/system is in place for timely referral		32%	28%	34%	35%	34%	40%	39%
Local network among multidisciplinary stakeholders		49%	56%	33%	50%	54%	50%	57%
Training provided by local, national authorities		43%	63%	36%	40%	40%	33%	NA
Availability of ICOPE screening/assessment tool in local language		48%	43%	NA	NA	NA	NA	NA
Proactive engagement of older people and their caregivers		70%	61%	57%	62%	65%	53%	65%
Local and/or global platform to share the experience		30%	27%	28%	32%	30%	26%	33%
Mobile ICOPE handbook app and data dashboard		43%	46%	44%	34%	38%	30%	NA
Financial incentives or reimbursement for this activity		40%	31%	28%	32%	29%	25%	28%
Access to telehealth for this activity		33%	26%	32%	23%	28%	29%	20%
Access to essential medicines		NA	19%	29%	23%	23%	22%	NA
Access to assistive technology		NA	29%	30%	22%	30%	23%	NA





Key for proportion of respondents Under 25% 25%–49% 50%–74% 75% or more
 NA = not applicable

TABLE 3.

Barriers to steps in the ICOPE care pathway in clinical and community settings

Data shown for 260 complete and valid responses, pooled across regions and income bands

	STEPS ①	②.1	②.2	②.3	③	④	⑤
Additional time required	65 %	67 %	65 %	63 %	67 %	59 %	66 %
Limited space for conducting the evaluation along with routine activities	34 %	40 %	35 %	NA	NA	NA	NA
Lack of available staff	58 %	57 %	57 %	56 %	59 %	50 %	59 %
Reimbursement for additional time and staff	37 %	35 %	35 %	41 %	39 %	34 %	40 %
Lack of knowledge and training to conduct this activity	47 %	39 %	39 %	40 %	37 %	NA	NA
Lack of integration in digital information platform (medical record, health record, social care needs)	33 %	33 %	34 %	33 %	36 %	44 %	NA
Competition, redundancy or conflict with other health services	14 %	14 %	14 %	13 %	17 %	17 %	13 %
Reaching older people is difficult	17 %	NA	NA	NA	NA	NA	NA
Screening/assessment tool needs to be adapted to local context	33 %	27 %	NA	30 %	NA	NA	NA
Lack of infrastructure and system to provide integrated health and social care	NA	NA	NA	33 %	52 %	NA	NA
No information on community activities	NA	NA	NA	NA	NA	NA	37 %
No, I do not see any barriers	6 %	8 %	11 %	8 %	9 %	17 %	10 %

Key for proportion of respondents Under 25 %  25%–49 %  50%–74 %  75 % or more 

NA = not applicable



Respondents consistently identified the proactive engagement of older people as a key enabler across all steps of the pathway

- STEP ①** ICOPE screening
- STEP ②.1** In-depth intrinsic capacity assessment
- STEP ②.2** Assessment and management of diseases
- STEP ②.3** Assessment and management of social and physical environment
- STEP ③** Develop a care plan
- STEP ④** Follow-up and referral
- STEP ⑤** Community engagement



Attitudes towards implementing ICOPE

Respondents' attitudes towards ICOPE and its implementation are summarized in **TABLE 4** across five domains. (Disaggregated data by income band and region are provided in **ANNEX 5**.)

Respondents overwhelmingly expressed positive attitudes towards the ICOPE approach, with 98% agreeing or strongly agreeing that integrated care is important to promoting the maintenance of, and preventing declines in, the intrinsic capacity and functional ability of older people. Some 95% also stated the need to change current practice to the provision of person-centred integrated care. However, almost 60% of respondents identified that integrated care was more time-consuming, complex and challenging than the care currently provided.

These observations highlight the positive attitudes and beliefs of the respondents and the importance of creating enabling environments to deliver person-centred integrated care, but also the barriers currently faced, pointing to a need for change at the systems and services levels. Enabling environments resonate with respondents, strongly supporting the:

- need for systems and services support to implement the ICOPE approach;
- need for training to build workforce capacity;
- added value of digital tools such as the ICOPE handbook app and data dashboard to support service delivery;
- importance of community engagement and support for ICOPE implementation, which can take a number of forms, including the use of community spaces and events to deliver ICOPE screenings and awareness raising of the importance of maintaining intrinsic capacity and functional ability by community leaders, groups and volunteers.

These trends were observed irrespective of country income levels and regions.

LEARNING

The results from the surveys with health and care workers highlighted:

- strong engagement with, and support for, the ICOPE approach
- need for clinical- and service-level support for implementation, modifications to care workflow (e.g. staff time, staff reimbursement) and investment in workforce capacity-building
- importance of community engagement to support all steps of the ICOPE pathway
- critical role of co-design in service delivery and shared decision-making for person-centred care
- potential of digital tools to support integrated care
- establishment of local networks of multi-disciplinary stakeholders as an important enabler

The importance of community engagement to support all steps of the ICOPE pathway was identified, reinforcing the critical role of co-design in service delivery and shared decision-making for person-centred care

TABLE 4.

Attitudes towards implementation of ICOPE and changes required to clinical practice

	STRONGLY DISAGREE	DISAGREE	NEUTRAL	AGREE	STRONGLY AGREE
Attitudes towards ICOPE					
Care that is integrated and person-centred is important to promoting the maintenance of, and preventing declines in, the intrinsic capacity and functional ability of older people	< 1%	0	< 1%	20%	78%
I believe it is necessary to change current practice to the person-centred integrated care model	< 1%	1%	3%	23%	72%
The assessment of social and environmental needs for older people is not my practice's responsibility	31%	38%	15%	10%	6%
The assessment and management of underlying diseases and disorders is my standard practice	4%	9%	17%	35%	35%
Care that is integrated and person-centred is more time-consuming, complex and challenging than my current day-to-day practice	7%	14%	19%	37%	22%
ICOPE will help older people and their caregivers to engage proactively in their health care	0	1%	6%	40%	53%
Systems and services support to implement ICOPE					
Extra reimbursement to my practice for following ICOPE would make it more feasible to implement	2%	4%	18%	35%	42%
A directive from the local health system or national authority (e.g. ministry of health) to implement ICOPE would help to change practice	0	1%	8%	39%	52%
Streamlined systems for the referral of older people will be important for ICOPE implementation	< 1%	0	4%	36%	60%
Workforce capacity-building					
I would feel more confident implementing ICOPE if I and my staff had access to online training tools in our local language	< 1%	1%	8%	41%	49%
Digital infrastructure support					
Digital tools like the ICOPE handbook app will need to communicate and integrate with existing medical records (electronic or traditional)	0	< 1%	9%	38%	53%
Digital tools like the ICOPE handbook app will be key to help with implementing ICOPE in my practice	< 1%	3%	15%	45%	37%
Community engagement and support					
Support from health experts and professional bodies (e.g. medical colleges) will be needed to implement ICOPE in my setting	2%	7%	15%	44%	33%
Support from civil society and local community organizations will be needed to implement ICOPE in my setting	< 1%	3%	12%	46%	38%
A media campaign in my local area about the positive impact of ICOPE on older people's health and well-being will help with engaging older people and encouraging my staff	< 1%	< 1%	8%	40%	50%

Key for proportion of respondents Under 10% 10%–24% 25%–49% 50%–74% 75% or more

COUNTRY CASE STUDIES: Readiness at level of service delivery and clinical care

The country case studies focused primarily on the pilot study of ICOPE at the clinical (micro) level and assessed the usability of the ICOPE approach within existing clinical settings and services (meso). Case studies provide real-world insights into the implementation of the ICOPE approach, including engagement with health and care workers and older people.

This section describes the experiences in four settings during preparation and implementation, and shares the findings and learning based on ICOPE pilots conducted in Canillo in Andorra, Chaoyang in Beijing, China, Occitanie in France and Jodhpur District, Rajasthan in India (14). The map on page 22 summarizes the study site characteristics and the participants involved in these four case studies.

Case studies provide real-world insights into the implementation of the ICOPE approach, including engagement with health and care workers and older people

Preparation and adaptation of ICOPE

At all the study sites, the preparation phase focused on:

- adapting or developing the ICOPE tools to be used during implementation;
- recruiting health and care workers and older people to participate in the studies;
- training health and care workers and building partnerships across sectors.

The WHO ICOPE tools for health and care workers, available in nine languages, include the ICOPE handbook on person-centred assessment and care pathways (9) and the ICOPE handbook mobile app. One of the first steps for each of the study sites was to review these tools to determine whether any adaptations were needed to suit their context, or to enable the collection of information needed to meet the study objectives. **BOX 1** summarizes the adaptations made, including by developing supplementary digital tools.

BOX 1:**Adaptation and augmentation of ICOPE tools**

Each of the four sites made some adaptations to the tools for integrated care for older people (ICOPE) for their contexts. In Canillo, Andorra, for example, the WHO ICOPE handbook app and dashboard, in Spanish, were used with additional functional health assessments such as a sleep scale. The paper-based handbook was used in Rajasthan, India, with added assessment for items, including self-reported health status, underlying conditions, social support, caregivers and risk of elder abuse.

DIGITAL TOOLS

The studies in Chaoyang and Occitanie included the following augmentations developed for the ICOPE digital tools.

CHAOYANG:

- Local mobile app for the screening step, for use both by health and care workers and, for self-screening, by older participants
 - Video explainers on completing screening
 - Audio clips for hearing impairment screening
- Local ICOPE data dashboard to collect and analyse data gained from screening and assessment
- Artificial intelligence system to support the design and delivery of personalized care plans

OCCITANIE:

- “ICOPE Monitor” mobile app for screening (19)
 - To collect longitudinal data from screening every six months
- “ICOPE Bot” online tool for screening (20)
 - Mobile phone, tablet or laptop use
 - Conversational robot to guide through the screening process
- FRAILITY-ICOPE database
 - For storing, reviewing and analysing data
 - Access to data on participants’ status, risks and follow up
 - Generates alerts for health workers



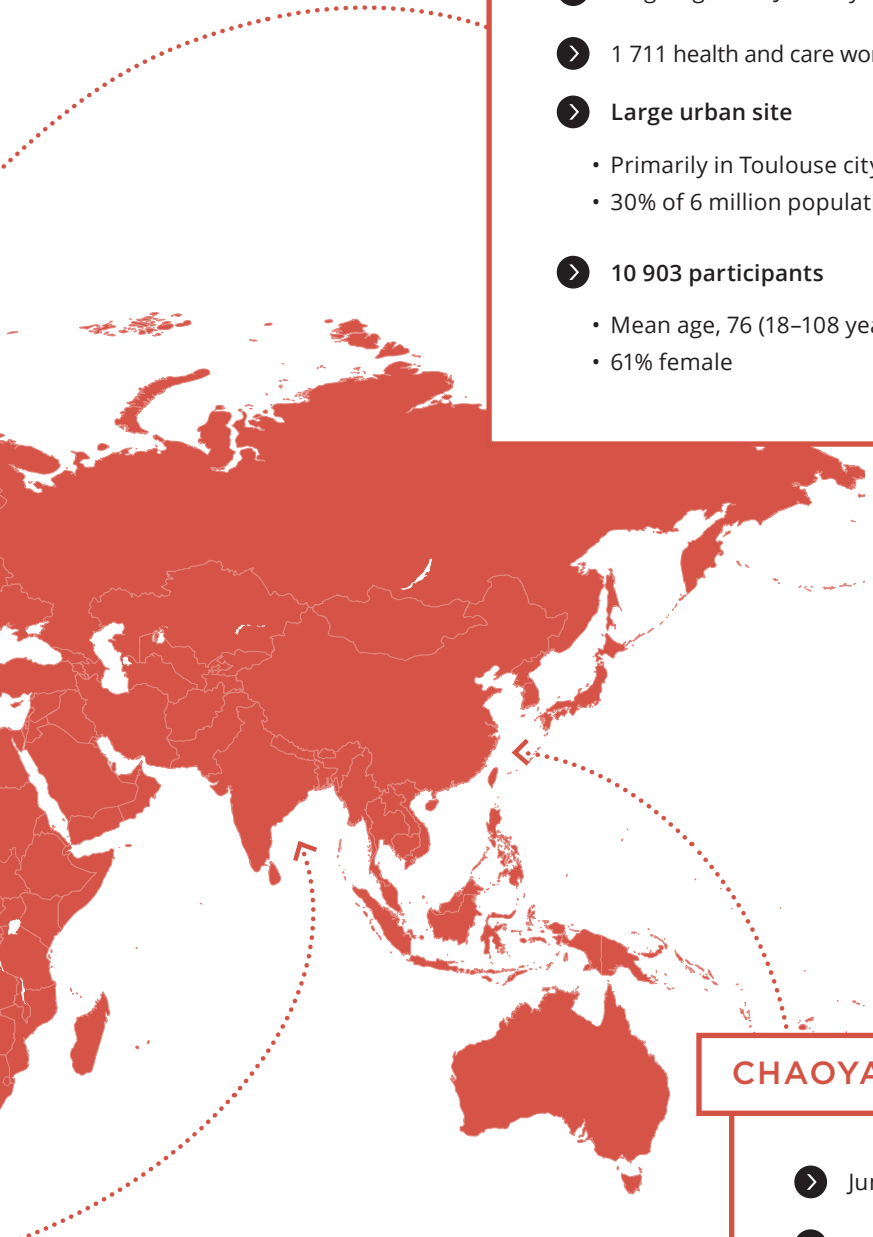
THE 4 STUDY SITES

CANILLO (ANDORRA)

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

RAJASTHAN (INDIA)

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



OCCITANIE (FRANCE)

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

CHAOYANG (CHINA)

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

RECRUITMENT OF OLDER PEOPLE

Each of the four sites took a tailored approach to efforts to engage and encourage older people to participate in the implementation pilot.

- The study in **Canillo** used a rolling recruitment process that followed a public health media campaign. The participants were screened and assessed as they were identified.
- A multimedia campaign through both traditional and social media was used at the **Chaoyang** site to recruit older participants.
- Older people having the opportunity to be centrally involved in their own care was a key message of the campaign in **Occitanie** to encourage participants to self-screen. This engagement and recruitment was achieved through a multimedia campaign using flyers, posters, a film promoting the ICOPE Monitor mobile app, webinars, conferences and interviews.
- The collaborating rural health centre in **Rajasthan** identified participants with the help of a word-of-mouth approach driven by members of the older community taking part in the recruitment strategy. ICOPE was viewed as a way for older people to access care tailored to their specific needs, something they had not seen before.

RECRUITMENT OF HEALTH AND CARE WORKERS AND COLLABORATING PARTNERS

The following points summarize how efforts were made in the case studies to recruit the health and care workers who would implement the ICOPE care pathway steps and help to pilot the approach.

- The study team in **Canillo** comprised two geriatricians and a geriatric nurse. It also engaged primary care doctors to ensure follow-up care.
- The multimedia campaign used to recruit participants in **Chaoyang** also targeted health and care workers (it reached some half a million people in total). This case study also proactively engaged health centres and professional associations. Over 22 000 health workers, including primary care physicians, nurses, rehabilitation therapists and social workers, showed interest in the study, and the team engaged over 200 partner organizations and facilities.
- A campaign promoting the ICOPE digital tools to health workers in **Occitanie** led to nearly 2 500 downloading content, including 906 nurses, 566 doctors, 230 pharmacists and 156 physiotherapists.
- The team in **Rajasthan** worked with students at the school of public health with existing responsibilities in community health. The school was a collaborating partner in the pilot.

Over 22 000 health workers, including primary care physicians, nurses, rehabilitation therapists and social workers, showed interest in the study in Chaoyang

TRAINING OF HEALTH AND CARE WORKERS

The following summarizes the broad approaches taken to ICOPE training at each case study site, and the numbers and types of trainees involved, determined by the scale of the pilot.

CANILLO

In this case, the team was small and already had awareness of ICOPE, so it needed minimal training.

CHAOYANG

- Basic familiarization: 22 705 health and care workers were sent:
 - articles explaining ICOPE and the implementation pilot
 - links to ICOPE tools and the *World report on ageing and health* (in Chinese) (2)
- ICOPE seminars for 5 300 community health workers:
 - ICOPE and study background, aim, key concepts and approaches
 - using the digital screening and assessment tools, care pathways, and reporting
 - protecting information and privacy
- Integrated care manager training for 431 health and care workers:
 - 217 nurses, 186 community doctors, 28 rehabilitation therapists, three geriatricians
 - all steps of the care pathway
 - how to be the link between providers, services and systems

OCCITANIE

- ICOPE concept and step 1 of the pathway for 1 711 health and care workers:
 - 1 053 nurses, 245 pharmacists, 104 doctors, 20 post office workers
 - 40 minutes online, offered two to three times a month
- ICOPE steps 2, 3 and 4:
 - twice yearly for 410 nurses

RAJASTHAN

- Fifteen public health students were trained to implement the screening step of ICOPE.



An integrated care manager/nurse assessing mobility as part of the person-centred assessment in the ICOPE approach. Pilot site in Chaoyang District, Beijing, China.

Photo credit: Pinetree Care Group, China

Implementation

While all four research teams aimed to implement all the steps of the ICOPE care pathway directly, this was not always feasible. Some built partnerships outside of those directly engaged in the study, to ensure referrals could be made to other providers who were able to be involved in the later steps of the pathway. **BOX 2** illustrates the extent to which the sites engaged in numerous partnerships to help with various elements of ICOPE implementation.

STEP ① SCREENING FOR DECLINES IN INTRINSIC CAPACITY

ICOPE screening, to detect potential declines in intrinsic capacity, was the priority for all four studies. The study teams reported that the screening sessions took between five and 20 minutes per person. The setting for this screening was:

- a social club for older people run by the city council in **Canillo** (two geriatricians and one geriatrics nurse);
- the homes of older people, and health centres in **Chaoyang** and **Occitanie** (431 integrated care managers and 724 health workers respectively, and some self-screening for follow up, periodic screening after an initial screening conducted by a health or care worker);
- the homes and the community in **Rajasthan** (15 public health students).

STEP ② ASSESSMENT OF DECLINES IN INTRINSIC CAPACITY, UNDERLYING DISEASES, AND NEEDS FOR SOCIAL CARE AND SUPPORT

- The studies in **Canillo**, **Chaoyang** and **Occitanie** included in-depth assessments after the ICOPE screening. In **Rajasthan**, assessments were planned but, due to COVID-19, no further activity was possible following the screening step.

Canillo: The team undertook an assessment of declines in intrinsic capacity with all participants, irrespective of their screening results. This was conducted at the community health facility.

Chaoyang: Assessments were carried out by integrated care managers with all participants, irrespective of their screening result

Occitanie: The assessments were organized and conducted by the primary care workers (physicians, nurses, physiotherapist) with participants who had a positive screening result in intrinsic capacity, at a health facility, or the participant's home, and using digital tools.

STEPS ③ ④ ⑤ CARE PLANS, REFERRAL, MONITORING AND COMMUNITY ENGAGEMENT

Canillo: The team met with all participants to discuss the results of their screening and assessment. Any person with a decline in mobility or cognition received an appointment with the lead geriatrician, to develop a personalized care plan then shared with the participant's primary care doctor.

Chaoyang: After developing personalized care plans with older people, integrated care managers (trained health and care workers) provided follow up sessions mainly through video calls. These aimed to support rehabilitative exercises, medication adherence and assistive care, and to check for any new or additional needs for social and health services.

Occitanie: development of care plans and any necessary follow up were referred to the primary care workers. The study at the Occitanie in France has reported the numbers of participants receiving referrals to care among those 958 older people for whom data were uploaded in the FRAILTY-ICOPE database from the step 2 assessment. The team provided recommendations and interventions to 374 participants (39%) for vision, including referring them to comprehensive eye care; 623 people (65%) on cognition, such as by referring them to a memory clinic or for cognitive stimulation; 396 (41.3%) for hearing care, including providing hearing aids; 838 older people (86.4%) on mobility, such as referring them to physiotherapy; 740 (77.2%) on nutrition, with dietary advice for example; and to 429 participants (44.8%) on mood, including to give them advice on their social environment.

BOX 2:**Building partnerships in local networks**

Having multisectoral involvement and using multidisciplinary teams are critical factors for the ICOPE approach. The case study teams built partnerships across the health and care sectors to support implementation. The roles of partners included providing funding for the research and implementation of ICOPE through insurance payments, supporting with recruitment of workers and participants, supporting training for health and care workers, and providing referral and follow up care. The four studies involved the following array of partner organizations for multisectoral, multidisciplinary implementation.

CANILLO (ANDORRA)

Ministry of Health; City Council of Canillo; national health-care system; older people's social clubs

CHAOYANG (CHINA):

Ministry of Civil Affairs; National Health Commission; National Healthcare Security Administration; National Committee on Ageing; National Research Centre on Ageing; Beijing Bureau of Civil Affairs; Beijing Health Commission; Beijing Healthcare Security Administration; Chaoyang Elderly Care Service Centre

Nineteen hospitals in Beijing; 109 health centres; 12 older people's care stations run by the government and 25 run by civil society organizations; WHO China office

OCCITANIE (FRANCE)

Regional Union of Health Professionals; University Department of General Medicine; Occitanie Roussillon Federation of Healthcare Homes; multi-professional health homes; Information and Prevention Centre; Health Insurance Examination Centre; Postal Service; Haute-Garonne Departmental Council; Pension and Occupational Health Insurance Fund; National Old Age Insurance Fund; several territorial professional health communities; town halls; seniors' residences

RAJASTHAN (INDIA)

All India Institute of Medical Science; Asian Centre for Medical Education, Research and Innovation; Rural Health Centre of State Medical and Health Services; Community leaders



“Thanks to ICOPE, I feel empowered to continue this way in order to preserve my health in the future.”

Austruy Micheline, ICOPE participant, France

Findings

STEP 1 SCREENING

Across the four study sites, all older participants were provided with at least one ICOPE screening, and in **Chaoyang** and **Occitanie**, follow-up screening was also conducted. The results of the first screening, shown in **TABLE 5** on page 29, suggest the greatest risk of a decline in capacity is in the vision domain. Caution is needed in the interpretation of this result, though, as a discrepancy was identified in whether the screening related to corrected or non-corrected vision. In both **Canillo** and **Occitanie**, screening identified potential declines in cognition, with both identifying possible cases among more than 50% of the people in their cohorts. In both the mobility and mood domains, there were declines detected in over a quarter of the older participants in three out of four sites. In **Rajasthan**, the screening suggested the most significant declines were in hearing and mobility, both scoring over 50%. Sex disaggregated data from the study in **Rajasthan** show higher levels of decline in the mobility domain among female (55%) than male (42%) participants.

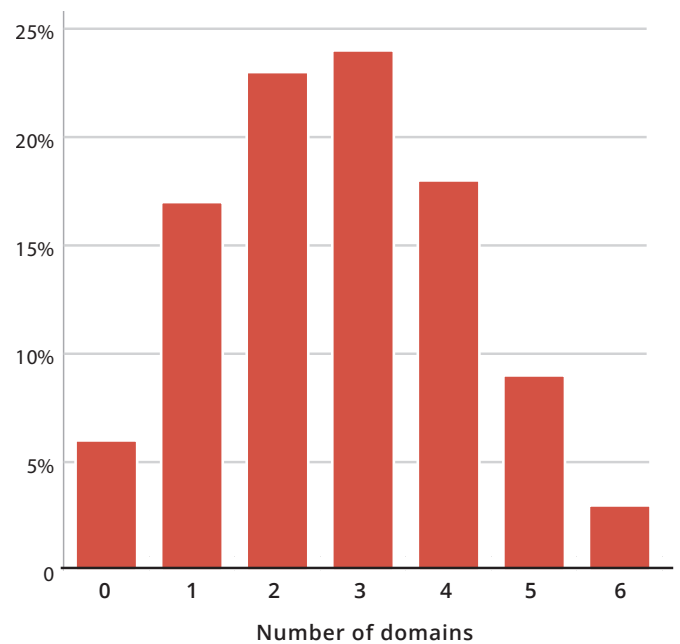


“The ICOPE programme helped us to see a lot of things at one go, instead of having to visit the various experts.”

Coraline Fetherstonhaugh, ICOPE participant, Andorra

The screening results from **Occitanie** suggest potentially high levels of decline across numerous conditions associated with declines in intrinsic capacity. Ninety-four percent of participants had potential declines in at least one condition and there were also high numbers of participants experiencing declines in multiple conditions simultaneously (**FIGURE 7**).

FIGURE 7. Number of conditions associated with declines in intrinsic capacity, identified by ICOPE screening (in Occitanie)



94% of participants in Occitanie had potential declines in at least one condition

STEP ② IN-DEPTH ASSESSMENT OF DECLINES IN INTRINSIC CAPACITY

For the three sites undertaking in-depth assessments of intrinsic capacity, the findings against domains are shown in **TABLE 6**. In **Canillo** and **Chaoyang**, assessments were conducted with all participants, irrespective of screening result. There were differences between the screening and assessment results in these contexts; for example, 14% of respondents in **Chaoyang** showed potential cognitive decline at screening compared with 37% at assessment, highlighting a need for revision of the ICOPE screening tool. The validation of the ICOPE screening tool in different populations is one of the objectives of latter phases of the pilot programme.

In **Occitanie**, assessments were recommended for those with a positive screening result. The data included from **Occitanie** are for a subset of participants whose results were uploaded by their primary care doctor into the FRAILTY-ICOPE database.

Across all three sites, a third of older participants were found to have cognitive decline. Nearly two thirds in **Occitanie** had a loss of mobility and over 40% had issues with malnutrition. Differences were seen between the sites in terms of depressive mood, with more than one in three experiencing this in **Canillo** and **Occitanie**, compared with only 5.5% in **Chaoyang**.

TABLE 5.
STEP ① : cases of potential decline in intrinsic capacity

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

TABLE 6.
STEP ② : cases of decline in intrinsic capacity
from the three sites that did step 2 of the care pathway

Condition associated with decline in capacity	Rate of positive cases (%)		
	CANILLO (N=72)	CHAOYANG (N=874)	OCCITANIE (N=958*)
Cognitive decline	39	37	44
Loss of mobility	29	18	66
Visual impairment	17	5	29
Hearing loss	Not included	21	30
Malnutrition	17	33	41
Depressive mood	36	6	39

Primary care doctors were responsible for these assessments but were not required to enter the results into the FRAILTY-ICOPE database, so the number of participants who went on to have a full assessment is not known for Occitanie. Results data were entered for 9.3% of those identified at the screening step





An integrated care manager/rehabilitation therapist coaching an ICOPE pilot participant to complete daily physical exercises at his home in Chaoyang District, Beijing, China.

Photo credit: Pinetree Care Group, china

Outcomes of ICOPE implementation

ACCEPTABILITY AND SATISFACTION WITH THE ICOPE APPROACH

The studies in **Chaoyang** and **Occitanie** reported how well received the implementation was for participants. The team in **Rajasthan** did not undertake any formal assessment of satisfaction but had anecdotal evidence to suggest a good level of buy-in and enthusiasm for ICOPE. Informal conversations suggested that older people here were encouraged to see interventions being designed specifically to meet their needs, and they welcomed the opportunity to speak and to be heard. Similarly, the team in **Canillo** did not undertake an assessment of satisfaction, but received positive feedback from participants who thanked the geriatricians and nurse in the research team for the comprehensive ICOPE assessment, with many also recommending their peers engage with the study.

Older people in Rajasthan felt encouraged to see interventions being designed specifically to meet their needs, and they welcomed the opportunity to speak and to be heard

- At the end of the study in **Chaoyang**, 99% of participants said they would be willing to continue with the piloting over the longer term and 63% said they were more satisfied with their health than they had been a year before. Of over 1 000 older participants in **Occitanie**, nearly 80% were satisfied with the ICOPE digital tools and 64% said they were useful.
- Responses to self-reported questions in **Chaoyang** suggested participants felt empowered by gaining more knowledge about their health and care, and felt they had better symptom control. They also reported reduced hospital visits, better communication with doctors and improved adherence to medication. In **Occitanie**, 70% said they felt that their engagement with ICOPE had helped them to better understand their own physical and mental capacities and needs.

EFFECTIVENESS AND IMPACT OF THE ICOPE APPROACH

- There has been some effort by the study teams in **Chaoyang** and **Occitanie** to evaluate the effectiveness of the ICOPE implementation on participants' health and well-being. With the short follow-up (around one year), it is too soon to reach conclusions on the effectiveness and systems impact of the ICOPE approach, including in the prevention of care dependency. In **Chaoyang**, preliminary results indicate, however, the effectiveness of the approach in the management of chronic conditions, improving activities of daily living and mental health and reducing the use of health care (e.g. hospital visits).



At the end of the study in Chaoyang, 99% of participants said they would be willing to continue with the piloting over the longer term



» LEARNING

Enablers

ENGAGEMENT OF OLDER PEOPLE

All teams stressed the importance of older people's participation as a crucial enabler for ICOPE implementation. Different approaches were taken to raising awareness and gaining the support of older people. This highlights that there is no one-size-fits-all approach and that, rather, the key is to rely on local experiences and approaches that resonate with communities.

- Community-level discussion generated through word of mouth has gained public acceptance of the study in **Canillo**, and secured the interest of older participants.
- Mass media campaigns were a key enabler in not only securing the positive engagement of older participants but also a wide range of health and care stakeholders in **Chaoyang**. A similar approach also proved successful in **Occitanie**.
- Older people actively sought to be involved in the study in **Rajasthan** after hearing about it from peers. Interest appeared to be driven by a desire among older people to be listened to, and to feel they were being proactively targeted and prioritized by the health and care systems.

PARTNERSHIPS UNDERPIN SUCCESS IN IMPLEMENTING ICOPE

A range of partnerships developed to support ICOPE implementation is listed in **BOX 2** on page 27. The teams in **Canillo** and **Chaoyang** highlighted the importance of building strong links with multiple stakeholders, and in particular the government, crucial to the study in **Chaoyang**, where the Government provided funding for the pilot. In **Occitanie** and **Rajasthan**, the status and reputation of the lead organization was critical to the establishment of key partnerships for implementation. In the former case, this has led to resources being leveraged, and commitments made to the forthcoming phases of ICOPE implementation scale up. In the latter case, the reputation of the **Rajasthan** team and its existing community relationships were key to the delivery of the pilot. The students in public health were also already well trusted.

DIGITAL INFRASTRUCTURE

Technology may be a useful enabler of ICOPE implementation.

- The use of telemedicine in **Occitanie** enabled nurses to support older participants to monitor their intrinsic capacity through follow-up screening and by responses to alerts generated through the ICOPE Monitor app and the FRAILTY-ICOPE database.
- Online screening and follow-up were also cited as an enabler by the team in **Chaoyang**, particularly in the context of the restrictions to in-person contact caused by COVID-19.



“The evaluation helped me a lot. I realized the necessity of health checkup and need to take care of my health in future.”

Mangi Lal, ICOPE participant, India

Barriers and challenges

HUMAN RESOURCE CONSTRAINTS

A consistent barrier highlighted by all the study teams was human resource constraints, both in terms of the number of health and care workers, and the time they were able to give to implement the ICOPE care pathway. The extent and nature of this challenge differed across sites.

- The small team responsible for implementation in **Canillo** had time constraints.
- The ratio of integrated care managers to participants was low in **Chaoyang**, making it difficult for them to deliver effectively. This was further exacerbated by the small number of primary care doctors available to support the more complex cases, and the challenges to engage specialist health workers outside of geriatrics.
- Primary care doctors in **Occitanie** were observed to lack both the time and the reimbursement to be able to support ICOPE assessments and interventions.



All teams stressed the importance of older people's participation as a crucial enabler for ICOPE implementation

WORKFORCE ATTITUDES, KNOWLEDGE AND SKILLS

A shared barrier in **Occitanie** and **Rajasthan** was the limited knowledge of, and limited interest in, older people's care among health and care workers. The **Occitanie** team highlighted a lack of awareness among primary care doctors about the opportunities to support older people to change the trajectories of their intrinsic capacity, to slow decline.

FINANCING CONSTRAINTS TO SUPPORT IMPLEMENTATION RESEARCH AND SCALE-UP

Financial barriers to implementation were also highlighted by the teams in **Rajasthan** and **Occitanie**. This was a shared challenge despite the different scales of the studies and resource settings. The study in **Rajasthan** was implemented without any stand-alone funding, limiting its size and challenging the ongoing phases of implementation. In **Occitanie**, the lack of financial incentive within the health system to integrate ICOPE interventions with other health interventions was cited as a particular barrier to scale-up, especially for the latter steps of the pathway (only the screening step was covered by health insurance).

COVID-19

A consistent challenge across the sites was the disruption caused by the COVID-19 pandemic. This had an impact on the delivery of the care pathway, the availability of health workers and services to support implementation and the timeframes in which the studies could be delivered. Some older people were also more reluctant to engage with the study due to concerns about their potential exposure to COVID-19.



LEARNING (cont.)

Improvements

Based on their experiences of implementation, the study teams highlighted the following areas for possible improvement in the ICOPE approach.

- The **Canillo** team suggested:
 - modification of the ICOPE screening tool to increase its specificity and sensitivity, for example supporting cognition screening through the inclusion of another test in step 1, such as asking the older person to draw a clock;
 - modifications to the data dashboard, simplifying it for the benefit of users with limited capacity using information technology, and increasing the functionality to support summarized and visual data.
- The **Chaoyang** team suggested:
 - changes to address sustainability and scalability, including advocacy to ensure national funding and a standardized accreditation system for training and the integrated care manager role;
 - cost-effectiveness analysis.
- The **Occitanie** team suggested addressing problems with the usability of digital tools.
- The **Rajasthan** team suggested further thinking on how to support the level of resourcing needed to implement ICOPE in resource-constrained environments.

Strengths

OPPORTUNITY TO EMPOWER OLDER PEOPLE

The engagement of older people was identified not only as an enabler of ICOPE, but the approach was also found to promote empowerment and increased knowledge.

- Older participants highlighted a greater sense of self-empowerment in the **Canillo** case study, and the team identified strengths in the holistic and proactive nature of ICOPE, and in its role to prevent declines in intrinsic capacity and functional ability.
- The detailed assessments that led to older participants and caregivers being supported and coached in the development of personalized care plans were found to be beneficial for older people's knowledge and demand for services in **Chaoyang**.
- In the **Rajasthan** case study, screening was found to help raise awareness among older people of their health and care needs.
- Building an understanding of what intrinsic capacity was, and how decline could happen and be prevented or slowed, led to a sense of empowerment among the participants in **Rajasthan**.
- Also in the **Rajasthan** study, where older people had previously accepted declines as a "natural part of ageing" and had not sought services and support, the change in understanding suggested a shift in health-seeking behaviour. This finding was based on the observations and would warrant more formal evaluation as the pilot continues.

HEALTH WORKFORCE CAPACITY-BUILDING

- The exposure of health workers to assessing declines in intrinsic capacity with an ability to monitor these through the FRAILTY-ICOPE database was important to the team in **Occitanie**, given that health and care workers generally had not previously been aware of the different conditions of intrinsic capacity, and had had no way to observe changes.
- This opportunity to fill a knowledge gap on integrated care for older people was also a strength highlighted by the **Rajasthan** team.

COORDINATION AND COLLABORATION BETWEEN HEALTH AND CARE WORKERS AND SYSTEMS

In addition to health and care worker capacity-building, the studies highlighted the role ICOPE can play in encouraging coordination and collaboration between workers and between the stakeholders in the health and social care systems, including local and national government.

- ICOPE supports improved communication between health and care workers, and between older people and health and care workers, according to the **Canillo** team.
- The study in **Chaoyang** demonstrated the importance of having specific human resource capacity in the form of integrated care managers. The strength of the role was its focus on coordination between disciplines and systems, thereby countering fragmentation.
- A large network of health professionals across cadres in **Occitanie** supported collaboration and a more integrated approach to care.

DIGITAL IMPLEMENTATION

The general approach of digitizing ICOPE and using technological solutions was perceived as a strength, albeit with some improvements needed on specific aspects. In **Chaoyang**, for example, more than three quarters of participants were positive about their experiences with telephone consultation and coaching, and many highlighted the benefits of video-based physical exercise therapies provided by integrated care managers online. The ability to deliver screening using the digital tools was highlighted by the **Occitanie** case study, as was the possibility of supporting health worker engagement through the FRAILTY-ICOPE database.



“I was happy with the pilot. For my wife, be it nursing care, or seeking advice, there is hope now.”

Haizhen Ren, ICOPE participant, China

SURVEY RESULTS:**Readiness at the services and systems level**

The services and systems-level survey using the ICOPE implementation scorecard had 259 complete valid responses from 35 nominated Member States (1 low income, 11 lower-middle-income, 12 upper-middle-income, and 11 high-income countries; listed in **ANNEX 3 TABLE A3.1**) Respondents represented Member States across all levels of economic development, but with higher response rates from high-income settings (**FIGURE 8**), and most frequently represented national or subnational ministries of health (**FIGURE 9**).

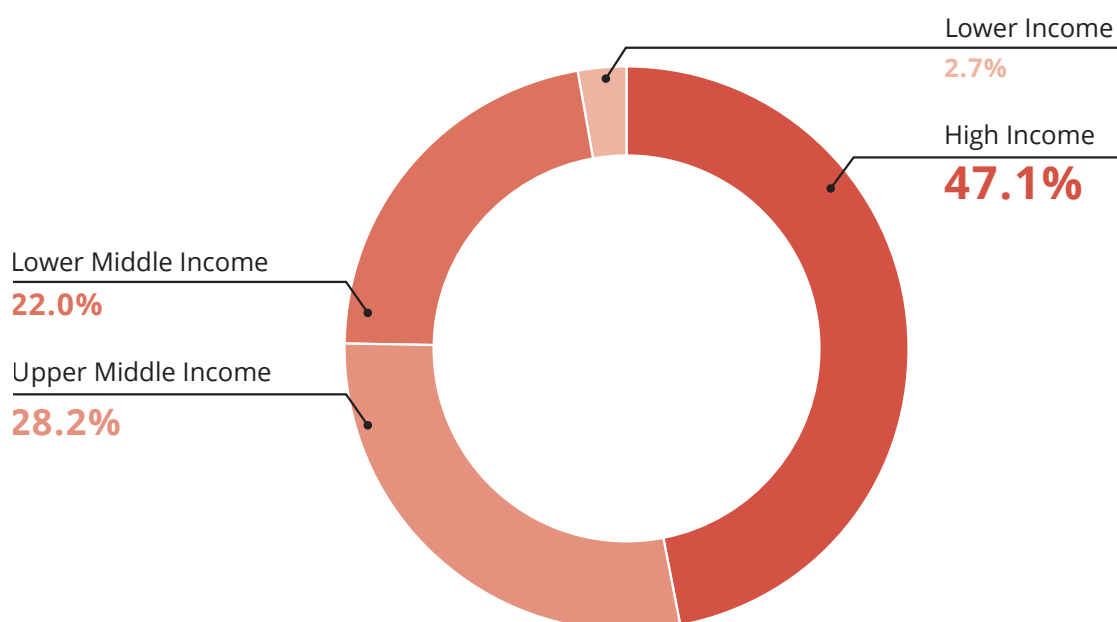
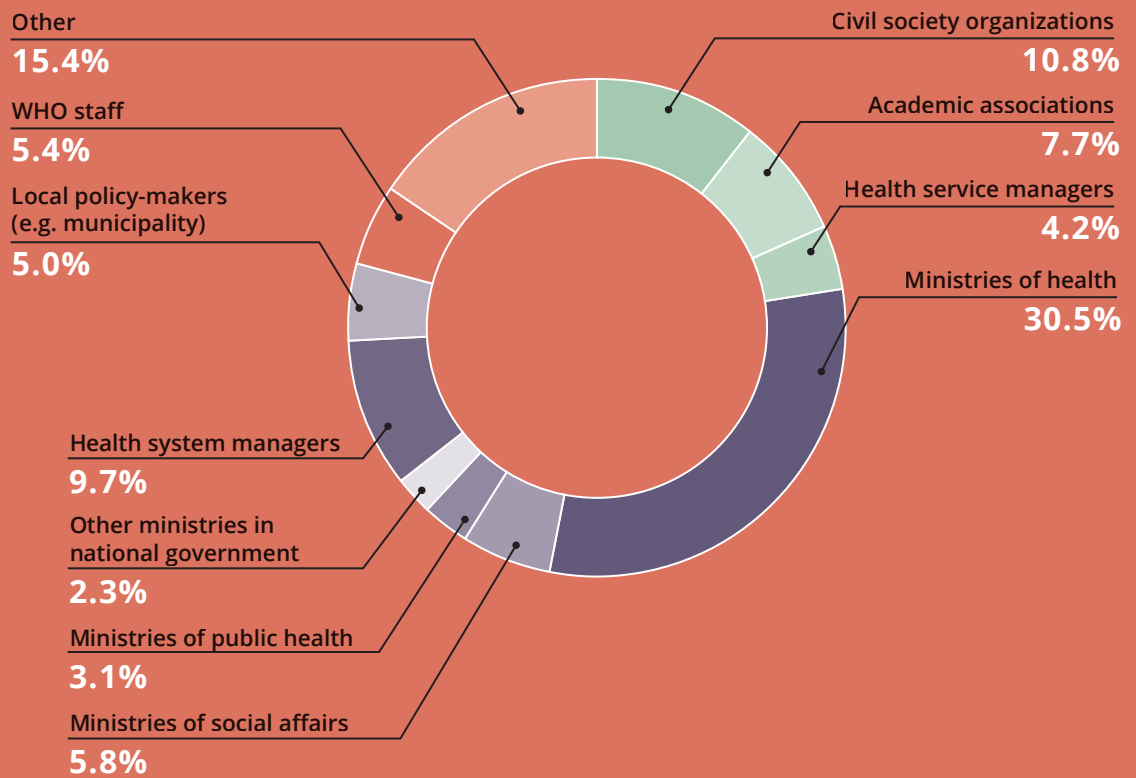
FIGURE 8.**Distribution by country income level of respondents to services and systems survey**

FIGURE 9.
Sectors represented by respondents to services and systems-level survey



Readiness by country income levels and regions

Scorecard ratings for implementation readiness at the services, systems and overall levels used the scoring ranges set out by the implementation framework for policy-makers and programme managers (8), as given in **FIGURE 10**.

As **FIGURE 11A** shows, readiness varies across the levels of economic development indicated by country income bands (see **ANNEX 6** for the data disaggregated by WHO region). On average, countries with higher incomes reported more

readiness overall and also against the identified collective actions within services and systems that would facilitate the implementation of ICOPE. Looking at the overall average scores, high-income and upper-middle-income countries fell within the "initiating implementation" range while those in the two lowest-income brackets scored in the "no to minimal implementation" range. Across all countries, there was a large range of scores, suggesting that implementation readiness is context-specific. Irrespective of economic development, implementation readiness was higher on average for services than for systems **FIGURE 11B**.

FIGURE 10.
Scorecard ratings used in the framework measure of ICOPE readiness

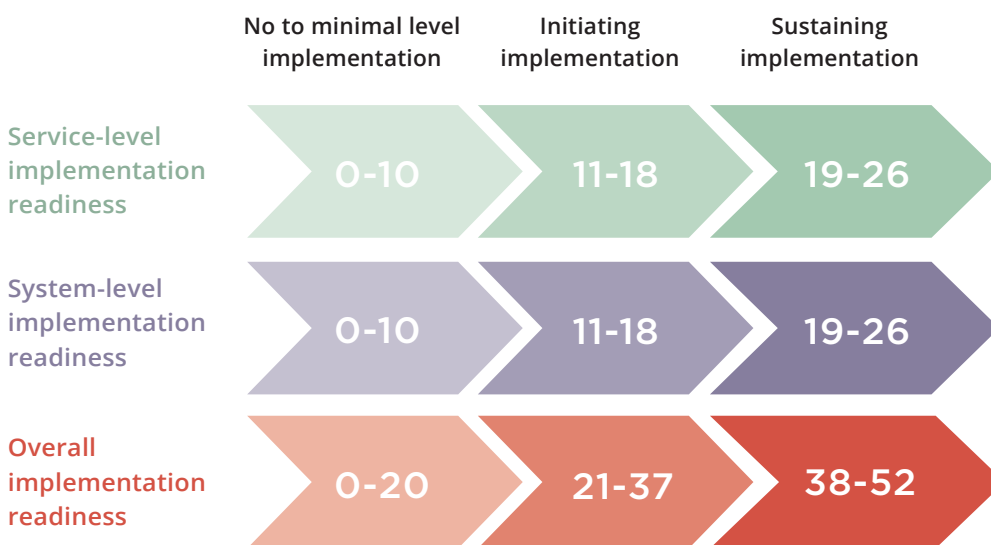


FIGURE 11.
Implementation readiness by country income groupings

HIC = high-income country, **LIC** = low-income country, **LMIC** = lower-middle-income country, **UMIC** = upper-middle-income country

Surveys of a total of 35 Member States with 259 respondents. The median scores with the first and third quartile are presented as a box with bars (minimum and maximum scores).

FIGURE 11A.

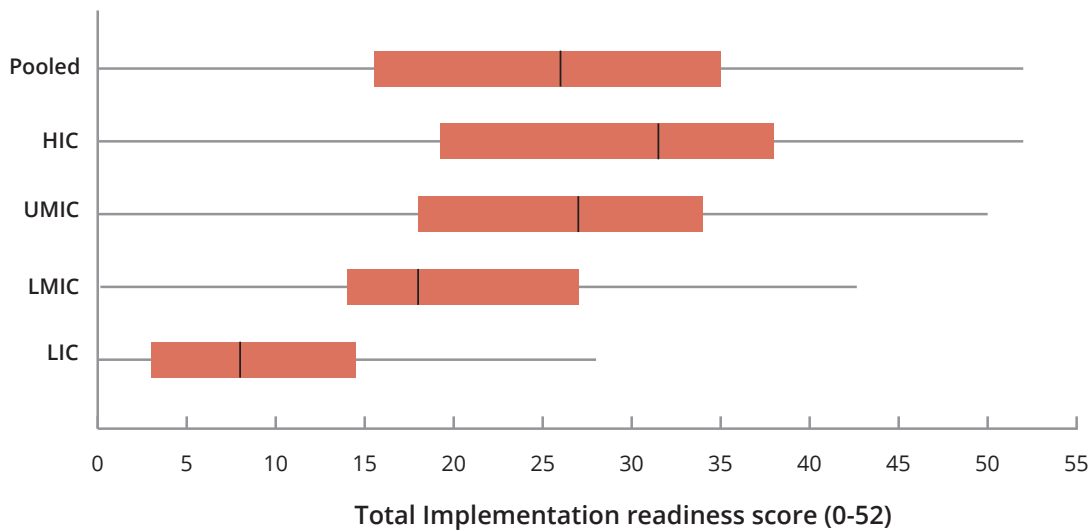
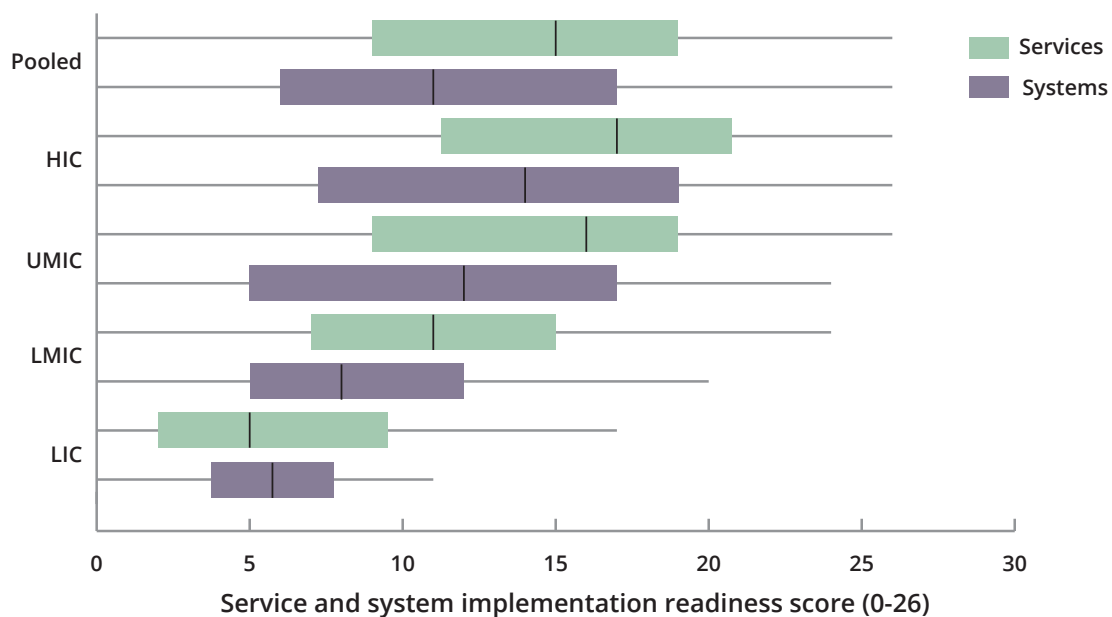


FIGURE 11B.



Readiness by specific actions in support of ICOPE

The results on implementation readiness by scorecard themes for systems and services are displayed in the charts in **FIGURE 12**, giving both the pooled results and those by country income levels (disaggregation by WHO region is given in **ANNEX 6**). **ANNEX 7** summarizes implementation readiness by individual actions, considering each of the 19 actions independently.

For each of the three themes of service actions about empowerment, multidisciplinary coordination and community-based care (**FIGURES 12A to 12C**), around a third of respondents identified no to minimal implementation, another third were initiating implementation and the remainder cited sustaining implementation. Overall, the greatest implementation readiness was associated with the service action to “actively engage older people, their families and caregivers and civil society”, while the least was with “deliver care that is acceptable to older people, effective and targets functional ability” (**ANNEX 7**).

For the system-level strengthening actions (**FIGURES 12D and 12E**), for both themes of system actions about governance and accountability, as well as system strengthening, respondents from low-income countries reported no implementation. Overall, the greatest implementation readiness was associated with the system action to “develop capacity in the current and emerging workforce to deliver integrated care”, while the least was with “use digital technologies to support older people’s self-management” (**ANNEX 7**).

Across the Member States involved in the scorecard survey, implementation readiness for the ICOPE approach varied substantially. Higher levels of readiness on average were seen at the meso level, in health and social care services, compared with the macro, systems, level. High-income

countries tended to report more readiness than lower-resourced ones. These findings highlight the importance of considering:

- local meso- and macro-level contextual factors for implementation;
- the need for more overall, comprehensive implementation support for lower-resourced settings.

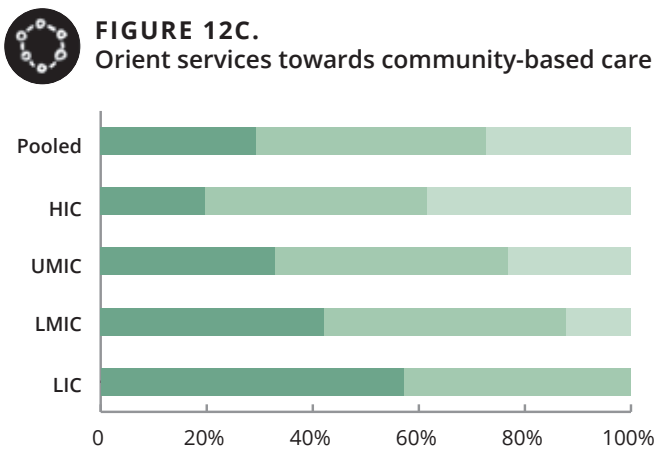
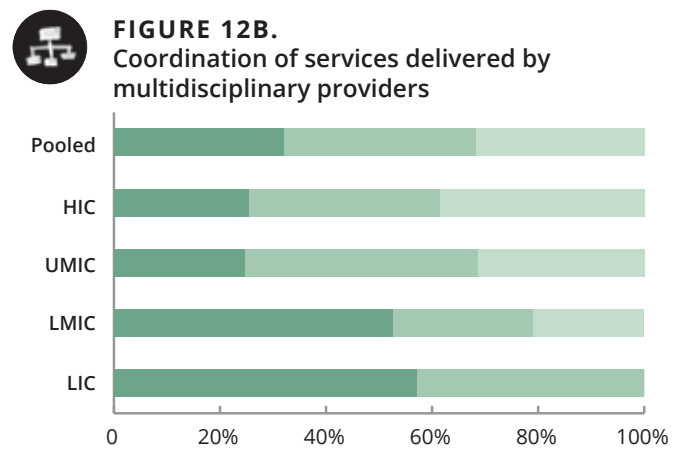
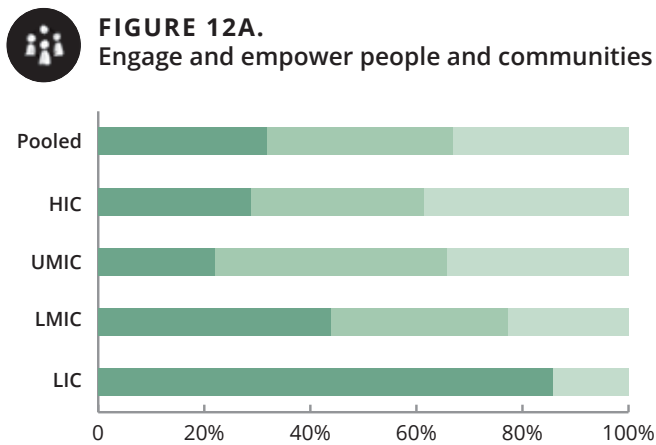
Across all countries and regions, notable gaps in implementation readiness were identified for orienting services towards community-based care as well as strengthening governance and accountability systems. For lower-resourced settings, supporting the coordination of services delivered by multidisciplinary providers and system strengthening were identified as areas for greater implementation support. This suggests that greater attention to the development of community-based service delivery models – with capacity-building and integration across health and care workers – is needed for the ICOPE approach to be sustained in community and primary care settings.

Member States showed the most implementation readiness on community engagement and the co-design of services, highlighting progress in the acceptance of ICOPE and community engagement in healthy ageing. Low systems readiness related to service-level capacity in monitoring and the adoption of digital technologies to support self-management points to the need for investment and infrastructure for the relevant systems-strengthening activities.



For the ICOPE approach to be sustained in community and primary care settings, greater attention to the development of community-based service delivery models is needed

FIGURE 12.
Implementation readiness for three service-level themes and two system-level themes



Services

- None to minimal implementation
- Initiating implementation
- Sustaining implementation

Systems

- None to minimal implementation
- Initiating implementation
- Sustaining implementation

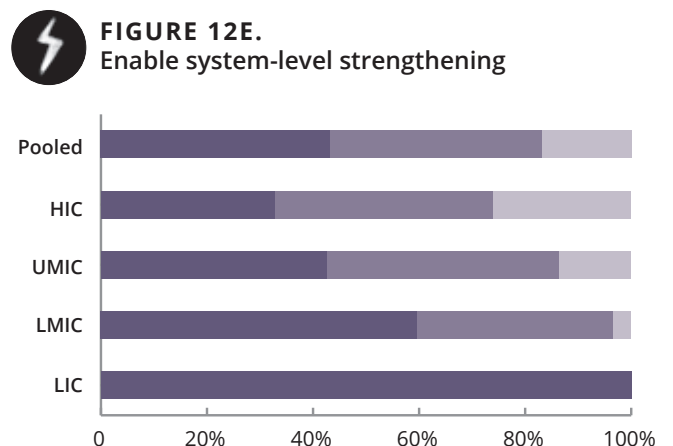




Photo credits:
Yuka Sumi, WHO (left)
Eva Heras, Andorra (right)



**More than 40 Member States
have expressed interest and requested
technical support from WHO to
implement ICOPE in the near future
(2022-2023)**

LEARNING GAINED IN THE ICOPE PILOT READY PHASE

The ICOPE approach is continuing to generate interest globally. It is also garnering support across the health and social care sectors in many Member States, from the level of national ministries to the subnational and local government levels. Growing support for ICOPE is further evidenced by the establishment of multisectoral partnerships with community, civil society and professional organizations. More than 40 Member States have expressed interest and requested technical support from WHO to implement ICOPE in the near future (2022–2023).

This momentum has continued despite the challenges posed by COVID-19. While the pandemic has affected the implementation of pilot studies in some contexts, it has also highlighted the importance of providing integrated and person-centred care for older people. ICOPE provides an opportunity to respond to the challenges within health and social care systems that have been laid bare by the pandemic, and to ensure more targeted, accessible and quality care for current and future generations of older people.

The scorecard survey for implementation readiness of health and social care services and systems identified that implementation readiness varies considerably across settings. This finding highlights the need for supportive actions to be oriented towards the unique needs of individual settings. On average, implementation readiness is more advanced in service areas than at the systems levels, and more advanced overall in high-income countries. Supporting the system-level adoption of ICOPE, particularly in lower-resourced settings, will be important for global scalability.

KEY FINDINGS

Three key findings of the ready phase pilot highlight opportunities for ICOPE implementation:

- **Positive attitudes from health and care workers towards the principles of integrated care** and high levels of commitment to the adoption and implementation of ICOPE. The fact that the workforce is engaged with the provision of integrated care for older people demonstrates that with appropriate workforce capacity-building (volume, training) and creating enabling service delivery environments (optimising workflow, infrastructure, universal health coverage), service delivery can change (bottom up).
- **Proactive engagement of older people and their communities** is crucial across all steps of the pathway, and in particular step 5. This was highlighted in feedback from both older participants, and health and care workers.
- **ICOPE is feasible to implement in different contexts**, as shown by real-world case studies from different countries. They also demonstrate the value of local co-design and adaptation to suit local context and to optimise local workforce engagement and training.



Specific barriers to implementation can be addressed

As well as highlighting those opportunities, the ready phase has identified some challenges that will need further consideration and action in the later phases of the ICOPE implementation and scale-up.

HUMAN RESOURCES

A lack of health and care workers was the most commonly cited barrier to the implementation of ICOPE across studies and contexts. Insufficient workers across cadres present challenges for the delivery of integrated care and the ability of systems and services to ensure the appropriate division of labour to enable implementation of all the steps of the pathway. Addressing these barriers will require a multipronged approach focused on increasing the workforce, improving links with informal caregivers, and improving knowledge and skills among existing and new health and care workers, through enhanced training in the ICOPE approach. It will also be important to leverage clinical practice opportunities with digital tools and to share training resources to enable a consistent approach across contexts. There may also be opportunities to manage the workloads of health and care workers by encouraging self-screening among older people. For this to be an acceptable strategy, the effectiveness of a self-screening approach needs to be further assessed through the ICOPE pilot.

FINANCING

Another key issue relates to financing for integrated care, particularly to ensure the sustainability and scalability of the ICOPE approach. Respondents highlighted the need for a health economics assessment (cost-effectiveness analysis) that can inform advocacy for the adoption and implementation of ICOPE. This will be addressed during the set phase of the ICOPE implementation pilot programme. In addition, a sustainable financial model

for the implementation of ICOPE in different contexts is needed, taking into account measurement of the goal of the ICOPE approach and the need to appropriately remunerate and reimburse workers for their time. A financial model should support ICOPE care pathways to be included within universal health coverage in each Member State.

DIGITAL TECHNOLOGY

The studies highlighted the use of digital technology as a potential enabler of ICOPE implementation but pointed to particular challenges that need to be overcome. There is a need for a range of digital tools for screening, assessment, and monitoring and analysing data. Experiences from the case studies on the necessary adaptations to existing digital tools reinforce the need for further optimization of digital resources and the importance of a design flexibility that enables local adaptation to address issues of access, interoperability, integrity, data governance, cybersecurity and usability. Beyond clinical practice tools to optimize screening and assessment, there is a need to build capacity in electronic health and social care data systems and to ensure digital tools are integrated within these systems, to facilitate information sharing and coordination in service delivery so that personalized care plans can be optimally developed and implemented.

COORDINATION AND COLLABORATION

A lack of coordination and collaboration within and between health and social care systems was identified as a barrier to implementation readiness, but improvements in this area could also be an outcome of the ICOPE approach, particularly in the context of the implementation framework (8) for health and social care services and systems (e.g. the themes of "strengthening governance and accountability" and to "enable system-level strengthening"). The degree of existing integration versus fragmentation between health and social care systems in Member States needs to be understood to inform priority actions for implementation. The opportunity for participating Member States to more clearly define the different roles and responsibilities of the health and social care systems and workers to provide ICOPE could support improved coordination and collaboration. Use of the scorecard in the implementation framework may help to identify the areas of prioritized action for national and subnational systems.

Informing the next phases of ICOPE implementation

The ICOPE implementation pilot programme has allowed the identification of barriers and enablers in this ready phase, and these will inform subsequent adaptation that further supports the effective implementation of the ICOPE approach. The set phase, through planned and coordinated ICOPE implementation pilots around the world, will build on this experience and learning.

The teams behind the four case studies in this report have plans to implement the subsequent phases, and some of the work is already ongoing. They all aim to reach significantly greater numbers of older people with the ICOPE approach.

The work undertaken to date has also led to specific commitments from other stakeholders. In 2022, the Government of China has published a national plan for healthy ageing (21), which includes advancing integrated care for older people as a key action area, and has launched an action plan for capacity building in primary care to improve ability to implement integrated care for the older population. Andorra's healthcare service has committed to establishing a population-wide prevention strategy for older people focused on functional ability and the Ministry of Health in France plans to support the scale up of the ICOPE pilot in five regions, targeting 50,000 older people (over 60 years of age) with three years of follow up (22).

The United Nations Decade of Healthy Ageing is an important opportunity for stakeholders to come together to deliver its vision for "a world in which all people can live longer and healthier lives" (5). The ICOPE approach will play an important role in this effort and WHO will continue to support Member States to take action to strengthen health and social care systems to implement ICOPE, irrespective of their current level of readiness. If achieved, this will represent a paradigm shift in the way the world approaches the health and well-being of older people. By focusing on the promotion of intrinsic capacity and the prevention of declines through the provision of integrated, person-centred care, implementing ICOPE will move away from the traditional medical model of only diagnosing, and managing diseases and disorders.

If governments can recognize the value of responding to the additional resource needs of implementing ICOPE as part of efforts towards universal health coverage, while at the same time harnessing high levels of grassroots support and stakeholder engagement, as outlined in this ready phase pilot report, then we can expect a brighter future for older people around the world.



WHO will continue to support Member States to take action to strengthen health and social care systems to implement ICOPE, irrespective of their current level of readiness

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ANNEX 1:

Micro survey on ICOPE implementation in clinical and community setting

SURVEY PREPARATION

Review the generic ICOPE care pathway using the ICOPE handbook and app via a narrated two-minute online tutorial.

ABOUT YOU

Are you providing care to older people, with at least two years of experience?

- | | |
|--|---|
| <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| <input type="checkbox"/> Medical doctor (please specify) | <input type="checkbox"/> Health assistant |
| <input type="checkbox"/> General/primary care physician | <input type="checkbox"/> Physiotherapist |
| <input type="checkbox"/> Geriatrician | <input type="checkbox"/> Occupational therapist |
| <input type="checkbox"/> Specialist doctor | <input type="checkbox"/> Nutritionist |
| <input type="checkbox"/> Resident | <input type="checkbox"/> Psychologist |
| <input type="checkbox"/> Nurse | <input type="checkbox"/> Midwife |
| <input type="checkbox"/> Dentist | <input type="checkbox"/> Community health worker, including volunteer |
| <input type="checkbox"/> Pharmacist | <input type="checkbox"/> Social care worker |
| | <input type="checkbox"/> Other (please describe): |

If no, survey ends:

Thank you so much. This survey is targeting health and social care workers who provide care to older people, with at least two years of experience.

ABOUT YOUR SETTING

Where do you provide care to older people? (You can select more than one answer)

- | | |
|--|---|
| <input type="checkbox"/> General physician's office/primary care/family medical practice | <input type="checkbox"/> Long-term care facility |
| <input type="checkbox"/> Community health care centre | <input type="checkbox"/> Mobile clinic |
| <input type="checkbox"/> Outpatient care in secondary hospital | <input type="checkbox"/> Field outreach (e.g. monthly camp) |
| <input type="checkbox"/> Inpatient care in secondary hospital | <input type="checkbox"/> Home visit |
| <input type="checkbox"/> Outpatient care in tertiary hospital | <input type="checkbox"/> Other (please describe): |
| <input type="checkbox"/> Inpatient care in tertiary hospital | |

LOCATION

WHO region:

- African region
- Eastern Mediterranean region
- European Region
- Region of the Americas
- South-East Asia region
- Western Pacific region

Country:

- Urban
- Rural

SCENARIO-BASED QUESTIONNAIRE

ICOPE IMPLEMENTATION IN YOUR SETTING

Let's run through a very simple example of how ICOPE could be implemented in your clinical setting. In reality, many older persons face multiple complex challenges, and ICOPE has been designed to be able to guide the clinician through this complex scenario.

Reminder: please respond to all questions based on your experience, situation and context prior to the COVID 19 pandemic.

STEP ①

Screening for loss of intrinsic capacity in the community using ICOPE screening tool

Screening could occur in one of two scenarios:

- A.** In the first, it is done elsewhere outside your practice. For example, your local community health centre has set up an ICOPE screening site and older people are beginning to be referred to your clinic for further person-centred assessment and management; *or*
- B.** You begin to screen your older people using the ICOPE Screening tool in your practice.

1. What do you think is the *most likely* way that screening (step 1) and the following ICOPE steps will work in your context?

- Both screening and further ICOPE pathway steps will be conducted by you or your practice
- Screening and assessment would be conducted by different groups (e.g. screening by community health workers and additional steps by a primary care practice)

2. If you or your practice will do screening, do you have staff to do this?

- Yes
- No

3. Would you or your staff need additional training for this screening step?

- Yes
- No

4. If you or your practice will do screening, do you have sufficient space to do so?

- Yes
- No

5.

What are key enablers to conducting screening for loss of intrinsic capacity in your clinical setting?
(You can select more than one answer)

- Community engagement, including volunteers
- Support from:
 - local government
 - civil society organizations
 - academic associations (e.g. medical associations)
- Local mechanism/system for timely referral
- Local network of multidisciplinary stakeholders
- Training provided by local, national authorities
- Availability of screening tool in local language
- Proactive engagement of older people and their caregivers
 - Local and/or global platform to share the experience
- Mobile ICOPE handbook app and data dashboard
- Financial incentives or reimbursement for this activity
- Access to telehealth for this activity
- Other:

6.

Can you foresee any barriers to conducting screening for loss of intrinsic capacity in your clinical setting?
(You can select more than one answer)

- Additional time required
 - Limited space for conducting the evaluation along with routine activities
 - Lack of available staff
 - Reimbursement for additional time and staff
 - Lack of knowledge and training to conduct screening
 - Lack of integration with existing medical record
 - Competition, redundancy or conflict with other health services
 - Reaching to older people is difficult
 - ICOPE screening tool needs to be adapted to local context
 - Other:
- No, I do not see any barriers

STEP 2.1**Assessment of intrinsic capacity domains found positive on screening**

Let's imagine a 79-year-old woman has screened positive for possible loss of mobility.

1. Who will make an in-depth assessment of mobility (as per the ICOPE handbook, e.g. the short physical performance battery, SPPB)? (You can select more than one answer)

- Me
- Other staff in my practice
- Referral to other setting
 - If referring to other setting, what is the mechanism from step 1 to step 2?

2. If you or your practice would do an in-depth assessment on mobility, do you need additional staff to do this?

- Yes
- No

3. Would you or your staff need additional training for this step?

- Yes
- No

4. Do you have sufficient space to do this assessment at the same time as continuing your routine activities?

- Yes
- No

5. What are the key enablers to conducting detailed assessment for loss of intrinsic capacity in your clinical setting? (You can select more than one answer)

- Community engagement, including volunteers
- Support from:
 - local government
 - civil society organizations
 - academic associations (e.g. medical associations)
- Local mechanism/system is in place for timely referral
- Local network of multidisciplinary stakeholders
- Training provided by local, national authorities
- Availability of screening tool in local language
- Proactive engagement of older people and their caregivers
- Local and/or global platform to share the experience
- Mobile ICOPE handbook app and data dashboard
- Financial incentives or reimbursement for this activity
- Access to telehealth for this activity
- Other:

6. Can you foresee any barriers to conducting detailed assessment for loss of intrinsic capacity in your clinical setting? (You can select more than one answer)

- Additional time needed
- Limited space for conducting the evaluation along with routine activities
- Lack of available staff
- Reimbursement for additional time and staff
- Lack of knowledge and training to conduct assessment
- Lack of integration with existing medical record
- Competition, redundancy or conflict with other health services
- Assessment tool needs to be adapted to local context
- Other:
- No, I do not see any barriers

STEP **2.2****Assess and manage – diseases and associated conditions**

Following the ICOPE care pathways, the woman is found to have undiagnosed and untreated osteoarthritis that may be contributing to her loss of mobility. You therefore discuss osteoarthritis treatment options and develop a management plan, including follow up in six months.

1.

Who will make an assessment and manage diseases and associated conditions as detailed in the ICOPE handbook (e.g. polypharmacy, pain, frailty)? (You can select more than one answer)

- Me
- Other staff
- Referral to other setting (e.g. a specialist doctor)

If referring, what is the mechanism for disease management?

Please describe:

2.

If you or your practice will do an assessment and manage diseases and associated conditions, will you need additional staff to do this?

- Yes
- No

3.

Would you or your staff need additional training for this step?

- Yes
- No

4.

Do you have sufficient space to do this at the same time as continuing your routine activities?

- Yes
- No

5.

What are key enablers for disease assessment and management in your clinical setting?
(You can select more than one answer)

- Community engagement, including volunteers
- Support from:
 - local government
 - civil society organizations
 - academic associations (e.g. medical associations)
- Local mechanism/system is in place for timely referral
- Local network of multidisciplinary stakeholders
- Training provided by local, national authorities
- Availability of screening tool in local language
- Proactive engagement of older people and their caregivers
- Local and/or global platform to share the experience
- Mobile ICOPE handbook app and data dashboard
- Financial incentives or reimbursement for this activity
- Access to telehealth for this activity
- Other:

6.

Can you foresee any barriers against disease assessment and management in your clinical setting?
(You can select more than one answer)

- Additional time needed
- Limited space for conducting the evaluation along with routine activities
- Lack of available staff
- Reimbursement for additional time and staff
- Lack of knowledge and training to conduct assessment
- Lack of integration with existing medical record
- Competition, redundancy or conflict with other health services
- Other:

- No, I do not see any barriers

STEP **2.3****Assess and manage – social and physical environments, social care and support**

Using the ICOPE handbook you also assess her social and physical environment and needs of social care and support. You find that she lives on the third floor of an apartment building with no lift and so is homebound for most of the time, gets insufficient exercise, feels lonely and sometimes struggles to get her shopping.

1. Who will make an assessment and manage the social and physical environment as detailed in the ICOPE handbook (e.g. home assessment and adaptations to prevent falls; assessment of needs for assistive devices)?

(You can select more than one answer)

- Me
- Other staff
- Referral to other setting (e.g. to a social care worker)

If referring, what is the mechanism for assessing and managing social and physical environment?
Please describe:

2. If you or your practice will do the assessment and manage the social and physical environment, will you need additional staff to do this?

- Yes
- No

3. Would you or your staff need additional training for this step?

- Yes
- No

4. Do you have sufficient space and administrative support to do this at the same time as continuing your routine activities?

- Yes
- No

5.

What are key enablers in your clinical setting for the assessment and management of the social and physical environment? (You can select more than one answer)

- Proactive engagement of older people and their caregivers
- Local and/or global platform to share the experience
- Mobile ICOPE handbook app and data dashboard
- Financial incentives or reimbursement for this activity
- Access to telehealth for this activity
- Other:

6.

Can you foresee any barriers in your clinical setting against the assessment and management of the social and physical environment? (You can select more than one answer)

- Additional time needed
 - Lack of available staff
 - Reimbursement for additional time and staff
 - Lack of infrastructure and system to provide integrated health and social care
 - Lack of integration with existing medical record
 - Lack of knowledge and training to conduct assessment
 - Assessment tool needs to be adapted to local context
 - Competition, redundancy or conflict with other health and social services
 - Other:
- No, I do not see any barriers

STEP 3**Personalized care plan**

The ICOPE handbook app will assist you with creating a person-centred and integrated care plan for this woman. This includes setting a goal, the management for declines in intrinsic capacity and treatable medical conditions, and the plan for dealing with issues in the social and physical environment. Creating such a plan takes a little time and needs to be thought through carefully in consultation with the older person (and caregivers).

In this woman's example, you agree a multimodal exercise programme, first assessing the safety of starting one.

1.

Who will develop a care plan together with the older person?
(You can select more than one answer)

- Me
- Other staff
- Referral to other setting (e.g. to a social care worker)
 - If referring, what is the mechanism for developing a personalized care plan?
 - Please describe:

2.

If you or your practice will create the care plan, do you need additional staff to do this?

- Yes
- No

3.

Would you or your staff need additional training for this step?

- Yes
- No

4.

Do you have sufficient space to do this at the same time as continuing your routine activities?

- Yes
- No

5.

What are key enablers for developing a personalized care plan in your clinical setting?
(You can select more than one answer)

- Community engagement, including volunteers
- Support from:
 - local government
 - civil society organizations
 - academic associations (e.g. medical associations)
- Local mechanism/system is in place for timely referral
- Local network of multidisciplinary stakeholders (e.g. physiotherapist, occupational therapist)
- Training provided by local, national authorities
- Availability of screening tool in local language
- Proactive engagement of older people and their caregivers
- Local and/or global platform to share the experience
- Mobile ICOPE handbook app and data dashboard
- Financial incentives or reimbursement for this activity
- Access to telehealth for this activity
- Other:

6.

Can you foresee any barriers to developing a personalized care plan in your clinical setting?
(You can select more than one answer)

- Additional time required
- Lack of available staff
- Reimbursement for additional time and staff
- Lack of infrastructure and system to provide integrated health and social care
- Lack of integration with existing medical record
- Lack of knowledge and training to develop a care plan
- Competition, redundancy or conflict with other health and social services
- Other:

- No, I do not see any barriers

STEP ④**Ensure referral pathway and monitoring of care plan**

At the six-month review, the woman's osteoarthritis has not improved and she is suffering with pain. She therefore needs referral to a specialist.

1. Who will do this follow up and organize referral? (You can select more than one answer)

- Me
- Other clinic staff
- Referral to other setting

If referring, what is the mechanism for monitoring and referral?

Please describe:

2. If you or your practice will organize this, will you need additional staff to do so?

- Yes
- No

3. Would you or your staff need additional training for this step?

- Yes
- No

4. Do you have administrative support to do this at the same time as continuing your routine activities?

- Yes
- No

5. What are key enablers for follow-up and referral in your clinical setting?

(You can select more than one answer)

- Community engagement, including volunteers
- Support from:
 - local government
 - civil society organizations
 - academic associations (e.g. medical associations)
- Local mechanism/system is in place for timely referral
- Local network of multidisciplinary stakeholders
- Training provided by local, national authorities
- Availability of screening tool in local language
- Proactive engagement of older people and their caregivers
- Local and/or global platform to share the experience
- Mobile ICOPE handbook app and data dashboard
- Financial incentives or reimbursement for this activity
- Access to telehealth for this activity
- Other:

6

Can you foresee any barriers to follow up and referral in your clinical setting?
(You can select more than one answer)

- Additional time required
- Lack of available staff
- Reimbursement for additional time and staff
- No common digital information platform (e.g. medical record, health record, social care needs)
- Competition, redundancy or conflict with other health and social services
- Other:

- No, I do not see any barriers

STEP 5**Engage communities and support caregivers**

At her initial social assessment the woman was found to be lonely. You therefore referred her to local civil society organization that has arranged regular home visits. Through this she has started a weekly outing with other members of the local community and is reporting feeling much better about herself and more confident about her mobility.

1.

Do you have a contact with local government, a local civil society organization or a volunteer group to provide support for your older people?

- Yes
- No

2.

Who will carry out this kind of community engagement? (You can select more than one answer)

- Me
- Other staff
- Referral to others

If referring, what is the mechanism for referral to the community activities?
Please describe:

3.

If you or your staff will organize this, do you need additional staff to do so?

- Yes
- No

4.

What are the key enablers in your clinical setting for community engagement?
(You can select more than one answer)

- Support from:
 - local government
 - civil society organizations
 - academic associations (e.g. medical associations)
- Local mechanism/system is in place for timely referral
- Local network of multidisciplinary stakeholders
- Local mechanism/system is in place for timely referral
- Local network of multidisciplinary stakeholders
- Proactive engagement of older people and their caregivers
- Local and/or global platform to share the experience
- Financial incentives or reimbursement for this activity
- Access to telehealth for this activity
- Other:

5.

Can you foresee any barriers to community engagement in your clinical setting?
(You can select more than one answer)

- Additional time required
- Lack of available staff
- Reimbursement for additional time and staff
- No information on community activities
- Competition, redundancy or conflict with other health and social services
- Other:

- No, I do not see any barriers

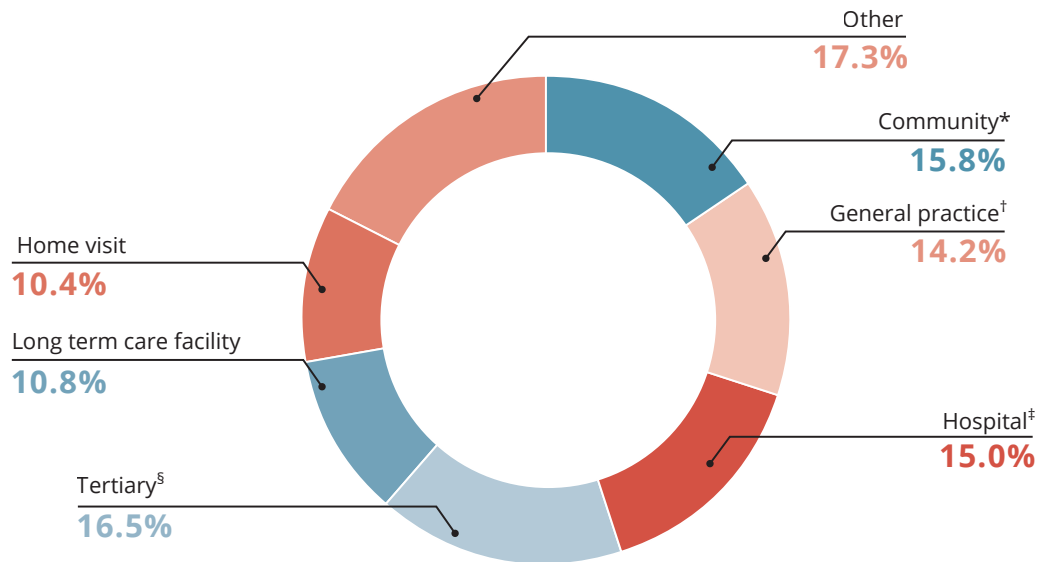
ANNEX 2: Respondents to micro survey

This annex gives fuller information to supplement the summary data presented in the main part of this report (Table 2 and Figure 6).

TABLE A2.1.
Distribution of respondents by regions and country income levels

WHO region	Country	Income level	N	%
African region	Cabo Verde	Lower middle	5	1.9
	Kenya	Lower middle	2	0.8
	Senegal	Lower middle	3	1.2
	South Africa	Upper middle	4	1.5
	Zimbabwe	Lower middle	3	1.2
subtotal			17	6.6
Region of the Americas	Argentina	Upper middle	9	3.5
	Brazil	Upper middle	1	0.4
	Chile	High	36	13.8
	Cuba	Upper middle	4	1.5
	Mexico	Upper middle	2	0.8
subtotal			52	20.0
Eastern Mediterranean region	Bahrain	High	1	0.4
	Egypt	Lower middle	1	0.4
	Oman	High	1	0.4
	Pakistan	Lower middle	1	0.4
	Qatar	High	1	0.4
subtotal			5	2.0
European region	Andorra	High	4	1.5
	France	High	6	2.3
	Italy	High	43	16.5
	Portugal	High	22	8.5
	Russian Federation	Upper middle	3	1.2
	Spain	High	19	7.3
	United Kingdom	High	7	2.7
subtotal			104	40.0
South-East Asia region	Bhutan	Lower middle	2	0.8
	India	Lower middle	1	0.4
	Indonesia	Upper middle	4	1.5
	Nepal	Lower middle	11	4.2
subtotal			18	6.9
Western Pacific region	China	Upper middle	34	13.1
	Republic of Korea	High	9	3.5
	Viet Nam	Lower middle	21	8.1
subtotal			64	24.7
grand total			260	

FIGURE A2.1.
Distribution of respondents by setting



* With health-care centres making up 14.2% of the whole pie, field outreach (e.g. camp) 1.2% and mobile clinics 0.4%

† General physician/primary care/family medicine practice

‡ Secondary care, with inpatient care representing 11.2% of the whole pie and outpatient 3.8%

§ With inpatient tertiary care making up 9.6% of the whole pie and outpatient 6.9%

ANNEX 3: Respondents to service- and system-level survey using scorecard

This annex gives fuller information to supplement the summary data presented in the main part of this report (Figure 8).

TABLE A3.1.
Distribution of respondents by regions and country income levels

WHO region	Country	Income level	N	%
African region	Cabo Verde	Lower middle	9	3.5
	Gabon	Upper middle	7	2.7
	Kenya	Lower middle	5	1.9
	Mozambique	Low	7	2.7
	Senegal	Lower middle	4	1.5
	South Africa	Upper middle	2	0.8
	Zimbabwe	Lower middle	5	1.9
			subtotal 39	15.0
Region of the Americas	Argentina	Upper middle	18	6.9
	Brazil	Upper middle	5	1.9
	Chile	High	31	12.0
	Costa Rica	Upper middle	3	1.2
	Cuba	Upper middle	3	1.2
	Mexico	Upper middle	5	1.9
			subtotal 65	25.1
Eastern Mediterranean region	Bahrain	High	2	0.8
	Jordan	Upper middle	4	1.5
	Kuwait	High	1	0.4
	Lebanon	Upper middle	1	0.4
	Morocco	Lower middle	1	0.4
	Oman	High	2	0.8
	Pakistan	Lower middle	3	1.2
	Saudi Arabia	High	1	0.4
	Tunisia	Lower middle	1	0.4
			subtotal 16	6.3
European region	Andorra	High	4	1.5
	France	High	1	0.4
	Italy	High	12	4.6
	Portugal	High	45	17.4
	Russian Federation	Upper middle	2	0.8
	Spain	High	4	1.5
	United Kingdom	High	19	7.3
			subtotal 87	33.5
South-East Asia region	Bhutan	Lower middle	1	0.4
	India	Lower middle	6	2.3
	Indonesia	Upper middle	7	2.7
	Nepal	Lower middle	5	1.9
			subtotal 19	7.3
Western Pacific region	China	Upper middle	16	6.2
	Viet Nam	Lower middle	17	6.6
			subtotal 33	12.8
			grand total 259	



ANNEX 4: Capacities, enablers and barriers for ICOPE adoption in clinical settings, by income levels and regions

This annex gives fuller information to supplement the summary data presented in the main part of this report (Tables 2 and 3).

TABLE A4.1.
High-income countries (N=149)

STEPS	①		②.1		②.2		②.3		③		④		⑤	
	ICOPE screening		In-depth IC assessment (e.g. limited mobility)		Assessment and management of diseases		Assessment and management of social and physical environment		Develop care plan		Follow-up and referral		Community engagement	
	n	%	n	%	n	%	n	%	n	%	n	%	n	%
Local requirements to implement ICOPE														
Need staff	49	32.90	93	62.42	104	69.80	103	69.13	106	71.14	89	59.73	110	73.83
Need training	104	69.80	101	67.79	99	66.40	97	65.10	104	69.80	88	59.06	NA	
Need space	79	34.20	69	46.31	61	40.90	76	51.01	68	45.64	NA		NA	
Need administrative support	NA		NA		NA		NA		NA		83	55.70	NA	
Enablers to ICOPE steps														
Support from local government	47	31.54	42	28.19	34	22.82	53	35.57	52	34.90	30	20.13	91	61.07
Support from civil society organizations	41	27.52	33	22.15	27	18.12	49	32.89	49	32.89	25	16.78	82	55.03
Support from academic associations such as medical associations	43	28.86	35	23.49	39	26.17	50	33.56	43	28.86	43	28.86	48	32.21
Local mechanism/system is in place for timely referral	40	26.85	32	21.48	37	24.83	45	30.20	43	28.86	48	32.21	52	34.90
Local network among multidisciplinary stakeholders	82	55.03	80	53.69	46	30.87	78	52.35	83	55.70	72	48.32	88	59.06
Training provided by local, national authorities	54	36.24	102	68.46	44	29.53	55	36.91	53	35.57	43	28.86	NA	
Availability of ICOPE screening/assessment tool in local language	69	46.31	65	43.62	NA		NA		NA		NA		NA	
Proactive engagement of older people and their caregivers	105	70.47	85	57.05	78	52.35	86	57.72	97	65.10	71	47.65	93	62.42
Local and/or global platform to share the experience	49	32.89	45	30.20	48	32.21	50	33.56	46	30.87	45	30.20	55	36.91
Mobile ICOPE handbook app and data dashboard	54	36.24	65	43.62	62	41.61	49	32.89	52	34.90	44	29.53	NA	
Financial incentives or reimbursement for this activity	57	38.26	45	30.20	37	24.83	41	27.52	42	28.19	33	22.15	38	25.50
Access to telehealth for this activity	45	30.20	34	22.82	45	30.20	35	23.49	45	30.20	43	28.86	23	15.44
Access to essential medicines	NA		22	14.77	41	27.52	34	22.82	27	18.12	30	20.13	NA	
Access to assistive technology	NA		36	24.16	38	25.50	23	15.44	40	26.85	37	24.83	NA	

STEPS	①		②.1		②.2		②.3		③		④		⑤	
	ICOPE screening		In-depth IC assessment (e.g. limited mobility)		Assessment and management of diseases		Assessment and management of social and physical environment		Develop care plan		Follow-up and referral		Community engagement	
	n	%	n	%	n	%	n	%	n	%	n	%	n	%
Additional time required	105	70.47	107	71.81	107	71.81	102	68.46	107	71.81	97	65.10	105	70.47
Limited space for conducting the evaluation along with routine activities	50	33.56	62	41.61	47	31.54	NA		NA		NA		NA	
Lack of available staff	86	57.72	83	55.70	87	58.39	82	55.03	90	60.40	80	53.69	93	62.42
Reimbursement for additional time and staff	53	35.57	52	34.90	51	34.23	59	39.60	54	36.24	45	30.20	49	32.89
Lack of knowledge and training to conduct this activity	66	44.30	56	37.58	58	38.93	48	32.21	46	30.87	NA		NA	
Lack of integration in digital information platform (medical record, health record, social care needs)	46	30.87	42	28.19	43	28.86	43	28.86	48	32.21	59	39.60	NA	
Competition, redundancy or conflict with other health services	23	15.44	24	16.11	22	14.77	20	13.42	26	17.45	22	14.77	20	13.42
Reaching to older people is difficult	21	14.09	NA		NA		NA		NA		NA		NA	
Screening/assessment tool needs to be adapted to local context	43	28.86	32	21.48	NA		39	26.17	NA		NA		NA	
Lack of infrastructure and system to provide integrated health and social care	NA		NA		NA		65	43.62	71	47.65	NA		NA	
No information on community activities	NA		NA		NA		NA		NA		NA		45	30.20
No, I do not see any barriers	5	3.36	6	4.03	8	5.37	9	6.04	9	6.04	22	14.77	8	5.37

TABLE A4.2.
Upper-middle-income countries (N=61)

STEPS	①		②.1		②.2		②.3		③		④		⑤	
	ICOPE screening		In-depth IC assessment (e.g. limited mobility)		Assessment and management of diseases		Assessment and management of social and physical environment		Develop care plan		Follow-up and referral		Community engagement	
	n	%	n	%	n	%	n	%	n	%	n	%	n	%
Local requirements to implement ICOPE														
Need staff	37	60.70	35	57.38	37	60.70	44	72.13	37	60.66	33	54.10	47	77.05
Need training	47	77.00	41	67.21	42	68.90	41	67.21	47	77.05	42	68.85	NA	
Need space	10	16.40	11	18.03	12	19.70	19	31.15	8	13.11	NA		NA	
Need administrative support	NA		NA		NA		NA		NA		11	18.03	NA	
Enablers to ICOPE steps														
Support from local government	31	50.82	25	40.98	18	29.51	28	45.90	25	40.98	21	34.43	38	62.30
Support from civil society organizations	17	27.87	12	19.67	13	21.31	20	32.79	20	32.79	20	32.79	33	54.10
Support from academic associations such as medical associations	24	39.34	21	34.43	27	44.26	27	44.26	23	37.70	22	36.07	30	49.18
Local mechanism/system is in place for timely referral	21	34.43	20	32.79	26	42.62	22	36.07	22	36.07	32	52.46	26	42.62
Local network among multidisciplinary stakeholders	29	47.54	32	52.46	20	32.79	33	54.10	35	57.38	32	52.46	31	50.82
Training provided by local, national authorities	30	49.18	41	67.21	25	40.98	23	37.70	23	37.70	21	34.43	NA	
Availability of ICOPE screening/assessment tool in local language	36	59.02	29	47.54	NA		NA		NA		NA		NA	
Proactive engagement of older people and their caregivers	46	75.41	44	72.13	38	62.30	41	67.21	40	65.57	41	67.21	40	65.57
Local and/or global platform to share the experience	15	24.59	11	18.03	11	18.03	17	27.87	18	29.51	10	16.39	16	26.23
Mobile ICOPE handbook app and data dashboard	28	45.90	27	44.26	24	39.34	18	29.51	21	34.43	17	27.87	NA	
Financial incentives or reimbursement for this activity	28	45.90	19	31.15	20	32.79	21	34.43	15	24.59	16	26.23	18	29.51
Access to telehealth for this activity	24	39.34	20	32.79	20	32.79	14	22.95	19	31.15	21	34.43	15	24.59
Access to essential medicines	NA		11	18.03	17	27.87	9	14.75	15	24.59	12	19.67	NA	
Access to assistive technology	NA		21	34.43	24	39.34	15	24.59	18	29.51	11	18.03	NA	

STEPS	①		②.1		②.2		②.3		③		④		⑤	
	ICOPE screening		In-depth IC assessment (e.g. limited mobility)		Assessment and management of diseases		Assessment and management of social and physical environment		Develop care plan		Follow-up and referral		Community engagement	
	n	%	n	%	n	%	n	%	n	%	n	%	n	%

Barriers to ICOPE steps

Additional time required	36	59.02	39	63.93	33	54.10	36	59.02	34	55.74	34	55.74	36	59.02
Limited space for conducting the evaluation along with routine activities	18	29.51	18	29.51	17	27.87	NA		NA		NA		NA	
Lack of available staff	38	62.30	36	59.02	34	55.74	35	57.38	34	55.74	26	42.62	33	54.10
Reimbursement for additional time and staff	20	32.79	18	29.51	18	29.51	22	36.07	23	37.70	25	40.98	30	49.18
Lack of knowledge and training to conduct this activity	29	47.54	26	42.62	25	40.98	28	45.90	26	42.62	NA		NA	
Lack of integration in digital information platform (medical record, health record, social care needs)	24	39.34	23	37.70	26	42.62	26	42.62	27	44.26	30.5	50.00	NA	
Competition, redundancy or conflict with other health services	5	8.20	7	11.48	7	11.48	6	9.84	8	13.11	23.18	38.00	7	11.48
Reaching to older people is difficult	4	6.56	NA		NA		NA		NA		NA		NA	
Screening/assessment tool needs to be adapted to local context	20	32.79	18	29.51	NA		17	27.87	NA		NA		NA	
Lack of infrastructure and system to provide integrated health and social care	NA		NA		NA		31	50.82	32	52.46	NA		NA	
No information on community activities	NA		NA		NA		NA		NA		NA		27	44.26
No, I do not see any barriers	8	13.11	9	14.75	13	21.31	7	11.48	9	14.75	12	19.67	13	21.31

TABLE A4.3.
Lower-middle-income countries (N=50)

STEPS	①		②.1		②.2		②.3		③		④		⑤	
	ICOPE screening		In-depth IC assessment (e.g. limited mobility)		Assessment and management of diseases		Assessment and management of social and physical environment		Develop care plan		Follow-up and referral		Community engagement	
	n	%	n	%	n	%	n	%	n	%	n	%	n	%
Local requirements to implement ICOPE														
Need staff	16	32.00	42	84.00	42	84.00	47	94.00	43	86.00	36	72.00	46	92.00
Need training	43	86.00	41	82.00	42	84.00	45	90.00	43	86.00	37	74.00	NA	
Need space	18	36.00	23	46.00	22	44.00	28	56.00	26	52.00	NA		NA	
Need administrative support	NA		NA		NA		NA		NA		20	40.00	NA	
Enablers to ICOPE steps														
Support from local government	29	58.00	25	50.00	27	54.00	35	70.00	32	64.00	27	54.00	40	80.00
Support from civil society organizations	23	46.00	20	40.00	19	38.00	23	46.00	23	46.00	23	46.00	31	62.00
Support from academic associations such as medical associations	17	34.00	19	38.00	18	36.00	19	38.00	20	40.00	18	36.00	21	42.00
Local mechanism/system is in place for timely referral	22	44.00	20	40.00	25	50.00	23	46.00	24	48.00	24	48.00	24	48.00
Local network among multidisciplinary stakeholders	16	32.00	34	68.00	19	38.00	19	38.00	22	44.00	25	50.00	28	56.00
Training provided by local, national authorities	29	58.00	22	44.00	24	48.00	26	52.00	27	54.00	23	46.00	NA	
Availability of ICOPE screening/assessment tool in local language	19	38.00	17	34.00	NA		NA		NA		NA		NA	
Proactive engagement of older people and their caregivers	32	64.00	29	58.00	33	66.00	34	68.00	33	66.00	25	50.00	36	72.00
Local and/or global platform to share the experience	15	30.00	15	30.00	14	28.00	17	34.00	15	30.00	12	24.00	15	30.00
Mobile ICOPE handbook app and data dashboard	29	58.00	28	56.00	28	56.00	22	44.00	25	50.00	18	36.00	NA	
Financial incentives or reimbursement for this activity	20	40.00	17	34.00	17	34.00	21	42.00	19	38.00	16	32.00	16	32.00
Access to telehealth for this activity	17	34.00	13	26.00	17	34.00	11	22.00	10	20.00	12	24.00	14	28.00
Access to essential medicines	NA		17	34.00	18	36.00	18	36.00	17	34.00	14	28.00	NA	
Access to assistive technology	NA		18	36.00	17	34.00	19	38.00	20	40.00	13	26.00	NA	

STEPS	①		②.1		②.2		②.3		③		④		⑤	
	ICOPE screening		In-depth IC assessment (e.g. limited mobility)		Assessment and management of diseases		Assessment and management of social and physical environment		Develop care plan		Follow-up and referral		Community engagement	
	n	%	n	%	n	%	n	%	n	%	n	%	n	%

Barriers to ICOPE steps

Additional time required	27	54.00	27	54.00	30	60.00	27	54.00	32	64.00	22	44.00	31	62.00
Limited space for conducting the evaluation along with routine activities	20	40.00	23	46.00	28	56.00	NA		NA		NA		NA	
Lack of available staff	26	52.00	29	58.00	28	56.00	29	58.00	29	58.00	25	50.00	28	56.00
Reimbursement for additional time and staff	23	46.00	22	44.00	22	44.00	25	50.00	24	48.00	19	38.00	25	50.00
Lack of knowledge and training to conduct this activity	27	54.00	20	40.00	19	38.00	27	54.00	25	50.00	NA		NA	
Lack of integration in digital information platform (medical record, health record, social care needs)	17	34.00	22	44.00	19	38.00	18	36.00	19	38.00	25	50.00	NA	
Competition, redundancy or conflict with other health services	9	18.00	6	12.00	8	16.00	9	18.00	9	18.00	19	38.00	7	14.00
Reaching to older people is difficult	19	38.00	NA		NA		NA		NA		NA		NA	
Screening/assessment tool needs to be adapted to local context	24	48.00	19	38.00	NA		23	46.00	NA		NA		NA	
Lack of infrastructure and system to provide integrated health and social care	NA		NA		NA		28	56.00	31	62.00	NA		NA	
No information on community activities	NA		NA		NA		NA		NA		NA		25	50.00
No, I do not see any barriers	3	6.00	6	12.00	7	14.00	5	10.00	6	12.00	10	20.00	6	12.00

TABLE A4.4.
African region (N=17)

STEPS	①		②.1		②.2		②.3		③		④		⑤	
	ICOPE screening		In-depth IC assessment (e.g. limited mobility)		Assessment and management of diseases		Assessment and management of social and physical environment		Develop care plan		Follow-up and referral		Community engagement	
	n	%	n	%	n	%	n	%	n	%	n	%	n	%
Local requirements to implement ICOPE														
Need staff	6	35.30	14	82.35	10	58.80	15	88.24	13	76.47	6	35.29	14	82.35
Need training	14	82.40	14	82.35	11	64.70	13	76.47	14	82.35	8	47.06	NA	
Need space	2	11.80	4	23.53	5	29.40	7	41.18	6	35.29	NA		NA	
Need administrative support	NA		NA		NA		NA		NA		8	47.06	NA	
Enablers to ICOPE steps														
Support from local government	4	23.53	3	17.65	4	23.53	9	52.94	8	47.06	6	35.29	10	58.82
Support from civil society organizations	6	35.29	3	17.65	3	17.65	7	41.18	5	29.41	5	29.41	10	58.82
Support from academic associations such as medical associations	5	29.41	5	29.41	4	23.53	2	11.76	4	23.53	6	35.29	4	23.53
Local mechanism/system is in place for timely referral	6	35.29	6	35.29	5	29.41	6	35.29	4	23.53	8	47.06	7	41.18
Local network among multidisciplinary stakeholders	6	35.29	11	64.71	7	41.18	10	58.82	9	52.94	9	52.94	11	64.71
Training provided by local, national authorities	13	76.47	6	35.29	10	58.82	8	47.06	8	47.06	8	47.06	NA	
Availability of ICOPE screening/assessment tool in local language	9	52.94	6	35.29	NA		NA		NA		NA		NA	
Proactive engagement of older people and their caregivers	10	58.82	9	52.94	10	58.82	12	70.59	11	64.71	10	58.82	13	76.47
Local and/or global platform to share the experience	5	29.41	3	17.65	6	35.29	6	35.29	6	35.29	5	29.41	7	41.18
Mobile ICOPE handbook app and data dashboard	6	35.29	6	35.29	7	41.18	5	29.41	8	47.06	5	29.41	NA	
Financial incentives or reimbursement for this activity	4	23.53	3	17.65	2	11.76	4	23.53	4	23.53	3	17.65	3	17.65
Access to telehealth for this activity	7	41.18	5	29.41	5	29.41	5	29.41	5	29.41	4	23.53	2	11.76
Access to essential medicines	NA		4	23.53	5	29.41	4	23.53	7	41.18	2	11.76	NA	
Access to assistive technology	NA		4	23.53	5	29.41	7	41.18	7	41.18	2	11.76	NA	

STEPS	①		②.1		②.2		②.3		③		④		⑤	
	ICOPE screening		In-depth IC assessment (e.g. limited mobility)		Assessment and management of diseases		Assessment and management of social and physical environment		Develop care plan		Follow-up and referral		Community engagement	
	n	%	n	%	n	%	n	%	n	%	n	%	n	%

Barriers to ICOPE steps

Additional time required	7	41.18	11	64.71	9	52.94	7	41.18	10	58.82	6	35.29	10	58.82
Limited space for conducting the evaluation along with routine activities	3	17.65	5	29.41	5	29.41	NA		NA		NA		NA	
Lack of available staff	9	52.94	10	58.82	8	47.06	9	52.94	7	41.18	7	41.18	9	52.94
Reimbursement for additional time and staff	6	35.29	5	29.41	2	11.76	1	5.88%	3	17.65	1	5.88	6	35.29
Lack of knowledge and training to conduct this activity	13	76.47	8	47.06	7	41.18	7	41.18	7	41.18	NA		NA	
Lack of integration in digital information platform (medical record, health record, social care needs)	8	47.06	11	64.71	9	52.94	5	29.41	5	29.41	8.5	50.00	NA	
Competition, redundancy or conflict with other health services	2	11.76	3	17.65	3	17.65	2	11.76	2	11.76	6.46	38.00	2	11.76
Reaching to older people is difficult	4	23.53	NA		NA		NA		NA		NA		NA	
Screening/assessment tool needs to be adapted to local context	4	23.53	2	11.76	NA		6	35.29	NA		NA		NA	
Lack of infrastructure and system to provide integrated health and social care	NA		NA		NA		7	41.18	8	47.06	NA		NA	
No information on community activities	NA		NA		NA		NA		NA		NA		8	47.06
No, I do not see any barriers	2	11.76	5	29.41	6	35.29	4	23.53	5	29.41	6	35.29	4	23.53

TABLE A4.5.
Region of the Americas (N=52)

STEPS	①		②.1		②.2		②.3		③		④		⑤	
	ICOPE screening		In-depth IC assessment (e.g. limited mobility)		Assessment and management of diseases		Assessment and management of social and physical environment		Develop care plan		Follow-up and referral		Community engagement	
	n	%	n	%	n	%	n	%	n	%	n	%	n	%
Local requirements to implement ICOPE														
Need staff	24	46.15	25	48.00	40	76.90	31	60.00	31	60.00	32	62.00	34	65.00
Need training	36	69.20	33	63.00	41	78.80	31	60.00	36	69.23	32	62.00	NA	
Need space	32	38.50	26	50.00	26	50.00	26	50.00	22	42.00	NA		NA	
Need administrative support	NA		NA		NA		NA		NA		26	50.00	NA	
Enablers to ICOPE steps														
Support from local government	22	42.30	16	31.00	17	33.00	24	46.00	23	44.00	15	29.00	29	56.00
Support from civil society organizations	14	26.90	12	23.00	10	19.00	18	35.00	16	31.00	12	23.00	24	46.00
Support from academic associations such as medical associations	17	32.70	16	31.00	19	37.00	22	42.00	17	33.00	17	33.00	20	38.00
Local mechanism/system is in place for timely referral	11	21.20	12	23.00	13	25.00	17	33.00	14	27.00	23	44.00	16	31.00
Local network among multidisciplinary stakeholders	36	69.20	19	37.00	15	29.00	38	73.00	34	65.00	33	63.00	39	75.00
Training provided by local, national authorities	14	26.90	45	87.00	13	25.00	15	29.00	13	25.00	14	27.00	NA	
Availability of ICOPE screening/assessment tool in local language	23	44.20	20	38.00	NA		NA		NA		NA		NA	
Proactive engagement of older people and their caregivers	39	75.00	35	67.00	28	54.00	32	62.00	33	63.00	26	50.00	38	73.00
Local and/or global platform to share the experience	16	30.80	13	25.00	16	31.00	13	25.00	13	25.00	12	23.00	14	27.00
Mobile ICOPE handbook app and data dashboard	22	42.30	22	42.00	21	40.00	15	29.00	22	42.00	18	35.00	NA	
Financial incentives or reimbursement for this activity	16	30.80	13	25.00	12	23.00	10	19.00	9	17.00	8	15.00	10	19.00
Access to telehealth for this activity	13	25.00	10	19.00	13	25.00	9	17.00	13	25.00	11	21.00	6	12.00
Access to essential medicines	NA		10	19.00	21	40.00	15	29.00	17	33.00	14	27.00	NA	
Access to assistive technology	NA		16	31.00	17	33.00	8	15.00	16	31.00	14	27.00	NA	

STEPS	①		②.1		②.2		②.3		③		④		⑤	
	ICOPE screening		In-depth IC assessment (e.g. limited mobility)		Assessment and management of diseases		Assessment and management of social and physical environment		Develop care plan		Follow-up and referral		Community engagement	
	n	%	n	%	n	%	n	%	n	%	n	%	n	%

Barriers to ICOPE steps

Additional time required	31	59.62	31	59.62	30	57.69	35	67.31	34	65.38	26	50.00	34	65.38
Limited space for conducting the evaluation along with routine activities	17	32.69	25	48.08	20	38.46	NA		NA		NA		NA	
Lack of available staff	29	55.77	26	50.00	33	63.46	24	46.15	27	51.92	24	46.15	26	50.00
Reimbursement for additional time and staff	15	28.85	14	26.92	15	28.85	14	26.92	12	23.08	15	28.85	16	30.77
Lack of knowledge and training to conduct this activity	23	44.23	16	30.77	24	46.15	17	32.69	19	36.54	NA		NA	
Lack of integration in digital information platform (medical record, health record, social care needs)	19	36.54	17	32.69	20	38.46	12	11.54	21	40.38	18	34.62	NA	
Competition, redundancy or conflict with other health services	9	17.31	8	15.38	7	13.46	13	12.50	8	15.38	7	13.46	7	13.46
Reaching to older people is difficult	3	5.77	NA		NA		NA		NA		NA		NA	
Screening/assessment tool needs to be adapted to local context	17	32.69	9	17.31	NA		20	19.23	NA		NA		NA	
Lack of infrastructure and system to provide integrated health and social care	NA		NA		NA		42	40.38	25	48.08	NA		NA	
No information on community activities	NA		NA		NA		NA		NA		NA		13	25.00
No, I do not see any barriers	3	5.77	4	7.69	6	11.54	8	7.69	4	7.69	9	17.31	8	15.38

STEPS	①		②.1		②.2		②.3		③		④		⑤	
	ICOPE screening		In-depth IC assessment (e.g. limited mobility)		Assessment and management of diseases		Assessment and management of social and physical environment		Develop care plan		Follow-up and referral		Community engagement	
	n	%	n	%	n	%	n	%	n	%	n	%	n	%
Additional time required	4	80.00	4	80.00	3	60.00	4	80.00	3	60.00	3	60.00	3	60.00
Limited space for conducting the evaluation along with routine activities	3	60.00	2	40.00	1	20.00	NA		NA		NA		NA	
Lack of available staff	2	40.00	2	40.00	2	40.00	3	60.00	2	40.00	1	20.00	2	40.00
Reimbursement for additional time and staff	1	20.00	1	20.00	1	20.00	2	40.00	2	40.00	1	20.00	1	20.00
Lack of knowledge and training to conduct this activity	3	60.00	3	60.00	3	60.00	2	40.00	2	40.00	NA		NA	
Lack of integration in digital information platform (medical record, health record, social care needs)	2	40.00	1	20.00	1	20.00	1	20.00	2	40.00	1	20.00	NA	
Competition, redundancy or conflict with other health services	5	100.00	5	100.00	5	100.00	5	100.00	5	100.00	5	100.00	5	100.00
Reaching to older people is difficult	5	100.00	NA		NA		NA		NA		NA		NA	
Screening/assessment tool needs to be adapted to local context	3	60.00	3	60.00	NA		3	60.00	NA		NA		NA	
Lack of infrastructure and system to provide integrated health and social care	NA		NA		NA		2	40.00	1	20.00	NA		NA	
No information on community activities	NA		NA		NA		NA		NA		NA		5	100.00
No, I do not see any barriers	0	0	0	0	1	20.00	0	0	1	20.00	1	20.00	1	20.00

TABLE A4.7.
European region (N=105)

STEPS	①		②.1		②.2		②.3		③		④		⑤	
	ICOPE screening		In-depth IC assessment (e.g. limited mobility)		Assessment and management of diseases		Assessment and management of social and physical environment		Develop care plan		Follow-up and referral		Community engagement	
	n	%	n	%	n	%	n	%	n	%	n	%	n	%
Local requirements to implement ICOPE														
Need staff	30	28.80	69	66.35	68	65.40	73	70.19	80	76.92	59	56.73	82	78.85
Need training	71	68.30	67	64.42	65	62.50	68	65.38	72	69.23	57	54.81	NA	
Need space	32	30.80	40	38.46	37	35.60	53	50.96	45	43.27	NA		NA	
Need administrative support	NA		NA		NA		NA		NA		48	45.71	NA	
Enablers to ICOPE steps														
Support from local government	32	30.77	31	29.81	21	20.19	39	37.50	37	35.58	17	16.35	69	66.35
Support from civil society organizations	28	26.92	24	23.08	19	18.27	35	33.65	37	35.58	15	14.42	64	61.54
Support from academic associations such as medical associations	29	27.88	22	21.15	25	24.04	30	28.85	29	27.88	29	27.88	35	33.65
Local mechanism/system is in place for timely referral	33	31.73	26	25.00	29	27.88	31	29.81	34	32.69	33	31.73	38	36.54
Local network among multidisciplinary stakeholders	52	50.00	61	58.65	32	30.77	46	44.23	56	53.85	45	43.27	53	50.96
Training provided by local, national authorities	44	42.31	64	61.54	35	33.65	42	40.38	41	39.42	29	27.88	NA	
Availability of ICOPE screening/assessment tool in local language	51	49.04	50	48.08	NA		NA		NA		NA		NA	
Proactive engagement of older people and their caregivers	76	73.08	61	58.65	58	55.77	63	60.58	75	72.12	52	50.00	68	65.38
Local and/or global platform to share the experience	34	32.69	33	31.73	33	31.73	38	36.54	35	33.65	31	29.81	42	40.38
Mobile ICOPE handbook app and data dashboard	40	38.46	45	43.27	41	39.42	33	31.73	30	28.85	25	24.04	NA	
Financial incentives or reimbursement for this activity	43	41.35	34	32.69	27	25.96	32	30.77	32	30.77	25	24.04	29	27.88
Access to telehealth for this activity	39	37.50	27	25.96	36	34.62	28	26.92	34	32.69	32	30.77	19	18.27
Access to essential medicines	NA		14	13.46	28	26.92	24	23.08	16	15.38	19	18.27	NA	
Access to assistive technology	NA		26	25.00	28	26.92	17	16.35	29	27.88	26	25.00	NA	

STEPS	①		②.1		②.2		②.3		③		④		⑤	
	ICOPE screening		In-depth IC assessment (e.g. limited mobility)		Assessment and management of diseases		Assessment and management of social and physical environment		Develop care plan		Follow-up and referral		Community engagement	
	n	%	n	%	n	%	n	%	n	%	n	%	n	%

Barriers to ICOPE steps

Additional time required	72	69.23	77	74.04	75	72.12	71	68.27	74	71.15	69	66.35	72	69.23
Limited space for conducting the evaluation along with routine activities	34	32.69	36	34.62	30	28.85	NA		NA		NA		NA	
Lack of available staff	66	63.46	64	61.54	61	58.65	60	57.69	66	63.46	58	55.77	68	65.38
Reimbursement for additional time and staff	36	34.62	38	36.54	36	34.62	45	43.27	42	40.38	31	29.81	36	34.62
Lack of knowledge and training to conduct this activity	45	43.27	41	39.42	36	34.62	37	35.58	28	26.92	NA		NA	
Lack of integration in digital information platform (medical record, health record, social care needs)	31	29.81	32	30.77	26	25.00	29	27.88	31	29.81	42	40.38	NA	
Competition, redundancy or conflict with other health services	14	13.46	16	15.38	13	12.50	13	12.50	18	17.31	14	13.46	13	12.50
Reaching to older people is difficult	19	18.27	NA		NA		NA		NA		NA		NA	
Screening/assessment tool needs to be adapted to local context	28	26.92	25	24.04	NA		30	28.85	NA		NA		NA	
Lack of infrastructure and system to provide integrated health and social care	NA		NA		NA		43	41.35	47	45.19	NA		NA	
No information on community activities	NA		NA		NA		NA		NA		NA		35	33.65
No, I do not see any barriers	5	4.81	4	3.85	6	5.77	7	6.73	7	6.73	17	16.35	7	6.73

TABLE A4.8.
South-East Asia region (N=18)

STEPS	①		②.1		②.2		②.3		③		④		⑤	
	ICOPE screening		In-depth IC assessment (e.g. limited mobility)		Assessment and management of diseases		Assessment and management of social and physical environment		Develop care plan		Follow-up and referral		Community engagement	
	n	%	n	%	n	%	n	%	n	%	n	%	n	%
Local requirements to implement ICOPE														
Need staff	7	38.90	14	78.00	15	83.30	17	94.00	14	78.00	11	61.00	16	89.00
Need training	17	94.40	15	83.00	15	83.30	16	89.00	14	78.00	11	61.00	NA	
Need space	11	61.10	12	67.00	10	55.60	13	72.00	10	56.00	NA		NA	
Need administrative support	NA		NA		NA		NA		NA		4	22.22	NA	
Enablers to ICOPE steps														
Support from local government	11	61.10	7	39.00	9	50.00	13	72.00	9	50.00	10	56.00	14	78.00
Support from civil society organizations	8	44.40	6	33.00	6	33.00	9	50.00	9	50.00	8	44.00	13	72.00
Support from academic associations such as medical associations	8	44.40	6	33.00	6	33.00	12	67.00	9	50.00	7	39.00	13	72.00
Local mechanism/system is in place for timely referral	8	44.40	7	39.00	11	61.00	10	56.00	10	56.00	12	67.00	11	61.00
Local network among multidisciplinary stakeholders	4	22.20	10	56.00	9	50.00	11	61.00	12	67.00	10	56.00	10	56.00
Training provided by local, national authorities	13	72.20	9	50.00	10	56.00	12	67.00	12	67.00	9	50.00	NA	
Availability of ICOPE screening/assessment tool in local language	13	72.20	10	56.00	NA		NA		NA		NA		NA	
Proactive engagement of older people and their caregivers	12	66.70	13	72.00	13	72.00	13	72.00	14	78.00	12	67.00	14	78.00
Local and/or global platform to share the experience	7	38.90	7	39.00	6	33.00	9	50.00	7	39.00	7	39.00	8	44.00
Mobile ICOPE handbook app and data dashboard	8	44.40	11	61.00	11	61.00	8	44.00	8	44.00	7	39.00	NA	
Financial incentives or reimbursement for this activity	8	44.40	8	44.00	7	39.00	10	56.00	8	44.00	7	39.00	7	39.00
Access to telehealth for this activity	7	38.90	6	33.00	8	44.00	8	44.00	7	39.00	9	50.00	9	50.00
Access to essential medicines	NA		9	50.00	9	50.00	11	61.00	7	39.00	9	50.00	NA	
Access to assistive technology	NA		8	44.00	7	39.00	7	39.00	8	44.00	7	39.00	NA	

STEPS	①		②.1		②.2		②.3		③		④		⑤	
	ICOPE screening		In-depth IC assessment (e.g. limited mobility)		Assessment and management of diseases		Assessment and management of social and physical environment		Develop care plan		Follow-up and referral		Community engagement	
	n	%	n	%	n	%	n	%	n	%	n	%	n	%

Barriers to ICOPE steps

Additional time required	13	72.22	12	66.67	14	77.78	13	72.22	16	88.89	13	72.22	15	83.33
Limited space for conducting the evaluation along with routine activities	11	61.11	13	72.22	14	77.78	NA		NA		NA		NA	
Lack of available staff	10	55.56	14	77.78	15	83.33	15	83.33	15	83.33	12	66.67	14	77.78
Reimbursement for additional time and staff	7	38.89	8	44.44	6	33.33	11	61.11	11	61.11	12	66.67	9	50.00
Lack of knowledge and training to conduct this activity	11	61.11	10	55.56	11	61.11	13	72.22	11	61.11	NA		NA	
Lack of integration in digital information platform (medical record, health record, social care needs)	7	38.89	8	44.44	8	44.44	11	61.11	11	61.11	10	55.56	NA	
Competition, redundancy or conflict with other health services	3	16.67	3	16.67	6	33.33	5	27.78	5	27.78	5	27.78	4	22.22
Reaching to older people is difficult	7	38.89	NA		NA		NA		NA		NA		NA	
Screening/assessment tool needs to be adapted to local context	11	61.11	11	61.11	NA		13	72.22	NA		NA		NA	
Lack of infrastructure and system to provide integrated health and social care	NA		NA		NA		13	72.22	11	61.11	NA		NA	
No information on community activities	NA		NA		NA		NA		NA		NA		14	77.78
No, I do not see any barriers	0	0	0	0	1	5.56	0	0	0	0	2	11.11	0	0

TABLE A4.9.
Western Pacific region (N=64)

STEPS	①		②.1		②.2		②.3		③		④		⑤	
	ICOPE screening		In-depth IC assessment (e.g. limited mobility)		Assessment and management of diseases		Assessment and management of social and physical environment		Develop care plan		Follow-up and referral		Community engagement	
	n	%	n	%	n	%	n	%	n	%	n	%	n	%
Local requirements to implement ICOPE														
Need staff	19	29.70	43	67.00	46	71.90	53	83.00	45	70.00	48	75.00	53	83.00
Need training	52	81.30	49	77.00	48	75.00	51	80.00	55	86.00	56	88.00	NA	
Need space	12	18.80	17	27.00	16	25.00	21	33.00	16	25.00	NA		NA	
Need administrative support	NA		NA		NA		NA		NA		16	25.00	NA	
Enablers to ICOPE steps														
Support from local government	37	57.80	35	55.00	8	42.00	31	48.00	32	50.00	30	47.00	44	69.00
Support from civil society organizations	24	37.50	19	30.00	6	31.00	22	34.00	25	39.00	28	44.00	34	53.00
Support from academic associations such as medical associations	25	39.10	26	41.00	8	47.00	29	45.00	26	41.00	24	38.00	25	39.00
Local mechanism/system is in place for timely referral	24	37.50	20	31.00	8	45.00	25	39.00	26	41.00	27	42.00	29	45.00
Local network among multidisciplinary stakeholders	26	40.60	42	66.00	6	31.00	24	38.00	28	44.00	30	47.00	31	48.00
Training provided by local, national authorities	26	40.60	39	61.00	6	34.00	23	36.00	25	39.00	24	38.00	NA	
Availability of ICOPE screening/assessment tool in local language	25	39.10	22	34.00	NA		NA		NA		NA		NA	
Proactive engagement of older people and their caregivers	45	70.30	40	63.00	11	63.00	41	64.00	37	58.00	37	58.00	36	56.00
Local and/or global platform to share the experience	16	25.00	14	22.00	3	19.00	17	27.00	18	28.00	12	19.00	15	23.00
Mobile ICOPE handbook app and data dashboard	35	54.70	34	53.00	9	48.00	26	41.00	29	45.00	22	34.00	NA	
Financial incentives or reimbursement for this activity	34	53.10	23	36.00	7	41.00	27	42.00	23	36.00	22	34.00	23	36.00
Access to telehealth for this activity	18	28.10	16	25.00	5	27.00	8	13.00	13	20.00	17	27.00	14	22.00
Access to essential medicines	NA		13	20.00	4	20.00	7	11.00	12	19.00	12	19.00	NA	
Access to assistive technology	NA		21	33.00	6	34.00	18	28.00	18	28.00	12	19.00	NA	

STEPS	①		②.1		②.2		②.3		③		④		⑤	
	ICOPE screening		In-depth IC assessment (e.g. limited mobility)		Assessment and management of diseases		Assessment and management of social and physical environment		Develop care plan		Follow-up and referral		Community engagement	
	n	%	n	%	n	%	n	%	n	%	n	%	n	%

Barriers to ICOPE steps

Additional time required	41	64.06	38	59.38	11	60.94	35	54.69	36	56.25	36	56.25	38	59.38
Limited space for conducting the evaluation along with routine activities	20	31.25	22	34.38	6	34.38	NA		NA		NA		NA	
Lack of available staff	34	53.13	32	50.00	8	46.88	35	54.69	36	56.25	29	45.31	35	54.69
Reimbursement for additional time and staff	31	48.44	26	40.63	9	48.44	33	51.56	31	48.44	29	45.31	36	56.25
Lack of knowledge and training to conduct this activity	27	42.19	24	37.50	6	32.81	27	42.19	30	46.88	NA		NA	
Lack of integration in digital information platform (medical record, health record, social care needs)	20	31.25	18	28.13	7	37.50	20	31.25	24	37.50	36	56.25	NA	
Competition, redundancy or conflict with other health services	9	14.06	7	10.94	2	12.50	9	14.06	10	15.63	16	25.00	8	12.50
Reaching to older people is difficult	11	17.19	NA		NA		NA		NA		NA		NA	
Screening/assessment tool needs to be adapted to local context	24	37.50	19	29.69	NA		17	26.56	NA		NA		NA	
Lack of infrastructure and system to provide integrated health and social care	NA		NA		NA		38	59.38	42	65.63	NA		NA	
No information on community activities	NA		NA		NA		NA		NA		NA		24	42.19
No, I do not see any barriers	6	9.38	8	12.50	2	12.50	6	9.38	7	10.94	9	14.06	7	10.94

ANNEX 5: Attitudes towards implementation of ICOPE and changes to clinical practice

This annex gives fuller information to supplement the summary data presented in the main part of this report (Table 4).

FIGURE A5.1.
Implementation attitudes (15 items) by country income levels

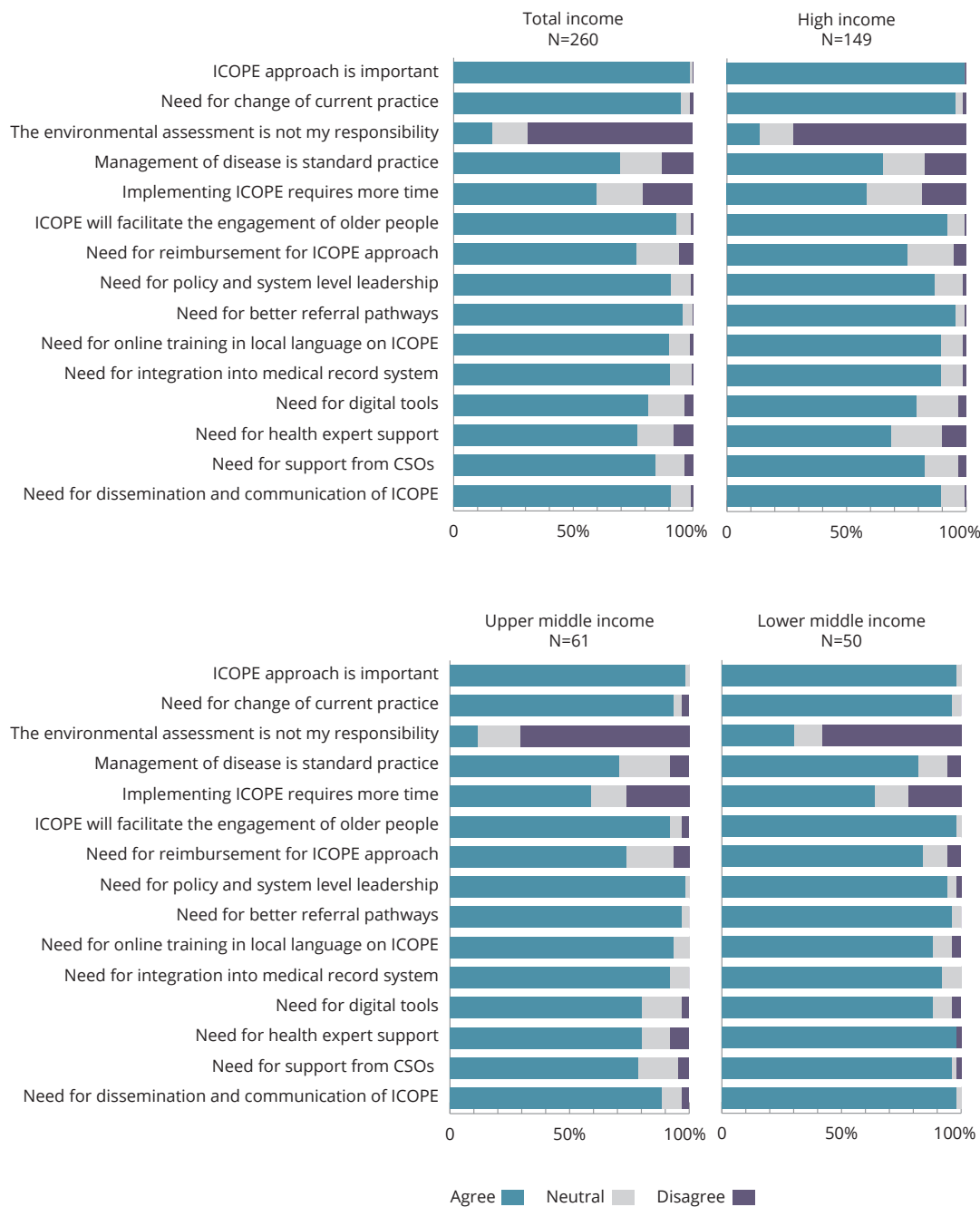


FIGURE A5.2.
Implementation attitudes (15 items) by WHO region



ANNEX 6: Implementation readiness by WHO region

This annex gives fuller information to supplement the summary data presented in the main part of this report (Figures 11 and 12).

FIGURE A6.1.
Overall services and systems implementation readiness

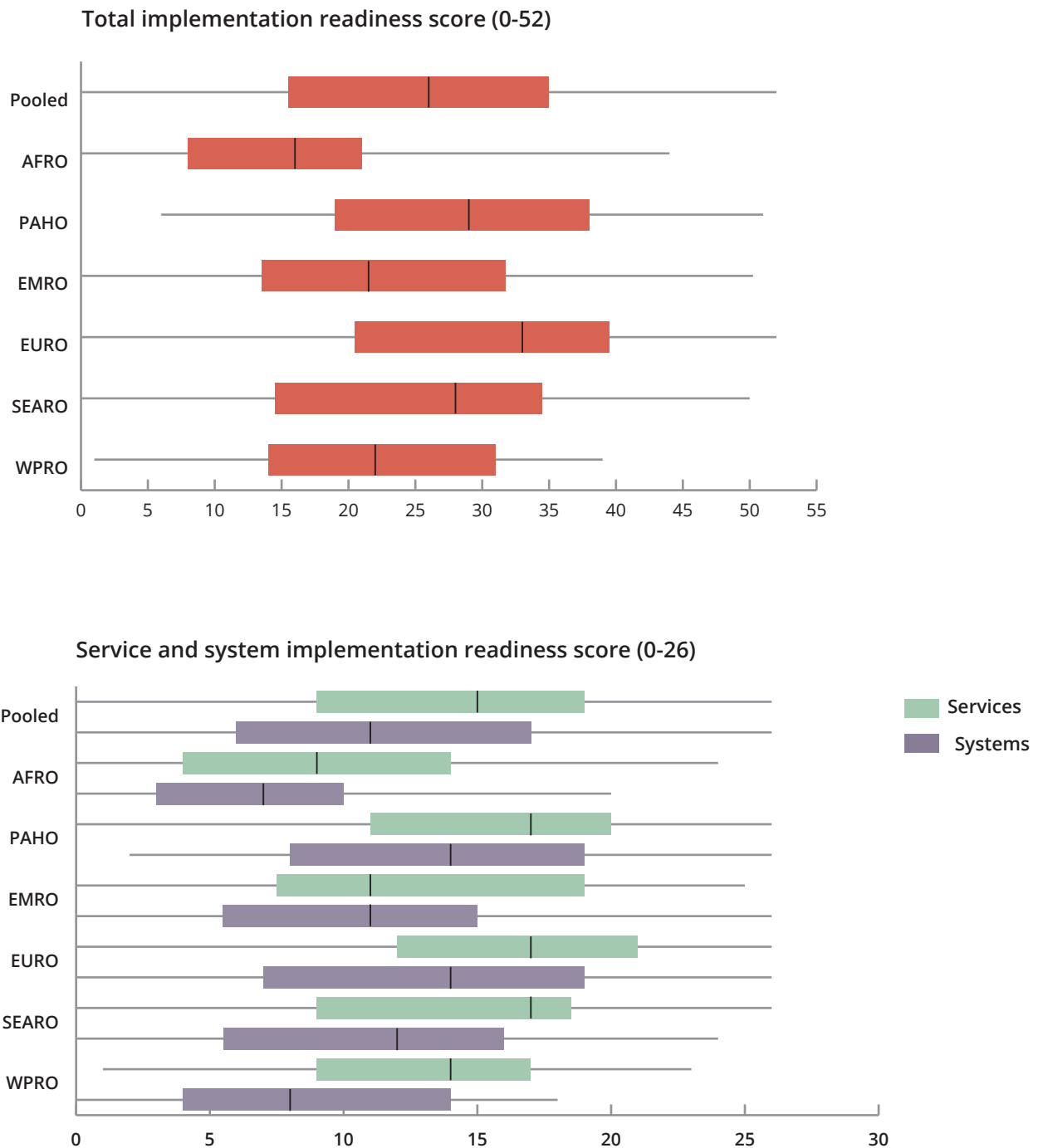
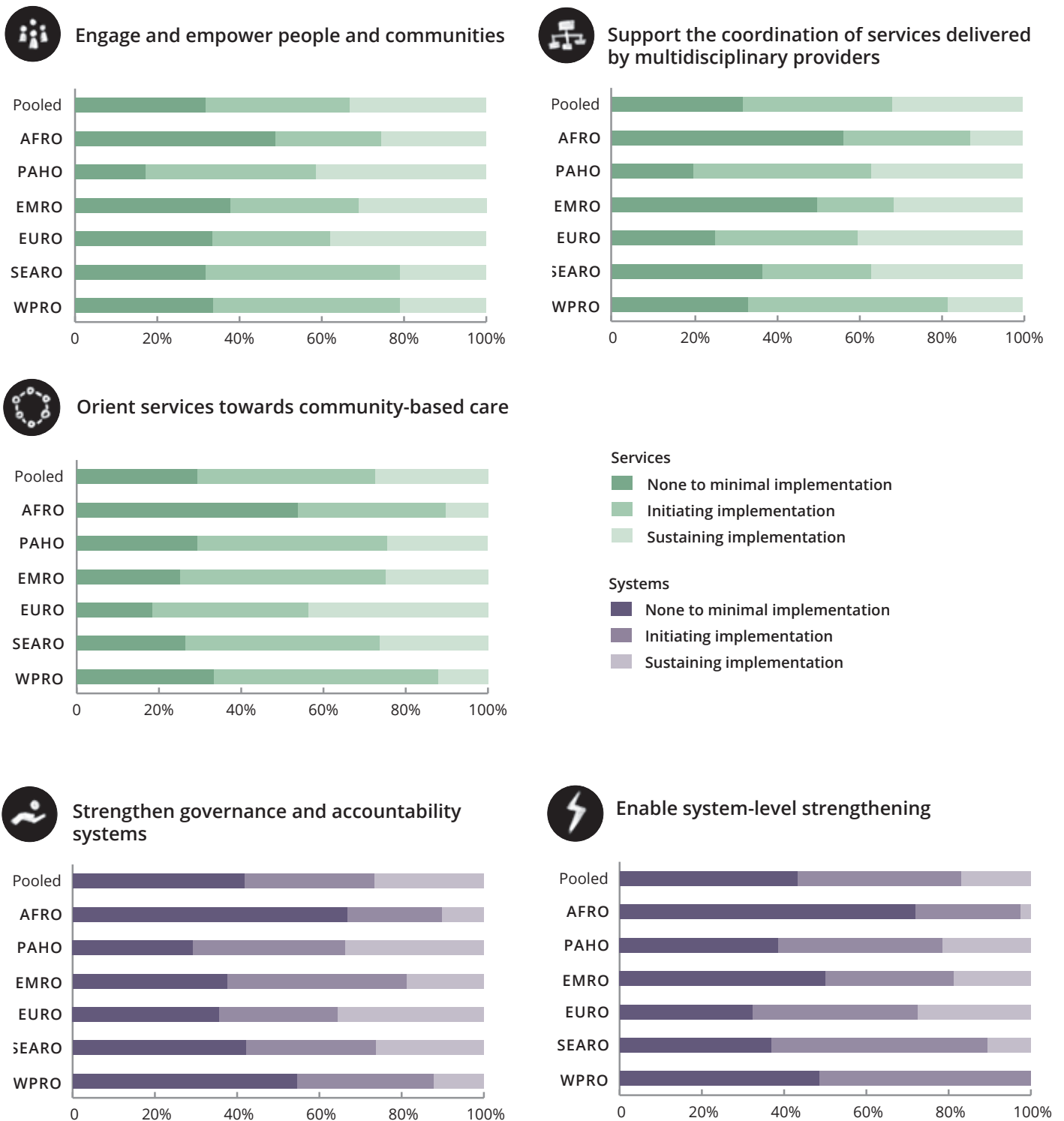


FIGURE A6.2.
Implementation readiness for three service-level themes and two system-level themes



ANNEX 7: Implementation readiness by specific actions

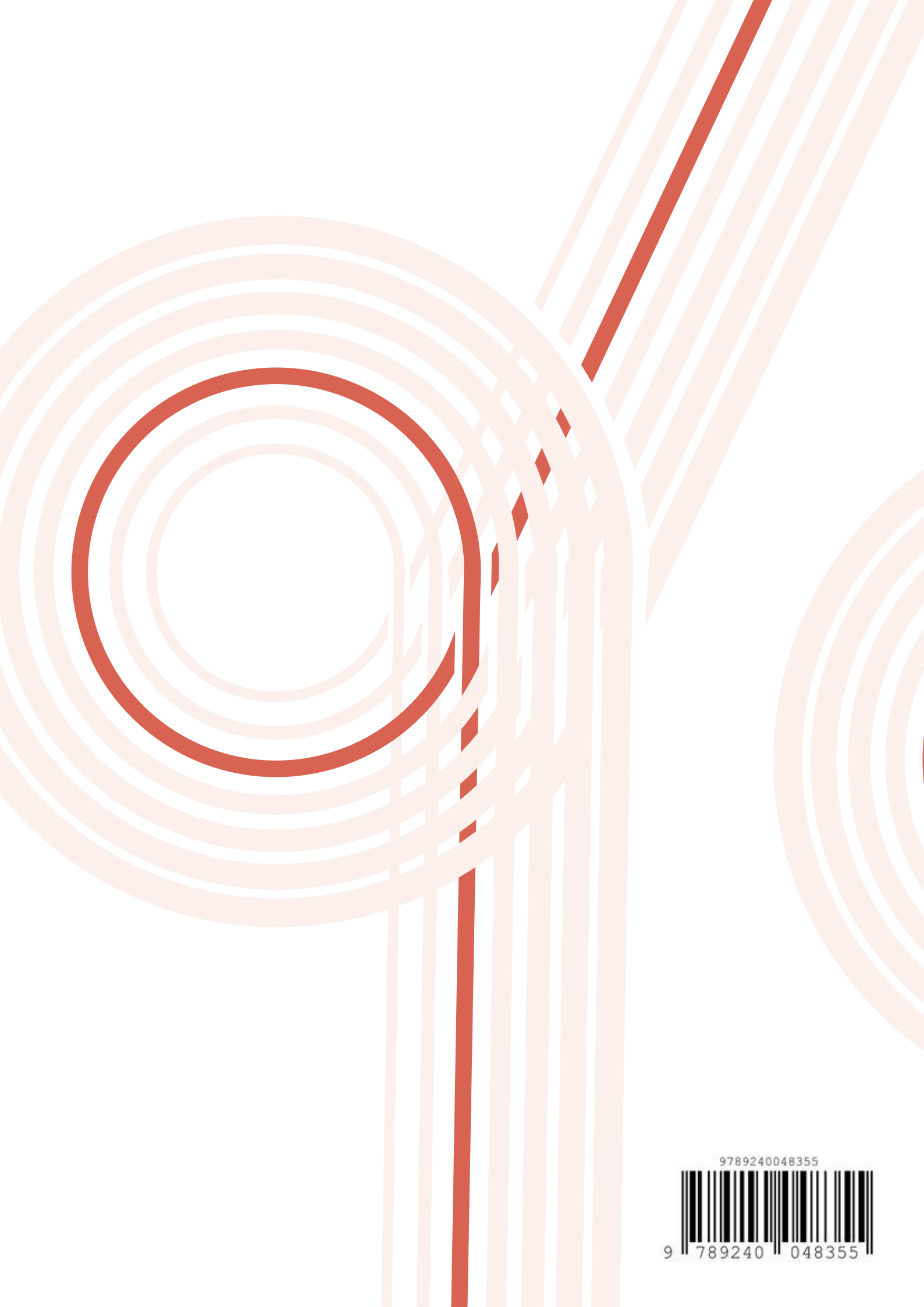
This annex gives fuller information to supplement the summary data presented in the main part of this report (Figure 12).

FIGURE A7.1.
Implementation readiness under specific service and system actions by country income levels



FIGURE A7.2.
Implementation readiness under specific service and system actions
by WHO regions





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