Integrated Care for Older People

A manual for primary care physicians (Facilitator's Guide)
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Populations across the WHO South-East Asia Region are ageing. Whereas in 2010 older people accounted for 8% of the Region’s population, by 2017 they accounted for 9.8%. This number will continue to rise, with older people expected to make up 13.7 percent of the population by 2030 – or 289 million people – and a significant 20.3% by 2050. Though the proportion of older people in the Region is projected to remain below global levels, the speed of the Region’s demographic transition is faster.

To ensure all older people can access quality health services, health workers must be equipped to provide dedicated care to older people. WHO’s 2021-2030 “Decade of Healthy Ageing” is clear: all countries must focus on ensuring the human resources necessary for integrated care. To do this, pre-service and in-service training for health workers, especially at the primary health care level, is crucial.

This manual is designed to help primary health care physicians in the Region provide the health services required for older people. The manual has 16 modules, each of them addressing a specific area of care. The contents are in line with the ICOPE (Integrated Care for Older People) approach to old age care, which proposes evidence-based recommendations for health care professionals to prevent, slow or reverse declines in the physical and mental capacities of older people.

By adopting and implementing the manual, policymakers and administrators will help ensure primary health care in the Region can meet the challenges of today and prepare for the challenges of tomorrow. WHO stands committed to supporting Member States in the Region as together we strive to achieve health for all at all ages.
Background and objectives of the training programme

Introduction

This manual is an instruction guide for facilitators to provide competence-based training to primary care physician (PCP) for integrated care of older people. The training is intended to assist the physician to learn and improve upon their skills to screen, assess as well as manage various physical, psychological as well as social aspects of old age care.

Facilitators are required to consult both the Facilitator’s Guide and the Trainee’s Manual while training participants through interactive presentations, group discussions, role plays etc. The Facilitator’s Guide contains detailed training methodologies, structure of the individual training sessions and guidelines for assessment of trainees. The Trainee’s Handbook contains different modules to assist trainees with step-by-step learning of various aspects of old age care. Training resources are based on the “Integrated Care for Older People” (ICOPE) manual for primary care physicians which will be the primary reference book for trainees. Henceforth, the book will be referred to as WHO Guidance book (WGB) in this document. Facilitators should be conversant with the contents of the WHO Guidance book since all the modules in the Trainee’s Handbook are linked to the corresponding chapters and the practice sheets in the practice guidelines.

Overall aim

The overall aim is to orient PCP to the special characteristics of older people and to appropriate approaches to addressing their health needs and problems. This will strengthen the abilities of PCP to respond to older people more effectively and with greater sensitivity. It is expected that the training programme will significantly contribute to building national and regional capacity on older people health and development.

Training objectives

The training module has been designed in a comprehensive manner to provide a holistic approach to short term human resource development with focus on in-service PCP, who provide care to older people in different levels of health-care facilities. The information on old age care contained in these modules is meant to be incorporated into the everyday clinical practice of PCP. The training package will be useful for the knowledge as well as skill enhancement of the PCP. The training is expected to improve the approach to issues of old age and act as a
stimulant for the holistic care of which will ultimately improve their quality of life. The objectives include both knowledge enhancement and skills development. After completion of the training, trainees will be able to:

» Perform screening of intrinsic capacity.
» Perform assessment of intrinsic capacity and functional status.
» Provide preventive, promotive, curative as well as rehabilitative services to the older people based on the available resources.
» Ensure appropriate follow-up of older people.

Knowledge-based objectives
By the end of the training, trainees will be able to:

» Describe the important concepts in geriatrics and gerontology.
» Describe the alteration in pharmacological properties with ageing.
» Describe the physical, psychological as well as social aspects of ageing and their clinical implications.
» Management of common morbidities of old age comprehensively.

Skill-based objectives
By the end of the training, trainees will be able to:

» Perform the screening as well as assessment of intrinsic capacities as well as functional status in older people.
» Provide preventive, promotive as well as rehabilitative services to older people presenting in primary care centres.
» Manage common morbidities of old age with the available resources.
» Manage the caregiver burden syndrome.
» Conduct follow-up of the older person after the management of morbidity.
» Provide counselling for appropriate referral.

Intended beneficiaries
This manual is intended for the licensed physicians working in the primary health care facility. The training module has been designed in a comprehensive manner to provide a holistic approach to short term human resource development with focus on in-service physician, who provide care to older people in different levels of health care facilities. The information on old age care
contained in these modules is meant to be incorporated into the everyday clinical practice of physician. The training package will be useful for the knowledge as well as skill enhancement of the physician. The training is expected to improve the approach to old age health and act as a stimulant for the holistic care to enhance quality of life through an integrated plan.

**Expected outcomes**

It is expected that primary care physicians who participate in the training programme will:

» Become more knowledgeable about the characteristics of older people and of different aspects of older people health and health related issues.

» Become more sensitive to the needs of older peoples.

» Be better equipped with facts and figures to argue for increased investment in older people health and development.

» Be better able to provide health services to older peoples that respond to their needs and are sensitive to their preferences.

» Have prepared a personal plan indicating the changes they will make in their work.

» The training programme is not intended to equip physicians with specific clinical or counselling skills in older people’s health care. In practical terms, it will provide participants with ideas and practical tips to two key questions:

» What do I as a primary care physician need to know and do differently if the older person who walks into my clinic is aged 60 years, rather than six or 36?

» How could I help other influential people in my community to understand and respond better to the needs and problems of older peoples?

**Components of the Facilitator’s Guide**

The training programme is designed to be implemented mainly in a programme context. It is intended to be a dynamic and interactive programme in which facilitators actively engage the participants in the teaching/learning process. A range of teaching and learning methods has been carefully selected to enable this to happen in an effective manner. This Facilitator’s Guide provides essential information to the organizers and facilitators to plan and implement the training programme.

**Aims of the Facilitator’s Guide**

» To provide information on planning and preparing for the programme.

» To provide an overview of the teaching and learning methods used in the programme.

» To give detailed instructions for conducting individual modules.
Components of the Facilitator’s Guide

The guide consists of two parts:

» Part I. Planning and preparing
» Part II. Guidelines for conducting individual modules

Part I: Planning and preparing

Part I is organized in seven sections as follows

Section I
» Introduction: Provides an overview on the content of the programme

Section II
» Designing the structure and content of the training programme and methodologies

Section III
» Training methodologies

Section IV
» Assessment of trainee

Section V
Inviting participants and other contributors: Provides suggestions on inviting the participants and other contributors to the training programme, with specific suggestions on:

» Drawing on the expertise of specialists
» Planning a formal opening ceremony
» Involving older peoples.

Section VI
» Planning of the training programme

Section VII
Evaluation methods for a training programme, providing an overview of programme evaluation methods:

» To measure the participants’ reactions
» To measure changes in the participants’ knowledge
To measure changes in the participants’ practice

Follow-up questionnaire

Part II: Guideline for conducting the individual module/training programme

Part II includes the module schedule and the “step-by-step instructions” to run each of the sessions. It also includes all the support materials needed to run the module, such as slides with accompanying talking points, flip charts and their contents, and case-study materials with notes on issues that they raise. Finally, it includes tips for you to help you respond to questions that may be raised by participants, identifies matters that may be sensitive and about how to deal with them.

Module 1: Integrated care for older people (ICOPE)

Module 2: Functional assessment of older adults

Module 3: Health promotion and disease prevention in old age

Module 4: Cardiovascular system

Module 5: Respiratory system

Module 6: Digestive system

Module 7: Endocrine system

Module 8: Musculoskeletal system

Module 9: Genitourinary system

Module 10: Neurological diseases of old age

Module 11: Brain ageing and cognitive impairment

Module 12: Mental health

Module 13: Sensory system

Module 14: Cancer and palliative care

Module 15: Elder abuse

Module 16: Long-term care and caregiver issues
Part I:
Planning and preparation
Introduction to the training programme
Contents of the training programme

The training programme consists of core modules which have been developed according to the need; it is necessary for all participants in the training programme to go through the core modules. This is because they cover the essential topics that will equip the participants with the knowledge and understanding they need to achieve the overall aims of the Programme.

Trainee’s profile

This training is intended for the physicians [completed undergraduate degree e.g. Bachelor of Medicine and Bachelor of Surgery (MBBS) or equivalent] working in the primary health care facility.

Facilitator’s profile

Facilitators should have adequate knowledge and skills in the concerned subjects. They should undergo training of trainers to be conversant with objectives, methodologies, session plans and the training materials. It is preferable that facilitators have training in training technology. They should be conversant with the management of medical issues of older adults in their respective countries/region. The facilitator should preferably be a geriatrician with a Master’s degree in geriatric medicine or an internist/general practitioner with some formal training in geriatric medicine.

Course coordinator

One of the facilitators will be designated as course coordinator whose responsibilities will be as follows:

- check the audio-visual system for proper functioning
- check availability of all training aids
- ensure that sessions are conducted as per schedule
- introduce the course
- oversee administrative aspects including record maintenance
- check for general facilities like running water, washrooms, power back-up, refreshments etc.
- check functioning of all equipment
- check availability of adequate number of instruments and adequate number of consumables, including those required for simulation sessions.

Batch size of trainees and number of facilitators

The total number of trainees should be 25–30 per batch. The number of facilitators per batch should be at least four.
**Training materials**

The following training materials will be provided:


» Flash drives containing the PowerPoint presentations, digital images, videos of various assessment tests and electronic copies of ICOPE Handbooks: Guidance on person-centred assessment and pathways in primary care.

» Flip charts

**Checklist of equipment and supplies required for the training**

<table>
<thead>
<tr>
<th>S.N.</th>
<th>Items</th>
<th>Remarks</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Folders for trainees containing:</td>
<td></td>
</tr>
<tr>
<td></td>
<td>» Trainee’s Handbook containing the modules for different training sessions</td>
<td></td>
</tr>
<tr>
<td></td>
<td>» Trainee’s log sheets</td>
<td></td>
</tr>
<tr>
<td></td>
<td>» Flash drives containing PowerPoint presentations, WHO-ICOPE Handbook</td>
<td></td>
</tr>
<tr>
<td></td>
<td>» Pen, pencil, eraser, sharpener</td>
<td></td>
</tr>
<tr>
<td></td>
<td>» Writing pad</td>
<td></td>
</tr>
<tr>
<td></td>
<td>» Agenda for the training programme</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>Name tags of trainees and facilitators</td>
<td></td>
</tr>
<tr>
<td></td>
<td>» Attendance sheet for trainees and facilitators</td>
<td></td>
</tr>
<tr>
<td></td>
<td>» Pens, pencils, A4-sized paper, note pads, staplers, punching machine, cello tape</td>
<td></td>
</tr>
<tr>
<td></td>
<td>» Laptop, LCD projector, extension cords, projection screen</td>
<td></td>
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<tr>
<td></td>
<td>» Microphone, podium,</td>
<td></td>
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<tr>
<td></td>
<td>» Flip charts and stand, marking pens – various colours, large clips to hold flip chart paper</td>
<td></td>
</tr>
<tr>
<td></td>
<td>» White board, duster, chart papers, tapes for posting papers on boards</td>
<td></td>
</tr>
<tr>
<td></td>
<td>» PowerPoint presentations, images for demonstration, flash cards</td>
<td></td>
</tr>
<tr>
<td></td>
<td>» Print outs of pre- and post-training knowledge assessment questionnaires, checklists, log sheets</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>For demonstration sessions</td>
<td></td>
</tr>
<tr>
<td></td>
<td>» Standees per group</td>
<td></td>
</tr>
<tr>
<td></td>
<td>» A4 print of ICOPE care pathways</td>
<td></td>
</tr>
</tbody>
</table>
## Training site

The training should be held in a well-equipped hall. The readiness of a proposed training site should be assessed by a competent person using the checklist provided below.

<table>
<thead>
<tr>
<th>S.N.</th>
<th>Items</th>
<th>Remarks</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td><strong>Infrastructure for classroom teaching:</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td>- Hall with minimum seating capacity of 35 (to accommodate 25–30</td>
<td></td>
</tr>
<tr>
<td></td>
<td>trainees, 4-5 facilitators and 1-2 observers), seating arrangement</td>
<td></td>
</tr>
<tr>
<td></td>
<td>preferably U-shaped</td>
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</tr>
<tr>
<td></td>
<td>- Classroom should be well-lit and ventilated</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- Lights and fans or air-conditioner in working condition</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- Audio-visual facilities in classroom</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- Electricity (sockets and extension cords)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- Electrical power backup</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- Drinking water supply and toilet facilities.</td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>Training aids</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Audio visual aids with accessories</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- LCD projector</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- TV monitor or projection screen</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- Microphone.</td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>Other teaching aids</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td>- Staplers, highlighters, stapler pins, punching machine, scissors</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- A4 size plain papers</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- Colored sticky labels, cello tapes</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- White board, marker pens and duster</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- Standee with A0 ICOPE care pathways.</td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>Computer facilities</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td>- Internet facility accessible to trainees</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- Printer</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- Photocopier</td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>Miscellaneous items</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td>- Chairs without arm rest (one per group)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- Stop watch (one per group)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- Measuring tape (to measure a 4 m distance)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- WHO Simple Eye Chart.</td>
<td></td>
</tr>
</tbody>
</table>
## Duration of training

The total duration of the training will be two days. Details of the training schedule and session plans are given in later sections.

### Dos and don’ts for facilitators:

<table>
<thead>
<tr>
<th>DO</th>
<th>DON’T</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Be conversant with the session plan and the training materials prior to start of training</strong></td>
<td><strong>Make adverse/negative comments on any trainee</strong></td>
</tr>
<tr>
<td><strong>Ensure that the training site is ready prior to onset of training</strong></td>
<td><strong>Be shy, nervous or worried</strong></td>
</tr>
<tr>
<td><strong>Maintain friendly and supportive environment</strong></td>
<td><strong>Use one-way teaching without any interaction</strong></td>
</tr>
<tr>
<td><strong>Call trainees by their name as much as possible</strong></td>
<td><strong>Ignore trainee’s queries</strong></td>
</tr>
<tr>
<td><strong>Speak clearly and loudly</strong></td>
<td><strong>Make presentations without facing the trainees or avoiding eye contact with them</strong></td>
</tr>
<tr>
<td><strong>Spend enough time with trainees so that all their queries can be answered</strong></td>
<td><strong>Use teaching aids or materials other than the prescribed ones</strong></td>
</tr>
<tr>
<td><strong>Give simple and clear instructions to trainees</strong></td>
<td><strong>Rush through any of the sessions</strong></td>
</tr>
<tr>
<td><strong>Ensure clear visualization of the presentations/demonstrations by all trainees</strong></td>
<td></td>
</tr>
</tbody>
</table>
Designing the structure and content of the training programme
This section contains the information you will need for developing the content and structure of the programme. There is flexibility in the structure and duration of the programme, together with a choice of health issues/topics (optional modules) to include. Given this modular structure, it is possible to adapt the programme to any context.

**Developing the structure and content of a two-day programme**

<table>
<thead>
<tr>
<th>Time</th>
<th>Session title</th>
<th>Method</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Day 1</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8:30–9:00</td>
<td>Registration</td>
<td></td>
</tr>
<tr>
<td>9:00–10:00</td>
<td>Opening session</td>
<td></td>
</tr>
<tr>
<td>10:00–10:45</td>
<td>Pre-training assessment of the trainees</td>
<td>MCQ-based</td>
</tr>
<tr>
<td>10:45–11:15</td>
<td>Health of the older people and geriatric medicine</td>
<td>PPT presentation</td>
</tr>
<tr>
<td>11:15–11:45</td>
<td>Integrated care for older people (ICOPE)</td>
<td>PPT and animation video</td>
</tr>
<tr>
<td>11:45–12:15</td>
<td>Functional assessment in older adults</td>
<td>PPT and animation video</td>
</tr>
<tr>
<td>12:15–12:45</td>
<td>ICOPE based screening of intrinsic capacities and functional ability</td>
<td>Role play</td>
</tr>
<tr>
<td>12:45–13:30</td>
<td>Break</td>
<td></td>
</tr>
<tr>
<td>13:30–14:00</td>
<td>Health promotion and disease prevention in old age</td>
<td>PPT</td>
</tr>
<tr>
<td>14:00–14:30</td>
<td>Cardiovascular system</td>
<td>PPT</td>
</tr>
<tr>
<td>14:30–15:00</td>
<td>Respiratory system</td>
<td>PPT</td>
</tr>
<tr>
<td>15:00–15:15</td>
<td>Break</td>
<td></td>
</tr>
<tr>
<td>15:15–15:45</td>
<td>Genitourinary system</td>
<td>PPT</td>
</tr>
<tr>
<td>15:45–16:15</td>
<td>Endocrine system</td>
<td>PPT</td>
</tr>
<tr>
<td>16:15–16:45</td>
<td>Hypertension and diabetes mellitus management in old age</td>
<td>Case based discussion</td>
</tr>
<tr>
<td>16:45–17:15</td>
<td>Digestive system</td>
<td>PPT</td>
</tr>
<tr>
<td>17:15–17:30</td>
<td>Wrap up of day 1</td>
<td>Course coordinator</td>
</tr>
<tr>
<td>Time</td>
<td>Topic</td>
<td>Format</td>
</tr>
<tr>
<td>--------------</td>
<td>----------------------------------------------------------------------</td>
<td>-----------------------</td>
</tr>
<tr>
<td>8:30–9:00</td>
<td>Musculoskeletal system</td>
<td>PPT</td>
</tr>
<tr>
<td>9:00–9:30</td>
<td>ICOPE based Locomotive capacity assessment and management</td>
<td>Role play</td>
</tr>
<tr>
<td>9:30–10:00</td>
<td>Neurological diseases of old age</td>
<td>PPT</td>
</tr>
<tr>
<td>10:00–10:45</td>
<td>Brain ageing and cognitive Impairment</td>
<td>PPT</td>
</tr>
<tr>
<td>10:45–11:15</td>
<td>ICOPE-based cognitive capacity assessment &amp; management</td>
<td>Role play and animation</td>
</tr>
<tr>
<td>11:15–11:45</td>
<td>Mental health in old age</td>
<td>PPT</td>
</tr>
<tr>
<td>11:45–12:30</td>
<td>ICOPE based psychological capacity assessment and management</td>
<td>Role play</td>
</tr>
<tr>
<td>12:30–13:00</td>
<td>Sensory system in old age</td>
<td>PPT</td>
</tr>
<tr>
<td>13:00–13:45</td>
<td>Break</td>
<td></td>
</tr>
<tr>
<td>13:45–14:15</td>
<td>ICOPE based sensory capacity assessment &amp; management</td>
<td>Role play</td>
</tr>
<tr>
<td>14:15–14:45</td>
<td>Cancer and palliative care</td>
<td>PPT</td>
</tr>
<tr>
<td>14:45–15:15</td>
<td>Break</td>
<td></td>
</tr>
<tr>
<td>15:15–15:45</td>
<td>Elder abuse</td>
<td>PPT</td>
</tr>
<tr>
<td>15:45–16:15</td>
<td>Long-term care &amp; caregiver issues</td>
<td>PPT</td>
</tr>
<tr>
<td>16:15–16:45</td>
<td>Post-training assessment of the trainees.</td>
<td>MCQ based</td>
</tr>
<tr>
<td>16:45–17:00</td>
<td>Closure session</td>
<td></td>
</tr>
</tbody>
</table>
Training methodologies
Introduction

The training on “Integrated care for older people” (ICOPE) involves knowledge development through interactive presentations and skill enhancement through facilitated group learning activities and clinical sessions. Training sessions should be conducted as per a predetermined schedule, and adherence to this schedule is important for timely and efficient conduct of the sessions. Facilitators should meet daily after all the sessions are over to review the day’s activities and plan for the next day’s training and to ensure availability of all training materials and teaching aids. All facilitators should agree about each other’s’ roles and responsibilities prior to the start of the training.

Role of facilitators

Learn in an active way, equal relationship between participants and those who run the programme when working with other facilitators. It is important that everyone agrees before the programme starts about the facilitator’s roles and responsibilities and who is responsible for which sessions. It is a good idea for facilitators to change their roles so that the participants can experience a change of style and voice.

It would be useful to stress to the participants that they must decide what is useful and important to them and their work. You are not supposed to tell anyone what to do; you can only advise them and give the support and the space to make up his or her own mind. The programme requires range of methods and approaches like short mini lectures to conduct role plays, stimulating problem-solving exercises in small groups.

Ground rules for participatory learning

- Treating everyone with respect at all times, irrespective of cultural, age or sex differences
- Ensuring and respecting confidentiality
Criteria for selecting the training programme facilitators

Having two or three facilitators for a programme, exposes the participants to different styles. The facilitators can also change roles between the main facilitator and co-facilitator.

Content areas of the modules on older peoples’ health issues

Below you will find information on the teaching methods used in the modules. Each module (independently of a number of formal sessions) has four main components:

» Introductory
» Input
» Participatory
» Concluding.
Introductory component: Module introduction

This opening session sets the stage for the module. It allows you to share with the participants the overall aim and objectives of the module and any special remarks about it. Participants will also have an opportunity to complete the spot checks for that module.

Input component: Mini lecture(s) and module handout

A mini lecture provides an opportunity for efficiently providing participants with the basic information that they need. For each mini lecture, some of the following resources are available:

» Slides on global aspects of the health issue – you will need to make your own slides on regional and country specific information;

» Handouts (reading material containing information to complement what is provided during the module);

» Additional references are usually listed at the end of the handout of each module.

In every module, there are a few mini lectures distributed across the sessions, to provide inputs on different aspects of the health issue covered.

The effectiveness of the mini-lectures can be increased by ensuring the following:

- Clear presentation and structure
- Good visual aids
- Clear and comprehensible language
The session will be more effective when the presentation (PPT) made is brief and addresses the key issues about the health issue, with particular reference to the local situation. It would be a good idea to allow adequate time for questions and discussion in plenary. Ask participants to review the handout and questions in small groups, and then discuss their findings in plenary. Distribute the handout at the start of the session. Allow adequate time for this and for plenary discussion of the questions in the handout – or for specific issues raised by the participants.

**Participatory component: Various participatory methods to explore the topic in more depth**

This training programme includes a balanced mix of methods order to maximize the participants' interaction and benefit. Few points are listed below:

» Filtering the points participants make as you write them up on a flip chart.

» Small group work ensures that every participant has an opportunity to contribute to the discussion and to work through the thought processes for him/herself. Each facilitator is able to trouble-shoot problems, re-focus the discussion, and respond to questions.
Visualization in participatory programmes (VIPP)

Cards of different sizes, colours and shapes should be used to show linkages between ideas and areas of consensus and disagreement. Rules for VIPP card-writing are:

» Write only one idea per card
» Write a maximum of three lines on each card
» Use key words
» Write large letters in both upper and lower case
» Write legibly
» Use different sizes, shapes and coloured cards to creatively structure the results of discussions
» Follow the colour code established by the facilitator for different categories of ideas to put down their responses to a question, the question asked be clear and unambiguous.

The use of cards enables the responses to be organized in a logical way and to show areas of consensus and disagreement allows all participants the opportunity to express themselves. VIPP methods are also used to evaluate how participants feel the programme is progressing and more information is provided in the section on evaluation methods. In this case, long sheets of plain wrapping paper can be obtained and prepared in advance. This would include cutting them in different sizes and shapes needed for VIPP exercises.

Brainstorming/buzz groups

It helps quickly generate ideas which can be used as a basis for later discussion. This technique is often used at the beginning of a session the responses are usually written on a flip chart or on VIPP cards, which at a later stage can be organized to show the themes that emerged from the exercise. Once this has been done, the ideas can be examined and discussed. It is important to decide in advance why you want the participants to brainstorm and what you will go on to do. Your initial brainstorming question should be clear and unambiguous. About 10 to 15 minutes is right, and make sure that everyone has the opportunity to contribute.

Role play

It provides an opportunity for the expression of emotions which cannot be achieved through discussion alone. Given the limited time available for each role play – only 3–5 minutes – it can illustrate both the problems and the ways of dealing with them. For example:

» The facilitators and/or participants can use role play to demonstrate “bad practice” or “model good practice”. A problem-identification tool, in which everyone in the role play is familiar with the scenario and role play the difficulties it illustrates. Again, this would normally occur in plenary, although small groups could also use it to develop their problem identification skills.
A means to practise clinical or counselling skills, or problem-solving role play for skills practice is best undertaken in groups of three, working in groups of three enables each person, in turn, to practise health-worker skills. “Real” situations relevant to them by asking participants to write a “difficult moment” on the card; the cards are then displayed on the wall or read aloud by the facilitator, maintaining anonymity.

Begin by asking the group to think about what they, as health-care providers (not the older peoples), would find most difficult when dealing with older peoples on the particular health issue. Ask them to focus on the interaction with an older people, or the family, rather than on abstract issues. Typical examples might be an older people who is:

- Too anxious to speak
- Angry or ashamed, and so unwilling to be there
- Afraid of a clinical examination
- With family who will not let him/her speak freely to the health-care provider.

Let the group select one or two such difficulties to illustrate typical problems faced in dealing with older people, and ways to overcome such difficulties. Ask for volunteers to play the roles in the chosen situation, explaining exactly what the health-care provider’s task is: to illustrate bad practice as part of a problem-solving exercise or work on good practice. In any case, explain that they will be expected to demonstrate a “typical” reaction, not an ideal one. Ask the volunteers to choose a name, age and sex. Start the first role play with the arrival of the older people to see how he or she is greeted by the health-care provider. Let the role play run for 3–5 minutes. The facilitator should observe, especially, what the healthcare provider does or says that makes a difference in the way the elderly reacts, what kind of “body language” is used by both health-care provider and elderly, what attitude the healthcare provider displays towards the adolescent and any family members, and any difficulties the health-care provider experiences.

Afterwards, ask the role players to stay where they are until the discussion is over. Be sure to thank and praise the role players, and then ask them to come out of their roles, i.e. say who they really are. Explain to the group that this is important to diminish the surprisingly powerful effect role plays can have on the players afterwards. Next, ask that comments be focused on what happened in the role play, not on general issues that can be taken up later. Begin by asking each of the role players how they felt in the role (in addition to what they thought). When they have finished, ask the group for their reactions. If necessary, refer to any behaviour that was significant and ask people to comment on it. Demonstrate that you expect people to give helpful positive and negative feedback. When the group has finished commenting, go back to the role players to give them the “last word”.

**Running the first role play session**

Although the participants should have the maximum opportunity for role playing, they may feel less inhibited if the facilitator begins by very briefly demonstrating bad practices.
Intervening if a role play becomes difficult
Occasionally, it may happen that someone involved in a role play becomes deeply emotional. Please do all you can to reassure the participants that they must go no further than they feel comfortable, and they are free to stop and come out of the role at any time. The facilitator requires tact, empathy and acute observation.

Case studies
Each case study should contain set of questions. Always remember to allow the participants sufficient time for read and answer questions, which are put directly to the participants, or provided to them in a “task sheet”. Devise a list of “good” and “bad” health-care practices based on the case studies. Ask each group to write up their agreed points on a flip chart and report their findings in plenary. Ask each group in turn for one point of feedback and write this up on a flip chart. Repeat the process until no one has anything more to add.

Guided discussions
Following the group work, it is likely that most participants will have in mind a range of ideas for change when they return to their work situation.

» Initially ask them to work alone, or in pairs or small groups, or even (if there is little time remaining) in plenary. After working alone or in pairs, the participants might move on to a bigger group to pull together ideas before finally sharing them in plenary.

» Separate tasks for each pair or small group it also provides an opportunity for each group to challenge, alter or affirm the solutions of others.

» Your role is to facilitate proper discussion by the whole group. This requires a careful balance between intervening and “taking a back seat”, noting on a flip chart or cards the main points as they occur, asking open-ended questions and directing the discussion.

» Draw out contributions from the shy or more silent participants can state their views, experiences and worries honestly and without fear of disapproval the group to summarize the main points that arise, or do this yourself.

Concluding component: Module review
It is important, at the end of each module, to summarize the key points brought out in the plenary discussion and group work. It is also necessary to go back to the module’s objectives and ask the participants to say whether they feel that these have been fully met. The section on evaluation methods gives some good examples of how you can obtain feedback.
Assessment of trainees
Introduction

Assessment of trainees is an essential component of training that helps in assessing if trainees have achieved the desired levels of knowledge and skills. The purpose of assessment is to analyse gaps in both training and learning processes.

It is recommended that the assessment of trainees be carried out in two phases:

a) Pre-training assessment, and
b) Post-training assessment.

The purpose of the pre-training assessment is to understand focused training needs and determine areas that require improvement. It helps to monitor progress towards achieving training objectives more effectively and efficiently.

Final assessment helps to assess how effective training efforts have been in enhancing the knowledge and related skills of trainees and to what extent the objectives of the training have been achieved. It also helps to determine how competently trainees would be able to provide integrated care to the older people when they return to their own place of work. The process of assessment includes knowledge assessment to be conducted in the classroom using assessment questionnaires having multiple-choice questions.

Guidelines for conducting knowledge assessment

Preparation

Keep the following ready for knowledge assessment in the classroom:

» Copies of the assessment questionnaire – you may use the sample questionnaire given in this manual or develop your own set of MCQs based on the sample MCQs given at the end of each module.

» Print outs of knowledge assessment matrix (Box 4.1).

» Flip charts, stand and marker pens

How to conduct the knowledge assessment?

» Inform trainees about the purpose of the assessment (pre or post, as appropriate).

» Brief them on the components of the knowledge assessment process and the order in which each component would be reviewed. (Trainees may be informed about the purpose of the assessment and the process to be followed a day prior to allow them to be prepared).

» Distribute the assessment questionnaire comprising 20 questions to all trainees and explain how to tick the correct responses.
» One mark should be allotted for each correct response and there should be no negative marking.

» Allow 20 minutes to answer the questions.

» Collect all the completed questionnaires after the specified time.

» Ask trainees to respond to all the questions by putting a tick \( \checkmark \) against the correct response on the assessment form.

» Collect all the completed forms.

» Evaluation of the responses in the submitted assessment questionnaires can be done immediately after the assessment or may be done later at a more convenient time.

» Trainees can evaluate each other’s responses.

» Identify knowledge gaps from the assessment matrix sheets and write them down on the flip chart.

» Thank trainees after the knowledge assessment.

**Box 4.1: Knowledge assessment matrix**

<table>
<thead>
<tr>
<th>Trainee</th>
<th>Correct response to question no.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1</td>
</tr>
<tr>
<td>1</td>
<td></td>
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<td>13</td>
<td></td>
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<tr>
<td>14</td>
<td></td>
</tr>
</tbody>
</table>
Note: Mark ‘X’ in the row of each participant for questions that have a correct response
Inviting participants and other contributors
Selection of participants

It would be useful to invite physicians from different specialities. This would enhance the opportunity for information-sharing and networking during the programme, and for post-programme collaboration. As part of your preparation for the training program, we would like you to spend some time thinking through the questions given below please jot down some notes and bring them with you to the programme.

» For what kind of health issues do older peoples come to you or are brought to you?

» What challenges have you faced, if any, when dealing with elderly and their families?

» What difficulties do you think elderly might face in using health services?

» What else would you like to know about elderly health?

Its purpose is to prepare participants for the training programme, by asking them to reflect on their current work with older people. Potential candidates should be invited one to two weeks in advance of the programme. A useful way to deal with this in the context of the training programme is to invite a small group of older people to participate throughout the programme. It is advised to invite an appropriate group of local older people, perhaps from a community group of elders, to participate in the programme. It is important to have both male and female older people represented. Once they are selected, it is necessary to meet them before the programme and introduce them to their roles during the programme. Some suggestions are given below.

Before the programme

Explain the themes and purpose of the training programme and how they could contribute. Reinforce their important contribution as equal participants in the programme, regardless of their background.

During the programme

The facilitation team (of 2–3 individuals maximum) should encourage them to participate in small group discussions and activity to provide an adolescent perspective on key issues.

Drawing on the expertise of specialists

Once the programme structure has been decided and the health issues and problems selected, the facilitation team should decide which resource individuals to be invited. We advise that some time is spent reading the rest of these preparation notes and the selected health issue modules so that you can be clear about the role that these specialists could play; for example, a psychiatrist for mental health or a nutritionist for healthy eating add strength to training.
Planning for the training programme
Training programme organizers and facilitators will need to address the proposed items in the preparation and planning in advance of the programme. We recommend that a small group of 2–3 individuals form a planning group, review the proposed list below, and distribute responsibilities 6–8 weeks before the training programme.

**Programme preparation and planning checklist**

**4–6 weeks before the programme**
» Training programme structure and agenda
» Selection of participants
» Accommodation, meals and coffee breaks
» Programme facility
» Photocopying and computers
» Programme equipment and tools
» Participants’ tools
» Notify participants of the course objectives, dates and venue
» Start gathering relevant local data on elderly health and development.

**Two weeks before the course**
» Make photocopies of programme agenda, local data, support materials
» Make transparencies out of the slides files or just have them ready for PPT
» Prepare VIPP cards or alternatives
» Check that the needed pieces of equipment are available.

**One week in advance of the course**
» Confirm that those invited to the formal opening ceremony can attend
» Confirm that the participants can all attend
» Confirm venue and accommodation arrangements
» Confirm catering arrangements
» Check the programme meeting room/facility
» Greet the participants who have arrived early.

**Planning a formal opening ceremony**
When planning a formal opening, there should be backup speaker/s for opening ceremony. The speakers should be advised to keep to time and a break should be arranged after the opening to compensate for any loss of time and adhere to the theme of the programme.
Evaluation methods for the training programme
Evaluation methods should be quick and easy to use and to obtain immediate feedback. Using them will provide the following information:

» Evidence of how the programme has affected the participants.

» Facilitators can see where the programme has been less effective, which means you can try to address the reasons for that in the future.

» Future support for the training programme will be easier because you can show that you can evaluate the results or, even better, because you can show the positive effect of a previous programme.

» Participants’ reactions to the programme changes in participants’ attitude and knowledge changes in participants’ practice.

**Evaluation methods to measure participants’ reactions to the programme**

We have included three ways of keeping in touch with how the participants experience the programme on a daily basis as it goes on. By getting their early reactions you will be able to make changes immediately, rather than receiving complaints at the end of the programme when it is too late to respond to them.

**The mood meter**

As its name suggests, the mood meter allows you to get a sense of the group’s mood as it changes during the programme. Put the mood meter in an accessible location but one that is not in a busy place like a corridor. Use the mood meter as a means of tracking the group’s feelings about how the programme is proceeding, and as a starting point for discussion.

**Discussion groups**

Facilitator can hold a discussion group with a small group of interested persons. Ask about five participants if they are willing to talk about the session, and let them discuss a small number of questions.

» How do you feel about this module?

» Which sessions worked best?

» Which sessions did not work well?

» What could we have done differently?

» What did you get out of the module?

Please remember that the point of such a discussion is for you to hear the participants’ opinions. Try not to talk much yourself, and listen to criticism without becoming defensive. There is no need to respond directly to any criticism.
Part II: Guidelines for conducting the individual modules
**Introduction**

The training comprises sessions of classroom-based trainings (lectures and demonstration of skills). A standard session plan has been included in the document. The timing of the classroom sessions may be re-arranged at times convenient for the facility where the training is organized.

**Classroom training**

Classroom training has been structured in the form of 11 modules. Each module starts with an overview that refers to the chapter and sections of the WHO Guidance book on which that particular module is based. The module contains a discussion of key points and the list of relevant group learning activities. The checklists for clinical skills trainings are also included in the module where appropriate. The topics in each module are arranged in a logical sequence and it is recommended that facilitators follow the given sequence during teaching.

**Training assessment**

The pre-training assessment is to be conducted on Day 1 before the classroom teaching starts and final assessment on Day 2 after the completion of the modules. The assessment process comprises assessment knowledge.

**Distribution of sessions and flow of events**

**Day 1**

**Opening session**

**Session length:** 60 minutes

» Welcome trainees to the session.

» Display a slide showing the overall objectives of the training. Explain the objectives.

» Self-introduction of facilitators and trainees:

  * Explain to the trainees that a few minutes will be spent on introduction of facilitators and trainees.
  
  * For the introduction of facilitators and trainees, write the following points on a flip chart:

    ▪ Your name
    ▪ Place where you currently work
    ▪ A few words about the organization you work for
    ▪ Nature of your work
  
  * You and your co-facilitators should introduce yourselves first, based on the points listed on the flip chart.

  * Ask each trainee to introduce himself or herself briefly based on the same points.

  » Inform trainees about the ground rules (show as a slide and explain).
Ground rules for trainees

- Adhere to the training schedule according to session plans
- Maintain an attendance record for certification by the facilitator
- Go through the subjects discussed during various sessions in the WHO ICOPE nursing manual at the end of the day, for better understanding and discussion with the facilitator
- Attend all clinical sessions according to the schedule
- Participate in group activities according to the session plan
- Complete the specified number of worksheets during each clinical session, and get them certified by the facilitator
- Ensure and respect the privacy and rights of clients in the examination rooms
Inform trainees about the available facilities (refreshment, toilets, computers, internet facility).

Inform them about reimbursement of expenses and names of the support staff providing secretarial assistance.

Display a slide showing the contents of the folder given to the trainees and ask them to verify.

Explain the parts of the training package.

Divide trainees into smaller groups as per the instructions given in box below for group learning activities.

Discuss the overall session plan: Show the agenda of the training in a slide (modify session time according to local needs).

Discuss how to use the Trainee’s Handbook:

- Ask trainees to take out the Trainee’s Handbook from the folder.
- Ask them to open the page for Module 5, so they can see the structure of a sample module.
- Display the slide on the structure of a sample module.
- Explain that each module presents key information to complement the materials in the corresponding chapter of the WHO Guidance book. Trainees are required to be well-versed with the contents of the chapter before they attend clinical sessions.

List trainee’s expectations:

- Put up a flip chart with the heading “Expectations”.
- Ask each participant to mention at least one expectation. Note it on the flip chart.
- At the end, discuss how expectations will be addressed during the training.
Display the slide listing dos and don’ts instructions for trainees and discuss.

**DO**

- Reach the training venue at least 15 minutes before the session starts each day
- Put your mobile phones on silent mode
- Be familiar with training sessions and training materials provided
- Interact with facilitators as and when required, and get doubts cleared
- Get to know your group members and stay with your allocated group, during group activities
- Listen carefully to the instructions given by facilitators for the clinical sessions
- Be respectful of each other and considerate to fellow colleagues

**DON’T**

- Cross-talk among yourselves during teaching sessions
- Use mobile phones, or do anything to distract your colleagues during training sessions
- Hesitate to ask questions
- Make racist or gender-biased comments
- Eat in the classrooms
How to conduct pre-training knowledge assessment?

» Prepare a set of multiple choice questions (MCQs) from the sample MCQs listed in the appendix of facilitator’s manual before commencement of the training.

» Distribute question sheets to trainees and explain how to tick correct responses.

» Allow 15 to 20 minutes for trainees to answer questions.

» Evaluate responses immediately after the pre-test using the knowledge assessment matrix or on another convenient time on Day 1. Ask your fellow facilitators for help, if necessary.

» Facilitator will prepare a quiz with five questions and explain how to respond.

» Identify knowledge gaps from the assessment matrix and share them with other facilitators. This need not be shared with trainees at this point of time.

» Participants have to give five suggestions about the training and five take-home messages after every session.
Session: Health of the older people and geriatric medicine

Method: PowerPoint presentation

Session length: 30 minutes

- PowerPoint presentation: 20 minutes
- Question/Answer and Discussion: 10 minutes.
  - Welcome trainees to the session.
  - Display the slide with learning objectives of the module as given below.
  - Explain the learning objectives to trainees; by the end of this module, they will be able:
    - To understand the health of older people and geriatric medicine
    - To understand important concepts and principles of geriatric medicine
    - To understand comprehensive geriatric assessment
    - To understand the role of primary care physicians in old age care.
- Project the presentation on “Chapter 2: Health of the older people and geriatric medicine”.
- Discuss the contents of the slides.
- Ask trainees if they have any questions or doubts. List these on the flip chart.
- Respond to questions and doubts.
- Thank the group at the end of the session.

Key points for discussion

- Health challenges in old age
- Normative changes of ageing vis-á-vis pathological states
- Important concepts in geriatric medicine
- Concept of frailty syndrome and sarcopenia
- Concept of acute care in old age
- Stereotypes of ageing
- Concept of Comprehensive geriatric assessment
- Geriatric history taking and physical examination
- Role of the primary care physician in care of older adults
Session: Integrated care for older people (ICOPE)

**Method:** PowerPoint presentation and animation video

**Session length:** 30 minutes

» PowerPoint presentation: 20 minutes

» Animation video: 5 minutes

» Question/answer and discussions: 5 minutes

- Welcome trainees to the session.
- Display the slide with learning objectives of the module as given below.
- Explain the learning objectives to trainees; by the end of this module, they will be able:
  - To understand integrated care for older people
  - To learn to measure the intrinsic capacity of an older adult
  - To learn about the concept of ICOPE person-centred and care pathways.

» Project the presentation on “Module 1: Integrated care for older people”.

» Discuss the contents of the slides.

» Ask trainees if they have any questions or doubts. List these on the flip chart.

» Respond to questions and doubts.

» Thank the group at the end of the session.

**Key points for discussion**

» Introduction to ICOPE approach

» Concept of intrinsic capacity and its various domains

» WHO ICOPE intrinsic capacity screening tool

» Generic pathways of ICOPE strategy
Session: Functional assessment in older people

Method: PowerPoint presentation and animation video

Session length: 30 minutes

» PowerPoint presentation: 20 minutes
» Animation video: 5 minutes
» Question/answer and discussions: 5 minutes
  • Welcome trainees to the session.
  • Display the slide with learning objectives of the module as given below.
  • Explain the learning objectives to trainees; by the end of this module, they will be able:
    ▪ To understand the relevance of good functional status in older patients
    ▪ To learn to use tools for the assessment of functional status.
» Project the presentation on “Module 2: Functional assessment in older people”.
» Discuss the contents of the slides.
» Ask trainees if they have any questions or doubts. List these on the flip chart.
» Respond to questions and doubts.
» Thank the group at the end of the session.

Key points for discussion

» Introduction to functional assessment
» Concept of basic, instrumental and advanced activities of daily living
» Clinical implications of functional status
» Commonly used scales for functional assessment and the interpretation of scores
Session: ICOPE based screening of intrinsic capacities and functional status

**Method:** Role play

**Session length:** 30 minutes

- Role play: 20 minutes
- Question/answer and discussions: 10 minutes

- Divide the trainees into proportionate groups (maximum 10 in each).
- **Scene:**
  The facilitator to appoint a trainee to act as an older person coming to the OPD for periodic follow-up for diabetes mellitus for the last one year having difficulty in walking because of balance issues and a history of fall in the bathroom one month ago. He/she also needs support of his/her family members while bathing.

- One of the trainees will act as an assessor.

- The assessor will make the following enquiries:
  a) Chief complaints: (For what the older person has come to the primary health centre)
  b) History of presenting complaints: (Detailed elaboration of the complaints)
  c) History of geriatric syndromes: (Enquiry into falls, incontinence, memory issues, depressive symptoms, etc.)
  d) Past history: (Transient ischaemic attacks, strokes, acute coronary syndromes, syncope, tuberculosis etc.)
  e) Socioeconomic history: (Family support, financial handling, employment/engagement)
  f) History of addiction: (Smoking/chewing tobacco, alcoholism)
  g) History of treatment/drugs
  h) History of vaccination: (Adult vaccination: influenza, pneumococcal vaccines etc.)
## WHO ICOPE SCREENING TOOL

<table>
<thead>
<tr>
<th>Priority conditions associated with declines in intrinsic capacity</th>
<th>Test</th>
<th>Assess fully any domain with a checked circle</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>COGNITIVE DECLINES</strong> (Chapter 4)</td>
<td>1. Remember three words: flower, door rice (for example)</td>
<td>□ Wrong to either question or does not know</td>
</tr>
<tr>
<td></td>
<td>2. Orientation in time and space: What is the full date today? Where are you now (home, clinic, etc.)?</td>
<td>□ cannot recall all three words</td>
</tr>
<tr>
<td></td>
<td>3. Recalls the three words?</td>
<td></td>
</tr>
<tr>
<td><strong>LIMITED MOBILITY</strong> (Chapter 5)</td>
<td>Chair rise test: Rise from chair five times without using arms Did the person complete five chair rises within 14 seconds?</td>
<td>□ No</td>
</tr>
<tr>
<td><strong>MALNUTRITION</strong> (Chapter 6)</td>
<td>1. Weight loss: Have you unintentionally lost more than 3 kg over the last three months?</td>
<td>□ Yes</td>
</tr>
<tr>
<td></td>
<td>2. Appetite loss: Have you experienced loss of appetite?</td>
<td>□ Yes</td>
</tr>
<tr>
<td><strong>VISUAL IMPAIRMENT</strong> (Chapter 7)</td>
<td>Do you have any problems with your eyes: difficulties in seeing far, reading, eye diseases or currently under medical treatment (e.g. diabetes, high blood pressure)?</td>
<td>□ Yes</td>
</tr>
<tr>
<td><strong>HEARING LOSS</strong> (Chapter 8)</td>
<td>Hears whispers (whisper test) or Screening audiometry result is 35 db or less or passes automated app based digit in noise test</td>
<td>□ Fail</td>
</tr>
<tr>
<td><strong>DEPRESSIVE SYMPTOMS</strong> (Chapter 9)</td>
<td>Over the past two weeks, have you been bothered by feeling down, depressed or hopeless? little interest or pleasure in doing things?</td>
<td>□ Yes □ Yes</td>
</tr>
</tbody>
</table>
• The assessor will do the general physical examination including vitals.
• The assessor will do the relevant systemic examination:
  a) Cardiovascular examination
  b) Nervous system examination
  c) Other relevant system-based examination.
• The assessor will carry out screening of the intrinsic capacities based on WHO Intrinsic Capacity Screening Questionnaire.
• The assessor will inform the observer trainee about the positive screening in the locomotor domain.
• The assessor will inform the observer trainees that a detailed assessment of locomotor ability will be required based on ICOPE strategies.

**Total score**
• The accessor will summarize the findings of the assessment of the intrinsic capacity and the functionality in this individual to the trainees.
• The facilitator will ask the other trainees about their comments on the role play.
• The facilitator will give feedback.
• The facilitator will respond to the questions and doubts of the trainees.
• The facilitator will thank the actors as well as the other trainees.
Session: Health promotion and disease prevention in old age

**Method:** PowerPoint presentation

**Session length:** 30 minutes

» PowerPoint presentation: 20 minutes

» Question/answer and discussions: 10 minutes
  - Welcome trainees to the session.
  - Display the slide with learning objectives of the module as given below.
  - Explain the learning objectives to trainees; the end of this module, they will be able:
    - To assess the general status of older adults in terms of health promotion
    - To enumerate strategies for health promotion among older people
    - To enumerate strategies for disease prevention in old age.

» Project the presentation on “Module 3: Health promotion and disease prevention in old age”

» Discuss the contents of the slides.

» Ask trainees if they have any questions or doubts. List these on the flip chart.

» Respond to questions and doubts.

» Thank the group at the end of the session.

**Key points for discussion**

» Health promotion strategies:
  - Nutrition:
    - Importance
    - Assessment of nutritional status in older people using MNA
    - Nutritional management based on MNA
    - Nutritional advice for older adults

Continue
Exercise:
- Importance
- Types of physical activity
- WHO recommendation for physical activity
- Social support and social interaction

Disease prevention strategies:
- Prevention of use of tobacco products and prevention of alcoholism
- Screening for disease prevention
- Vaccination
- Prevention of polypharmacy and principle of prescribing in older people
Session: Cardiovascular system

Method: PowerPoint presentation

Session length: 30 minutes

- PowerPoint presentation: 20 minutes
- Question/answer and discussions: 10 minutes

- Welcome trainees to the session.
- Display the slide with learning objectives of the module as given below.
- Explain the learning objectives to trainees; the end of this module, they will be able:
  - To enumerate age-related changes which occur in the cardiovascular system
  - To enumerate common cardiovascular diseases and strategies to screen and manage
  - To develop short-term and long-term care plans.
- Project the presentation on “Module 4: Cardiovascular system”.
- Discuss the contents of the slides.
- Ask trainees if they have any questions or doubts. List these on the flip chart.
- Respond to questions and doubts.

Key points for discussion

- Age-related changes in the cardiovascular system
- Primary prevention of cardiovascular diseases
- Common cardiovascular problems of old age; diagnosis and management
  - Hypertension
  - Acute coronary syndrome
  - Dizziness and syncope
Session: Respiratory system

**Method:** PowerPoint presentation

**Session length:** 30 minutes

- PowerPoint presentation: 20 minutes
- Question/answer and discussions: 10 minutes

- Welcome the trainees to the session.
- Display the slide with learning objectives of the module as given below.
- Explain the learning objectives to trainees; the end of this module, they will be able:
  - To enumerate age-related changes which occur in the respiratory system
  - To enumerate common respiratory diseases
  - To develop screening strategies and care plans for these conditions.
- Project the presentation on “Module 5: Respiratory System”.
- Discuss the contents of the slides.
- Ask trainees if they have any questions or doubts. List these on the flip chart.
- Respond to questions and doubts.

**Key points for discussion**

- Age-related changes in the respiratory system
- Common respiratory problems of old age; diagnosis and management
  - Community acquired pneumonia: symptoms, severity assessment
  - Tuberculosis
  - Chronic obstructive pulmonary disease
  - Lung cancer
Session: Endocrine system

Method: PowerPoint presentation

Session length: 30 minutes

» PowerPoint presentation: 20 minutes
» Question/answer and discussions: 10 minutes

• Welcome trainees to the session.
• Display the slide with learning objectives of the module as given below.
• Explain the learning objectives to trainees; the end of this module, they will be able:
  ▪ To enumerate the normal age-related changes in the endocrine system
  ▪ To develop care plans for older patients with diabetes mellitus
  ▪ To identify thyroid disease among older patients and develop care plans.
• Project the presentation on “Module 7: Endocrine system”
• Discuss the contents of the slides.
• Ask trainees if they have any questions or doubts. List these on the flip chart.
• Respond to questions and doubts.

Key points for discussion

» Age related changes in the endocrine system

» Common endocrine problems of old age; diagnosis and management
  ▪ Diabetes mellitus, Hypoglycemia and Hyperglycemic hyperosmolar state
  ▪ Hypothyroidism
  ▪ Hyperthyroidism
Session: Hypertension and diabetes mellitus management in old age

Method: Case-based discussion

Session length: 30 minutes

» Divide the trainee into proportionate groups (maximum 10 in each)
» Initiate discussion among the trainee in the group based on the similar case scenario.

Example of case scenario
A 70-year-old hypertensive male (on daily Amlodipine 5 mg) is brought to your primary health centre/clinic by his son for routine evaluation.

Q1. What are the other relevant enquiries for history taking?
   i. Past history
   ii. Socioeconomic history
   iii. Dietary history
   iv. Medication history
   v. History of geriatric syndrome
   vi. Functionality

On further enquiry, the patient complained of history of fall in bathroom three months ago. He did not suffer any injury, but he had a fear of fall.

Q2. How will you proceed for further physical examination?
   i. Vitals: BP in sitting position 150/90 mmHg and standing 155/90 mmHg
   ii. General: Bilateral pedal oedema
   iii. Systemic examination: normal

Q3. How will you assess ICOPE based intrinsic capacity in this patient?
On using ICOPE screening test, cognitive impairment present.

Q4. What will you do next?
Mini-Cog: Normal.
Q5. How will you assess functionality in this patient?

Katz activities of daily living: Normal.

On routine investigations, random blood sugar was 110 mg/dl. The patient was advised to get serum thyroid stimulating hormone (TSH) and serum creatinine tested and to follow up with the reports.

Q6. How will you manage the issue of pedal oedema and increased BP in this patient?

The patient will be advised to stop Amlodipine 5 mg; to start Hydrochlorthiazide 12.5 mg in the morning; and visit for follow up assessment after 2 weeks.

Q7. After two weeks, the patient comes back with reports and TSH of 1.8 milli-international units per litre and creatinine of 0.6 mg/dl with BP of 140/90 mmHg. Pedal oedema subsided. He has improvement in overall quality of life. What will you advise him now?

He will be advised to continue Hydrochlorthiazide as before and restrict salt in food.
Session: Digestive system

**Method:** PowerPoint presentation

**Session length:** 30 minutes

» PowerPoint presentation: 20 minutes

» Question/answer and discussions: 10 minutes

» Welcome trainees to the session.

» Display the slide with learning objectives of the module as given below.

» Explain the learning objectives to trainees; the end of this module, they will be able:
  - To enumerate the age-related changes in the digestive system
  - To enumerate common diseases of the digestive system among older patients
  - To screen for common disease conditions and develop care plans.

» Project the presentation on “Module 6: Digestive system”.

» Discuss the contents of the slides.

» Ask trainees if they have any questions or doubts. List these on the flip chart.

» Respond to questions and doubts.

**Key points for discussion**

» Age-related changes in the digestive system

» Common disorders of the digestive system:
  - Compromised oral health
  - Hiatus hernia and gastro-oesophageal reflux
  - Gastropathy and gastric ulcers
  - Cancers of the gastrointestinal tract
  - Constipation
  - Diarrhoea
  - Red flag signs and symptoms of gastrointestinal system
Distribution of sessions and flow of events

Day-2

Session: Musculoskeletal system

Method: PowerPoint presentation

Session length: 30 minutes

» PowerPoint presentation: 20 minutes
» Question/answer and discussions: 10 minutes

• Welcome trainees to the session.
• Display the slide with learning objectives of the module as given below.
• Explain the learning objectives to trainees; the end of this module, they will be able:
  ▪ To enumerate normal age-related changes in the musculoskeletal system
  ▪ To enumerate common musculoskeletal disorders of older patients
  ▪ To identify common musculoskeletal diseases and develop care plans.
• Project the presentation on “Module 8: Musculoskeletal system”
• Discuss the contents of the slides.
• Ask trainees if they have any questions or doubts. List these on the flip chart.
• Respond to questions and doubts.

Key points for discussion

» Age-related changes in the bones, muscles and joints
» Locomotor capacity in older adults: Screening, assessment and management using ICOPE care pathways
» Common disorders of the musculoskeletal system:
  • Osteoarthritis
  • Osteoporosis
  • Falls and fractures
Session: ICOPE based locomotive capacity assessment and management

**Method:** Role play

**Session length:** 30 minutes

» Role play: 20 minutes
» Question/answer and discussions: 10 minutes

**Material required:**
- ICOPE-A manual for primary care physicians
- A chair of appropriate height without arm rest
- A measuring tape
- A stop-watch.

The facilitator will measure and mark spot a distance of 4 metres on the floor before the session.

» Divide the trainee into proportionate groups (maximum 10 in each).

**Scene:**

The facilitator to designate a trainee to act as an older person coming to the OPD of the primary health centre for periodic follow up for hypertension for last one year with difficulty in walking because of imbalance and a history of fall in the bathroom one month ago. Now, he needs help from a family member while going to the toilets or while taking bath.

» One of the trainees will act as an assessor.

» The assessor will make the following enquiries:
  - Chief complaints
  - History of presenting complains
  - History of geriatric syndrome
  - Past history
  - Family history
  - Socioeconomic history
  - History of addiction
  - History of treatment/drugs
  - History of vaccination
» The assessor will do the general physical examination including vitals.

» The assessor will do the systemic examination:
  • Cardiovascular examination
  • Nervous system examination
  • Other relevant system-based examination

» The assessor will carry out screening of the intrinsic capacities based on WHO Intrinsic Capacity Screening Questionnaire:

  The actor can do chair-rise only for four times in 14 seconds.

» The assessor will inform the trainees about the positive screening in the locomotor domain.

» The assessor will inform the trainees that a detailed assessment of the locomotor ability will be based on ICOPE strategies.

» The assessor will summarize the findings of the assessment of the intrinsic capacity and the functionality in this individual to the trainees.

» As screening is positive for losses, the assessor should assess the patient’s mobility using the short physical performance battery (SPPB).
Note: Please refer to WHO ICOPE Screening Tool on page 41

Short physical performance battery (SPPB):

The actor could do the following:

a) Balance test: Could stand side-by-side for more than 10 seconds (1 point)
   - Could stand semi-tandem for 4 seconds only (0 points)
   - Couldn’t attempt tandem stand at all (0 points)

b) Gait speed test: Could walk 4 metres in 7 seconds only (2 points)

c) Chair rises test: Took 15 seconds to rise from chair 5 times (2 points)

Total score: 1+0+0+2+2= 5

» The facilitator now asks the observer trainees about their comments on the act.

» The facilitator gives his/her feedback on the assessment techniques.

» The facilitator explains to the trainees that,
   - As the older person displays “limited mobility” on SPPB:

   » Advise multimodal exercise with close supervision:
     - strength/resistance training
     - aerobic/cardiovascular training
     - balance training
     - flexibility training.

» Advice for physiotherapy.

» Advice for increasing protein intake.

» Manage hypertension as an associated condition in this patient.

» Polypharmacy: Review medications that can interfere with balance e.g. sedatives, diuretics.

» Evaluate for osteoarthritis and consider pain management.

» Assess and manage the person’s social and physical environments to reduce risk of falls.

» The facilitator will respond to the questions and doubts of the trainees.

» The facilitator will thank the actors as well as the other trainees.
Short physical performance battery (SPPB):

Describe each test and ask if the person feels able to do it. If not, score accordingly and move to the next step.

1. Balance tests:
   
   Stand for 10 seconds with feet in each of 3 positions. Use the sum of the score of each of the three positions. (Side-by-side stand, Semi-tandem stand, Tandem stand)

2. Gait speed test: Time to walk 4 metres. (If they use a cane or walking aid and feel they need it to walk a short distance, they may use it.)

3. Chair rise test: Time to rise from a chair 5 times

Total SPPB score: Sum of each of the three tests

<table>
<thead>
<tr>
<th>Balance test</th>
<th>Time for 4-meter walk</th>
<th>Chair rise test</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>A. Side-by-side stand</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Held for 10 sec:</td>
<td>&gt; 8.70s: 1 point</td>
<td></td>
</tr>
<tr>
<td>Not held for 10 sec.</td>
<td>6.21-8.70s: 2 points</td>
<td></td>
</tr>
<tr>
<td>Not attempted</td>
<td>4.82-6.20s: 3 points</td>
<td></td>
</tr>
<tr>
<td>&lt; 4.82s: 4 points</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

If not attempted, end balance tests.

| **B. Semi-tandem stand** |
| Held for 10 sec: | > 8.70s: 1 point |
| Not held for 10 sec. | 6.21-8.70s: 2 points |
| Not attempted | 4.82-6.20s: 3 points |
| < 4.82s: 4 points |

If not attempted, end balance tests.

| **C. Tandem stand** |
| Held for 10 sec: | > 8.70s: 1 point |
| Held for 3 to 9.99 sec. | 6.21-8.70s: 2 points |
| Held for < 3 sec. | 4.82-6.20s: 3 points |
| Not attempted | < 4.82s: 4 points |

If not attempted, end balance tests.
Session: Genitourinary system

Method: PowerPoint presentation

Session length: 30 minutes

» PowerPoint presentation: 20 minutes
» Question/answer and discussions: 10 minutes

- Welcome trainees to the session.
- Display the slide with learning objectives of the module as given below.
- Explain the learning objectives to trainees; the end of this module, they will be able:
  - To enumerate normal age-related changes in the genitourinary system
  - To enumerate common health problems of genitourinary system and develop care plans.
- Project the presentation on Module 9: “Genitourinary system diseases of old age”.
- Discuss the contents of the slides.
- Ask trainees if they have any questions or doubts. List these on the flip chart.
- Respond to questions and doubts.

Key points for discussion

» Age-related changes in the genitourinary system
» Common diseases of the nervous system and their diagnosis and management
  - Urinary incontinence
  - Urinary tract infection
  - Benign prostatic hypertrophy
Session: Neurological diseases of old age

**Method:** PowerPoint presentation

**Session length:** 30 minutes

- PowerPoint presentation: 20 minutes
- Question/answer and discussions: 10 minutes
  - Welcome the trainees to the session.
  - Display the slide with learning objectives of the module as given below.
  - Explain the learning objectives to trainees; the end of this module, they will be able:
    - To enumerate normal age-related changes in the nervous system
    - To diagnose stroke; and learn its management strategy and understand the need for timely referral
    - To detect Parkinson’s disease and understand referral and management.
  - Project the presentation on “Module 10: Neurological diseases of old age”
  - Discuss the contents of the slides.
  - Ask trainees if they have any questions or doubts. List these on the flip chart.
  - Respond to questions and doubts.

**Key points for discussion**
- Age-related changes in the nervous system
- Common diseases of the nervous system and their diagnosis and management
  - Stroke
  - Parkinson’s disease
  - Essential tremor
  - Delirium
Session: Brain ageing and cognitive impairment

Method: PowerPoint presentation

Session length: 30 minutes

» PowerPoint presentation: 20 minutes
» Question/answer and discussions: 10 minutes

• Welcome trainees to the session.
• Display the slide with learning objectives of the module as given below.
• Explain the learning objectives to trainees; the end of this module, they will be able:
  ▪ To enumerate age-related changes in cognition
  ▪ To screen and identify cognitive impairment
  ▪ To assess and develop care plans for older patients with dementia.
  ▪ Discuss the contents of the slides.
• Project the presentation on “Module 11: Brain ageing and cognitive impairment”

Key points for discussion

» Age-related changes in cognition
» Differences between age-related memory changes and cognitive impairment
» Dementia: types and clinical manifestation
» Role of primary care physicians on dementia evaluation and management

• Discuss the contents of the slides.
• Ask trainees if they have any questions or doubts. List these on the flip chart.
• Respond to questions and doubts.
Session: ICOPE-based cognitive capacity assessment and management

**Method:** Role play and animation video

**Session length:** 30 minutes

» PowerPoint presentation: 20 minutes

» Question/answer and discussions: 5 minutes

» Animation video: 5 minutes
  - Divide the trainee into proportionate groups (maximum 10 in each)
  - Case scenario:

One of the trainees to act as an older person coming to the OPD with his/her spouse with recurrent episodes of forgetfulness while going for fetching household stuff in the nearby shops and occasionally overshooting his/her way back to her house. He/he has been dependent on his/her spouse for putting on clothes and bathing.

» One of the trainees will act as an assessor.

» The assessor will make the following enquiries:
  a. Chief complaints
  b. History of presenting complaints
  c. History of geriatric syndrome
  d. Past history
  e. Family history
  f. Socioeconomic history
  g. History of addiction
  h. History of treatment/drugs

» The assessor will do the general physical examination including vitals.

» The assessor will do the systemic examination:
  a. Nervous system examination
  b. Cardiovascular examination
  c. Other relevant system-based examination

» The assessor will carry out screening of the intrinsic capacities based on WHO Intrinsic Capacity Screening Questionnaire.
» The assessor will inform the trainee about the positive screening in the cognitive domain.

» The assessor will inform the trainees that a detailed assessment of the cognitive capacity will be required based on ICOPE strategies.

» Now, the assessor will demonstrate the screening for functionality (ADL) in the client using the Katz ADL index and calculate the total score:

### Katz activities of daily living scoring table

<table>
<thead>
<tr>
<th>Activities points (1 or 0)</th>
<th>Independence: 1 point (No supervision, direction or personal assistance)</th>
<th>Dependence: 0 points (With supervision, direction, personal assistance or total care)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bathing</td>
<td>Bathes self completely or needs help in bathing only a single part of the body such as the back, genital area or disabled extremity.</td>
<td>Needs help with bathing more than one part of the body, getting in or out of the tub or shower.</td>
</tr>
<tr>
<td>Dressing</td>
<td>Gets clothes from closets and drawers and puts on clothes and outer garments complete with fasteners. May have help tying shoe.</td>
<td>Needs help with dressing self or needs to be completely dressed.</td>
</tr>
<tr>
<td>Toileting</td>
<td>Goes to toilet, gets on and off, arranges clothes, cleans genital area without help.</td>
<td>Needs help transferring to the toilet, cleaning self or uses bedpan or commode.</td>
</tr>
<tr>
<td>Transferring</td>
<td>Moves in and out of bed or chair unassisted. Mechanical transferring aides are acceptable.</td>
<td>Needs help in moving from bed to chair or requires a complete transfer.</td>
</tr>
<tr>
<td>Continence</td>
<td>Exercises complete self-control over urination and defecation.</td>
<td>Is partially or totally incontinent of bowel or bladder.</td>
</tr>
<tr>
<td>Feeding</td>
<td>Gets food from plate into mouth without help. Preparation of food may be done by another person.</td>
<td>Needs partial or total help with feeding or requires parenteral feeding.</td>
</tr>
</tbody>
</table>

» The assessor will summarize the findings of the assessment of the intrinsic capacity and the functionality in this individual to the trainees.

» Now, the assessor will perform the Mini-Cog assessment of the cognition.
Mini-Cog - Cognitive assessment tool

Step 1: Three word registration
Say any three unrelated words to the person. Then ask him/her to repeat the words. If the person is unable to repeat the words after three attempts, move on to Step 2 (clock drawing).

Step 2: Clock drawing
Ask the person to draw a clock by putting all the numbers in the correct positions in an already pre-printed circle. When that is completed, ask the person to set the hands to 10 past 11 (11:10). Repeat instructions as needed as this is not a memory test. Move to Step 3 if the clock is not complete within three minutes.

Step 3: Three word recall
Ask the person to recall the three words you stated in Step 1. Record the person’s answers.

Scoring:

<table>
<thead>
<tr>
<th></th>
<th>Points:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Word recall (0-3 points)</td>
<td>1 point for each word spontaneously recalled without clues</td>
</tr>
<tr>
<td>Clock draw (0 or 2 points)</td>
<td>Normal clock = 2 points (all numbers placed in the correct sequence and approximately correct position) Inability or refusal to draw a clock (abnormal) = 0 points</td>
</tr>
<tr>
<td>Total score</td>
<td>Total score = Word recall score + Clock draw score A cut point of &lt;3 has been validated for dementia screening</td>
</tr>
</tbody>
</table>

» Now, the facilitator will inform the trainee that the diagnosis of ‘pseudo-dementia’ secondary to depression or delirium should be ruled out before considering the diagnosis of ‘dementia’ in this patient.

(Refer to the module on Mental Health in Older People.)
The facilitator should inform the trainees that associated medical issues should be identified.

- Onset of symptoms associated with head injury, stroke, or altered consciousness
- Clinical history of goitre, slow pulse, dry skin (hypothyroidism)
- History of sexually transmitted infection, including HIV/AIDS.

The facilitator should teach the trainee that the following symptoms should be enquired for any “behavioural and psychological symptoms of dementia (BPSD)”.

- Agitation
- Personality change
- Abnormal eating behaviour
- Wandering
- Mood disorder, depression
- Anxiety, phobias, fear
- Restlessness
- Hallucinations, delusions
- Aggression, shouting, rage, violence
- Dis-inhibition
- Compulsive behaviour
- Hypersexuality
- Repeating stories and statements
- Hoarding
- Resisting care
- Psychosis
- Screaming
- Taking clothes off in inappropriate places
- Smearing faecal matter.

The facilitator should now inform the trainees about evaluating for the needs of carers.

- Is the carer having difficulty coping with and experiencing strain?
- Does the carer feel depressed?
- Is the carer incurring loss of income and additional expenses because of care needs?

The facilitator should inform the trainees that the management of dementia symptoms, depends on the presence or absence of BPSD.
A. Dementia without BPSD:
• Provide the carers with basic education on the nature and progression of the illness.
• Encourage carers to conduct interventions to improve cognitive functioning.
• Promote independence, functioning and mobility.
• Refer to a specialist for the diagnosis of Alzheimer’s and other dementia subtypes.

B. Dementia with BPSD:
• Follow the management steps for dementia without BPSD.
• Start quetiapine 25 mg once a day. Gradually increase to 25 mg twice daily.
• If the BPSD are not controlled with the above dose, refer the patient to a specialist.

» The facilitator will inform the trainees about conducting follow-ups in such patients.
• Assess for improvement, and review adherence, adverse drug reactions and dosing.
• Review the psychosocial interventions.
• Evaluate the patient for comorbidities.
• Review basic activity of daily living (BADL) and instrumental activity of daily living (IADL) dependence.
• Review for safety risks and recommend appropriate modification of behaviour if the disease has progressed (limit driving, cooking, etc.).
• Review for new BPSD or symptoms of depression: refer to a specialist.

» Ask trainees if they have any questions or doubts. List these on the flip chart.
» Respond to questions and doubts.
Session: Mental health in old age

Method: PowerPoint presentation

Session length: 30 minutes

» PowerPoint presentation: 20 minutes
» Question/answer and discussions: 10 minutes

- Welcome trainees to the session.
- Display the slide with learning objectives of the module as given below.
- Explain the learning objectives to trainees; by the end of this module, they will be able:
  - To enumerate the common stresses of old age
  - To enumerate the social and cultural barriers to seeking mental health services
  - To identify common mental health problems and develop care plans.
- Project the presentation on “Module 12: Mental health in old age”.
- Discuss the contents of the slides.
- Ask trainees if they have any questions or doubts. List these on the flip chart.
- Respond to questions and doubts.

Key points for discussion

» Common stresses of old age
» Barriers to accepting mental health problems in old age
» Sleep and sleep hygiene in older adults
» Depression and its management
» Generalized anxiety disorder
Session: ICOPE-based psychological capacity assessment and management

**Method:** Role play

**Session length:** 30 minutes

» Role play: 20 minutes

» Question/answer and discussions: 10 minutes
  » Divide the trainee into proportionate groups (maximum 10 in each)

**Case scenario:**

The facilitator to ask one of the trainees to act as an older male coming to the OPD with his wife with the following complaints:

» Increasing tiredness while performing regular works x 3 weeks

» Doesn’t like going out of his house x 2 weeks

» Cries easily x 2 weeks

» The facilitator to ask one of the trainees to act as an assessor.

» The assessor will make the following enquiries:
  a. Chief complaints
  b. History of presenting complaints
  c. History of geriatric syndromes
  d. Past history
  e. Family history
  f. Socioeconomic history
  g. History of addiction
  h. History of treatment/drugs

» The assessor will do the general physical examination including vitals.

» The assessor will do the systemic examination:
  a. Nervous system examination
  b. Cardiovascular examination
  c. Other relevant system-based examination

» The assessor will carry out screening of the Intrinsic capacities based on WHO Intrinsic Capacity Screening Questionnaire:
The assessor will inform the trainee about the positive screening in the psychological/depressive domain.

The assessor will inform the trainees that a detailed assessment of the psychological capacity will be required based on ICOPE strategies.

**Total score**

The assessor will summarize the findings of the assessment of the intrinsic capacity and the functionality in this individual to the trainees.

Now the assessor would follow the following steps for the screening, assessment and management of depression in the actor:

**Step 1. Screening for depression**

The assessor will ask the actor, over the past two weeks, have you been:

- feeling down, depressed or hopeless?
- losing interest or pleasure in doing things?

The actor responds as losing interest in the things that were once pleasurable previously. The assessor informs the other trainees that the screening is positive for depression.

**Step 2.** As the answer to one of the questions is “Yes”, the assessor performs an assessment of mood, using the following set of questions.

**Step 3.** The assessor should rule out other conditions resembling/exacerbating depression which include:

- Anaemia
- Malnutrition
- Hypothyroidism
- Mood changes from substance use
- Side-effects of medications, e.g. steroids.

**Step 4. The assessor should assess for history of mania**

Take the patient’s history from the caregiver, asking whether the patient suffered from several of the following symptoms simultaneously, for at least one week, and severely enough to interfere significantly with work and social activities, or requiring hospitalization or confinement:

- Elevation of mood and/or irritability
- Decreased need for sleep
- Increased activity, feeling of increased energy, increased talkativeness or rapid speech
• Impulsive or reckless behavior, such as excessive spending, making important decisions without planning and sexual indiscretion
• Loss of normal social inhibitions resulting in inappropriate behaviors
• Being easily distracted
• Unrealistically inflated self-esteem.

(The caregiver tells that the patient doesn’t have the above symptoms, the diagnosis of a depressive episode in bipolar disorder is unlikely.)

**Step 5. Management of depression**

The assessor should take the following steps for the management of depression:

• Educate the patient and the family members on depression.
• Ask the person’s carers to keep and monitor the medications, and to follow up frequently to prevent overdose of any medication.
• Consider prescribing an antidepressant (if a specialist’s support is not available).

Selective serotonin reuptake inhibitors (SSRIs) are the first-choice antidepressants. Amitriptyline needs to be avoided in older adults. Use a low dose of benzodiazepine (Clonazepam 0.25 mg once a day) with the antidepressant for a maximum of two weeks to prevent rebound anxiety.

Antidepressants take at least a week or two to demonstrate gradual benefit. Medications should never be stopped just because the person experiences some improvement. Anti-depressants usually need to be continued for at least 9–12 months after the resolution of symptoms.

**Table. Medications for management of depression**

<table>
<thead>
<tr>
<th>Medication</th>
<th>Dosage</th>
<th>Side-effects</th>
<th>Contraindications</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fluoxetine</td>
<td>Start at 10 mg/day, increase to 20 mg after 1 week</td>
<td>Common for all: sedation, insomnia, headache, dizziness, gastrointestinal disturbances, sexual dysfunction</td>
<td>Avoid combination with warfarin (may increase risk of bleeding), may increase levels of tricyclic antidepressants, anti-psychotics, and beta-blockers, may cause QT prolongation in susceptible individuals</td>
</tr>
<tr>
<td>Escitalopram</td>
<td>Start at 5 mg/day. Increase to 10 mg after 1 week</td>
<td>Serious: Bleeding abnormalities in those using aspirin or other NSAIDs, hyponatremia</td>
<td></td>
</tr>
<tr>
<td>Sertraline</td>
<td>Start at 25 mg/day, increase to 50 mg/day after 1 week</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

» Ask trainees if they have any questions or doubts. List these on the flip chart.
» Respond to questions and doubts.
Session: Sensory system

Method: PowerPoint presentation

Session length: 30 minutes
» PowerPoint presentation: 20 minutes
» Question/answer and discussion: 10 minutes
  » Welcome trainees to the session.
  » Display the slide with learning objectives of the module as given below.
  » Explain the learning objectives to trainees; by the end of this module, they will be able:
    ▪ To describe the normal age-related changes in the sensory system and their implications
    ▪ To identify the common problems in the sensory system and develop care plans.
  » Project the presentation on “Module 13: Sensory system”.
  » Discuss the contents of the slides.
  » Ask trainees if they have any questions or doubts. List these on the flip chart.
  » Responds to questions and doubts.

Key points for discussion
» Age-related changes in sensory system: skin, eyes and ears
» Pressure ulcers: Risk factors and management
» Cataract: Diagnosis and management
» Glaucoma
» Hearing loss in old age: Assessment and management
Session: ICOPE-based sensory assessment and management

**Method:** Role play

**Session length:** 30 minutes

» Role play: 20 minutes

» Question/answer and discussions: 10 minutes

» Additional materials required: WHO Simple eye chart (Annexure 3)
  - Divide the trainee into proportionate groups (maximum 10 in each).

» Case scenario:
The facilitator will act as an older person visiting OPD for periodic follow up for diabetes mellitus. For last 1 year she has increasing difficulty in reading newspaper. Similarly, she also has been complaining of difficulty in hearing for past few years. She can do all the daily activities by herself and doesn’t require support of his family members for daily activities.

» The trainee will act as an assessor.

» The assessor will make the following enquiries:
  a. Chief complaints
  b. History of presenting complaints
  c. History of geriatric syndrome
  d. Past History
  e. Family history
  f. Socioeconomic history
  g. History of addiction
  h. History of treatment/drugs
  i. History of vaccination

» The assessor will do the general physical examination including vitals.

» The assessor will carry out screening of the intrinsic capacities based on WHO Intrinsic Capacity Screening Questionnaire:
The assessor will inform the trainee about the positive screening in the sensory domain (both hearing and vision).

The assessor will inform the trainees that a detailed assessment of the sensory capacity will be required based on ICOPE strategies.

Look into the actor’s eyes: If there are changes such as red eyes, secretions, scars, ongoing pain, intolerance to sunlight or a cataract, an eye care professional (ophthalmologist, optometrist) should examine the person.

Check for distance vision

The assessor will check the distance vision of the actor using WHO Simple eye chart.

Demonstrate close to the person how to do the E test by showing the direction the Es point.

1. Test with the four small Es at 3 metres.
   Vision is normal (6/18 or better) if the direction of at least ¾ small Es can be seen.

2. If not able to see at least 3 of the small Es, test with large Es at 3 metres.
   If the Es are seen, vision is 6/60.

3. If not able to see at least 3 of the large Es, test with the large Rs at 1.5 metres.
   If at least 3 out of 4 large Es are seen, vision is 3/30.

Check for near vision

The assessor will check the distance vision of the actor using WHO Simple eye chart. Demonstrate close to the person how to do the E test by showing the direction the Es point.

1. Let the actor hold the near vision test card as close as he/she wants. Test from the largest to the smallest Es. At least 3 out of 4 must be correct in each line before testing the next.

2. If only the largest size (N48) can be seen, refer for a comprehensive eye and vision examination and specialized eye care.

3. The medium size (N20) is similar to the print in large-print books. The smallest size (N8) is similar to print in newspaper.
Check for hearing: Whisper test: The following are the steps of the whisper test.

1. Stand about an arm’s length away behind and to the side of the person.
   Ask the person or an assistant to close off the opposite ear by pressing on the tragus.

2. Breathe out and then softly whisper several words. Use any common, unrelated words.
   Ask the person to repeat the words. If the person repeats the words and you are sure that he/she can hear you clearly, then the person is likely to have normal hearing in this ear.

3. Repeat the same with the other ear.

   The facilitator should inform the trainees that, if the person fails the screening test, he/she should be referred to a specialist for further management.
**Session: Cancer and palliative care**

**Method:** PowerPoint presentation

**Session length:** 30 minutes

- PowerPoint presentation: 20 minutes
- Case study: 5 minutes
- Question/answer and discussions: 5 minutes

- Welcome the trainees to the session.
- Display the slide with learning objectives of the module as given below.
- Explain the learning objectives to trainees, by the end of this session, trainees will be able:
  - To enumerate the peculiarities of cancer in old age
  - To enumerate the alarm signs for cancer in old age
  - To enumerate the role of primary care physicians in palliative care.
- Project the presentation on “Module 14: Cancer and palliative care”.
- Discuss the contents of the slides.
- Ask trainees if they have any questions or doubts. List these on the flip chart.
- Respond to questions and doubts

**Key points for discussion**

- Cancer and its delay in diagnosis in old age
- Alarm signs and symptoms for cancer
- Role of primary care physicians in management of cancer in the community
- Palliative care and its components
- Control of cancer pain and WHO analgesic ladder
Session: Elder abuse

Method: PowerPoint presentation and case study

Session length: 30 minutes

» PowerPoint presentation: 20 minutes
» Case study: 5 minutes
» Question/answer and discussions: 5 minutes

- Welcome the trainees to the session.
- Display the slide with learning objectives of the module as given below.
- Explain the learning objectives to trainees, by the end of this session, trainees will be able:
  - To define elder abuse and explain its various forms
  - To understand the signs and symptoms of elder abuse.
- Project the presentation on “Module 15: Elder abuse”
- Discuss the contents of the slides.
- Ask trainees if they have any questions or doubts. List these on the flip chart.
- Respond to questions and doubts.

Case scenario

A 84-year-old man was brought to the hospital by the neighbours with shortness of breath due to pneumonia. He appeared malnourished and was unable to walk due to extreme pain. He was unable to eat or go to the toilet. On careful examination doctor noted multiple bruises in the body. On detailed enquiry from the patient it was noted that family members were abusing him for his property.

Q1 What are the signs of abuse?

Q2 Role of physician in tackling this issue

Key points for discussion

» Definition of elder abuse and its various types
» Risk factors for abuse, its signs and symptoms
» Management of elder abuse by a primary care physician.
Session: Long-term care and caregivers’ issues

Method: PowerPoint presentation and case study

Session length: 30 minutes

- PowerPoint presentation: 20 minutes
- Case study: 5 minutes
- Question/answer and discussions: 5 minutes
  - Welcome the trainees to the session.
  - Display the slide with learning objectives of the module as given below.
  - Explain the learning objectives to trainees; by the end of this session, trainees will be able:
    - To understand the concepts of long-term care and its various forms
    - To understand the issues related to the caregiving.
  - Project the presentation on “Module 16: Long-term care and caregivers’ issues”.
  - Discuss the contents of the slides.
  - Ask trainees if they have any questions or doubts. List these on the flip chart.

Case study

After seeking follow-up advice for an 84-year-old man with moderately severe dementia in the Memory Clinic, the 45-year-old daughter-in-law visited the memory clinic with complaints of anxiety, lack of motivation, irritability and suicidal ideation for the last three months. On detailed enquiry it was noted that the father-in-law was having several behavioural symptoms such as aggressive behaviour, over-eating and going out from home.

Q1. What is the diagnosis? How to mitigate caregiver stress in elderly suffering from dementia? What is the role of primary care physician in this scenario?

Q2: What are the features of caregiver stress in this scenario?

Key points for discussion

- Define long-term care and its various models
- Issues related to care-giving
- Role of primary care physicians in managing caregiver stress syndrome.
Annexure 1: Sample questionnaire for pre- and post-training knowledge assessment
Sample questionnaire for pre- and post-training knowledge assessment

Instructions: Tick (✓) the correct answers after sample questionnaire for pre- and post-training knowledge assessment reading the questions carefully. Tick as many as applicable.

<table>
<thead>
<tr>
<th>S.N.</th>
<th>Question stem</th>
<th>Choices</th>
<th>Key</th>
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</thead>
</table>
| Q1   | Which of the following statement best describes the term ‘ageing’ | 1. Ageing is a disease.  
2. Ageing is physiological.  
3. Aging is the process by which a fit person becomes unfit.  
4. Ageing is process in which the body changes over time. | R1=0  
R2=0  
R3=1  
R4=0 |
| Q2   | Following are the important components of clinical geriatrics: | 1. Primary care  
2. Secondary and Tertiary care  
3. Palliative care  
4. All of the above | R1=0  
R2=0  
R3=0  
R4=1  
R4=0 |
| Q3   | What do you mean by the concept of long-term care? | 1. It is a concept of providing care for a long period of time.  
2. It is the care aimed at maintaining a certain level of functional capacity in a person who is at risk of losing significant intrinsic capacity over time.  
3. All of the above  
4. None of the above | R1=0  
R2=1  
R3=0  
R4=0 |
| Q4   | Which of the following is not used as an assistive device by older people? | 1. Wheel-chairs  
2. Spectacles  
3. Hearing-aids  
4. Mobile phone | R1=0  
R2=0  
R3=0  
R4=1 |
| Q5   | Choose the correct definition of ‘old-age vaccination’. | 1. Vaccines for older people with health conditions  
2. Vaccines given when decline in immunity is expected  
3. Vaccination for terminally ill patients  
4. Vaccination before a procedure | R1=0  
R2=1  
R3=0  
R4=0 |
Instructions: Tick (✓) the correct answers after sample questionnaire for pre- and post-training knowledge assessment reading the questions carefully. Tick as many as applicable.

<table>
<thead>
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</table>
| Q6   | What are the steps involved in screening of an older person in a primary care setting? | 1. Carry out a detailed medical case history  
2. Conduct a physical examination  
3. Do a medication review of geriatric patients  
4. All of the above | R1=0  
R2=0  
R3=0  
R4=1 |
| Q7   | The index to measure the functional capacity of an older patient is?           | 1. Activities of daily living (ADL)  
2. Instrumental activities of daily living (IADL)  
3. Medication Appropriateness Index (MAI)  
4. Both 1 and 2. | R1=0  
R2=0  
R3=0  
R4=1 |
| Q8   | The most accurate commeasure of nutrition in an older patient is?              | 1. Body mass index (BMI)  
2. Swallowing ability  
3. Calf circumference  
4. All the of the above | R1=0  
R2=0  
R3=0  
R4=1 |
| Q9   | Which of the practices are important for health promotion among older people? | 1. Counselling on dietary practices and physical activity  
2. Promoting social interaction among older persons  
3. Both 1 and 2.  
4. None of the above | R1=0  
R2=0  
R3=1  
R4=0 |
| Q10  | What do you mean by poly-pharmacy?                                            | 1. Practice of consuming many drugs at a time  
2. Use of 5 or more drugs by a patient  
3. Consumption of multiple systems of medicine  
4. All of the above | R1=0  
R2=1  
R3=0  
R4=0 |
| Q11  | The most common psychological problems among older people are?                 | 1. Substance abuse (tobacco, alcohol)  
2. Depression, anxiety  
3. Stress, neurosis  
4. All of the above. | R1=0  
R2=0  
R3=0  
R4=1 |
| Q12  | Which are most common health implications of elderly abuse?                    | 1. Physical injuries  
2. Psychological and psychosocial problems  
3. Neurological disorders  
4. All of the above. | R1=0  
R2=0  
R3=0  
R4=1 |
### Instructions: Tick (✓) the correct answers after sample questionnaire for pre- and post-training knowledge assessment reading the questions carefully. Tick as many as applicable.

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<tbody>
<tr>
<td>Q13</td>
<td>Which set of symptoms known as 4I’s in geriatrics?</td>
<td>1. Instability, Incontinence, Intellectual impairment, Immobility</td>
<td>R1=1 R2=0</td>
</tr>
<tr>
<td></td>
<td></td>
<td>2. Impairment, Incontinence, Instability, Immobility</td>
<td>R3=0 R4=0</td>
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<tr>
<td></td>
<td></td>
<td>3. Illusion, Incontinence, Impairment, Immobility</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>4. Insomnia, Iatrogenesis, Instability, Immobility</td>
<td></td>
</tr>
<tr>
<td>Q14</td>
<td>Inability to go to market for buying vegetables is a deficit in:</td>
<td>1. Basic activity of daily living</td>
<td>R1=0 R2=1</td>
</tr>
<tr>
<td></td>
<td></td>
<td>2. Instrumental activity of daily living</td>
<td>R3=0 R4=0</td>
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<td></td>
<td></td>
<td>3. Advanced activity of daily living</td>
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<td></td>
<td></td>
<td>4. Mental function</td>
<td></td>
</tr>
<tr>
<td>Q15</td>
<td>The timed –up-and-go (TUG) test is an indicator of:</td>
<td>1. Mental ability</td>
<td>R1=0 R2=0</td>
</tr>
<tr>
<td></td>
<td></td>
<td>2. Psychological preparedness</td>
<td>R3=1 R4=0</td>
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<td></td>
<td></td>
<td>3. Functional status</td>
<td></td>
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<td></td>
<td></td>
<td>4. Quality of life assessment</td>
<td></td>
</tr>
<tr>
<td>Q16</td>
<td>One of the following is a modifiable risk factors for functional decline in old age:</td>
<td>1. Gender</td>
<td>R1=0 R2=1</td>
</tr>
<tr>
<td></td>
<td></td>
<td>2. Polypharmacy</td>
<td>R3=0 R4=0</td>
</tr>
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<td></td>
<td></td>
<td>3. Age</td>
<td></td>
</tr>
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<td></td>
<td></td>
<td>4. Life expectancy at birth</td>
<td></td>
</tr>
<tr>
<td>Q17</td>
<td>Ischemic stroke can be treated with thrombolytic therapy within:</td>
<td>1. 3 hours</td>
<td>R1=0 R2=1</td>
</tr>
<tr>
<td></td>
<td></td>
<td>2. 4.5 hours</td>
<td>R3=0 R4=0</td>
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<td></td>
<td></td>
<td>3. 6 hours</td>
<td></td>
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<td></td>
<td></td>
<td>4. 7.5 hours</td>
<td></td>
</tr>
<tr>
<td>Q18</td>
<td>The most common physiological change in a 70-year-old man is:</td>
<td>1. Loss of sense of taste</td>
<td>R1=0 R2=1</td>
</tr>
<tr>
<td></td>
<td></td>
<td>2. Loss of sense of smell</td>
<td>R3=0 R4=0</td>
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<td></td>
<td>3. Cerebellar dysfunction</td>
<td></td>
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<td></td>
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<td>4. Anorexia</td>
<td></td>
</tr>
<tr>
<td>Q19</td>
<td>An indication for referring a 70-year-old man with diarrhea to a specialist is if he has:</td>
<td>1. Four stools per day</td>
<td>R1=0 R2=0</td>
</tr>
<tr>
<td></td>
<td></td>
<td>2. Mucus in stool</td>
<td>R3=0 R4=1</td>
</tr>
<tr>
<td></td>
<td></td>
<td>3. Nausea</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>4. Temperature 101°F</td>
<td></td>
</tr>
</tbody>
</table>
Instructions: Tick (√) the correct answers after sample questionnaire for pre- and post-training knowledge assessment reading the questions carefully. Tick as many as applicable.

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</thead>
<tbody>
<tr>
<td>Q20</td>
<td>The drug that is most likely to cause constipation is:</td>
<td>1. Amitriptyline</td>
<td>R1=1</td>
</tr>
<tr>
<td></td>
<td></td>
<td>2. Proton pump inhibitor</td>
<td>R2=0</td>
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<tr>
<td></td>
<td></td>
<td>3. Levosulpiride</td>
<td>R3=0</td>
</tr>
<tr>
<td></td>
<td></td>
<td>4. Paracetamol</td>
<td>R4=0</td>
</tr>
<tr>
<td>Q21</td>
<td>Serious UTI in elderly people may not exhibit the one of the following sign,</td>
<td>1. Cloudy/blood in urine</td>
<td>R1=0</td>
</tr>
<tr>
<td></td>
<td></td>
<td>2. Frequency/urgency</td>
<td>R2=0</td>
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<td></td>
<td>3. Fever</td>
<td>R3=1</td>
</tr>
<tr>
<td></td>
<td></td>
<td>4. Chills/sweat</td>
<td>R4=0</td>
</tr>
<tr>
<td>Q22</td>
<td>Stress incontinence is</td>
<td>1. Leakage of urine without pressure</td>
<td>R1=0</td>
</tr>
<tr>
<td></td>
<td></td>
<td>2. Not associated with any infection</td>
<td>R2=0</td>
</tr>
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<td></td>
<td>3. Leakage of urine with rise in intra-abdominal pressure</td>
<td>R3=1</td>
</tr>
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<td></td>
<td>4. Due to stress</td>
<td>R4=0</td>
</tr>
<tr>
<td>Q23</td>
<td>Which of the following refers to WHO guidelines for mental health?</td>
<td>1. WHO PEN</td>
<td>R1=0</td>
</tr>
<tr>
<td></td>
<td></td>
<td>2. WHO mhGAP</td>
<td>R2=1</td>
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<td></td>
<td>3. IMCI</td>
<td>R3=0</td>
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<tr>
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<td></td>
<td>4. ICOPE</td>
<td>R4=0</td>
</tr>
<tr>
<td>Q24</td>
<td>International Day of Older Persons is celebrated on:</td>
<td>1. 1st of October</td>
<td>R1=1</td>
</tr>
<tr>
<td></td>
<td></td>
<td>2. 1st of December</td>
<td>R2=0</td>
</tr>
<tr>
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<td></td>
<td>3. 21st of September</td>
<td>R3=0</td>
</tr>
<tr>
<td></td>
<td></td>
<td>4. 10th of December</td>
<td>R4=0</td>
</tr>
<tr>
<td>Q25</td>
<td>Which of the following affects intrinsic capacity in ICOPE strategy?</td>
<td>1. Osteoarthritis of knee</td>
<td>R1=0</td>
</tr>
<tr>
<td></td>
<td></td>
<td>2. Irritable bowel syndrome</td>
<td>R2=1</td>
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<td></td>
<td></td>
<td>3. Depression</td>
<td>R3=0</td>
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<tr>
<td></td>
<td></td>
<td>4. Macular degeneration</td>
<td>R4=0</td>
</tr>
</tbody>
</table>
Annexure 2: ICOPE care pathways
A. Cognitive pathway

1. Cognitive capacity

Care pathways to manage cognitive decline

Simple memory and orientation test
1. Remembering the words: Ask the person to remember these words that you will say. Use simple, concrete words such as "flower, "door," "rice.
2. Orientation in time and space: Then, ask, "What is the full date today?" and "Where are you now?" (home, clinic, etc.)?
3. Recalling these three words: Now, ask the person to repeat the three words that you mentioned.

Pass or fail? If a person cannot answer one of the two questions about orientation OR cannot remember all these words, cognitive decline is likely and further assessment is called for.

ASSESS & MANAGE
Associated conditions -> 4.1
- Malnutrition** -> See malnutrition pathway -> 6
- Delirium -> Identify cause (medical conditions, intoxication from substances, use of drugs) and treat
- Polypharmacy -> Review medications and withdraw as appropriate
- Cerebrovascular diseases -> Assess history of vascular diseases in the brain (stroke/transient ischaemic event) and prevent further events

PREVENT
Further declines in cognitive capacity
Multimodal exercise -> 5.1
Provide cognitive stimulation -> 4.2

ASSESS & MANAGE
Cardiovascular diseases and risk factors**
- Provide integrated management of diseases
- Reduce cardiovascular risk factors
  - Stop smoking cessation
  - Treat hypertension and diabetes
  - Provide dietary advice for weight control

Screen for cognitive decline
Do you have problems with memory or orientation (such as not knowing where is or what day it is)?

Reinforce positive health and lifestyle advice or usual care
B. Locomotor pathway

2

Locomotor Capacity

Care pathways to improve mobility

Multimodal exercise -> 5.1

A multimodal exercise programme for people with limited mobility combines exercise and cross training with emphasis on the core muscle groups of back, thighs, abdomen and lower body. A multimodal exercise programme should be tailored to suit individual capacities and needs. The Winfall project offers a practical guide to developing an exercise programme tailored to capacities.

http://winfall.com/resources

For WHO global recommendations on physical activity, see box, page 30.

*Specialized care needed

Limited mobility (SPPB score 0-9 points)

- Provide multimodal exercise with close supervision
- Consider referral to rehabilitation
- Consider increasing protein intake
- Consider and provide assistive device to aid mobility

Recommended multimodal exercise at home
- Support self-management to increase adherence -> 5.2

Normal mobility (SPPB score 10-12 points)

ASSESS MOBILITY 12 (SPPB or other physical performance test)

ASSESS & MANAGE

ASSOCIATED CONDITIONS

- POLYPHARMACY
- Review medication and aim to reduce

- OSTEOAARTHRITIS, OSTEOPOROSIS & OTHER BONE JOINT LIMITATIONS
- Integrated management of diseases

- FRAILITY & SARCOPENIA
- Pain
- Consider pain management

World Health Organization

*Specialized care needed

ASSESS & MANAGE

SOCIAL AND PHYSICAL ENVIRONMENTS
- Assess physical environment to reduce risk of falls -> 5.5
- Include falls prevention interventions such as home adaptations
- Consider and provide assistive device to aid mobility -> 5.6
- Provide safe spaces for walking
C. Visual pathway

**Visual capacity**

**Care pathways to manage visual impairment**

**VISUAL IMPAIRMENT (14)**
- Distance vision impairments:
  - Mild – visual acuity worse than 6/12
  - Moderate – acuity worse than 6/18
  - Severe – acuity worse than 6/60
  - Blindness – acuity worse than 3/60
- Near vision impairment
  - Near visual acuity worse than N6 or M.08 with existing correction

**ASSESS VISUAL IMPAIRMENT AND EYE DISEASES**
- Treat eye diseases
- Manage visual impairment
  - Review and update glasses prescription, or offer new glasses
  - Consider eye rehabilitation, including assistive vision devices such as desk and mobile magnifiers

**ASSESS & MANAGE**

**ASSOCIATED CONDITIONS**
- **HYPERTENSION**
  - Manage cardiovascular risk factors
- **DIABETES**
  - Refer to specialised eye care for retina check every year
- **STEROID USE**
  - Review medication to avoid adverse drug reactions on eyes

**ASSESS & MANAGE**

**SOCIAL AND PHYSICAL ENVIRONMENTS**
- Give advice on daily living with poor vision
- Introduce home adaptations (lighting, contrasting colours) to prevent falls
- Remove hazards from the usual walking path
D. Hearing pathway

**TEST HEARING**
- Whisper voice test: Able to hear whispers 13 OR
- Screening audiometry: 35 dB or less to pass OR
- Automated app-based digits-in-noise test

**Hearing capacity**

**Care pathways to manage hearing loss**

- Deafness (Audiometry: >81 dB)
- Moderate to severe hearing loss (Audiometry: 36-80 dB)
- Normal hearing capacity (Audiometry: ≤ 35 dB)

**ASSESS HEARING CAPACITY**

- ASSESS hearing capacity (Diagnostic audiometry)
- >8.1

**ASK ABOUT:**
- RISK FACTORS (such as noise exposure and ototoxic medications)
- PAIN IN THE EAR
- HISTORY of active drainage of fluid from the ear(s), sudden or rapidly progressive hearing loss
- DIZZINESS
- CHRONIC OTITIS MEDIA
- UNILATERAL HEARING LOSS

**Refer to specialized hearing care**

* Evaluate and provide hearing device ∈ 8.4 (hearing aids or cochlear implants)

**ASSESS & MANAGE**

**SOCIAL AND PHYSICAL ENVIRONMENTS**
- Provide emotional support and help with managing emotional distress
- Provide auditory aids across the house (telephone, door bells)
- Provide the person with hearing loss, their family members and caregivers with strategies to stay connected and maintain relationship

*Specialized care needed*
E. Psychological pathway

5 Psychological capacity

Care pathways to depressive symptoms

ASK
Over the past two weeks, have you been bothered by
Feeling down, depressed or hopeless?*
Little interest or pleasure in doing things?

SCREEN FOR DEPRESSIVE SYMPTOMS

DEPRESSIVE SYMPTOMS (0-2 additional symptoms)

ASSESS MOOD II

DEPRESSION (≥ 3 ADDITIONAL SYMPTOMS)

-Offer brief structured psychological interventions > 9.1
-cognitive behavioural therapy
-problem-solving counselling or therapy
-behavioural activation
-life review therapy

Multimodal exercise > 9.2
Mindfulness practice > 9.3

*Offered to people who have a diagnosis of major depression generally need specialised care. They should be advised and treated as recommended in the WHO mhGAP intervention guide
https://apps.who.int/iris/handle/10665/250239

ASSESS & MANAGE

ASSOCIATED CONDITIONS > 9.4-9.7

Major loss in the last six months – POLYPHARMACY
History of mania ANAEMIA
Cognitive impairment MALNUTRITION
Hearing loss HYPOTHYROIDISM
Vision impairment PAIN
Disability due to illness or injury

Review medications such as antidepressants, antihistamines, antipsychotics
Integrated management of conditions > 9.6
Assess and manage pain

*Specialized care needed

*Older people use a wide variety of terms for low mood, like sadness, depressed, down, etc.

SOCIAL AND PHYSICAL ENVIRONMENTS
-Reduce stress and strengthen social support
-Motivate older people to stay mobile and socially connected
-Promote functioning in daily activities
-Encourage participation in community-based exercise programmes and skills development
-Identify and tackle loneliness and social isolation (consider technology assisted interventions)
F. **Social care pathway**

---

### 6. Social care and support

#### Care pathways for social care and support

1. **Do you have difficulty getting around indoors?**
   - **YES**
2. **Do you have difficulty using the toilet (or commode)?**
3. **Do you have difficulty dressing yourself?**
4. **Do you have difficulty using the bath or shower?**
5. **Do you have difficulty keeping up your personal appearance?**
6. **Do you have difficulty feeding yourself?**
7. **Do you have problems with the place where you live (accommodation)?**
8. **Do you have problems with your finances?**
9. **Do you feel lonely?**
   - **YES**
10. **Are you able to pursue leisure interests, hobbies, work, volunteering, supporting your family, educational or spiritual activities that are important to you?**
   - **NO**
11. **Assess risk of elder abuse**

---

#### ASSESS

**SOCIAL CARE AND SUPPORT NEEDS**

#### ASK

**HELP WITH SOCIAL CARE (PERSONAL ASSISTANCE)**

- Assess and modify physical environment to compensate for loss of intrinsic capacity, improve mobility and prevent falls
- Consider use of assistive technologies, aids and adaptations
- Assess support from spouse, family or other unpaid caregivers and include an assessment of the caregiver’s needs
- Review needs for support from paid care workers
- Caregivers and services should be available such as home base care, day care, nursing home

#### ASK SUPPLEMENTARY QUESTIONS

**Do you have concerns because of:**

1. **Your safety and security where you live in?**
2. **The condition of your house?**
3. **The location of your home?**
4. **The costs of housing?**
5. **The repair and maintenance of your home?**
6. **Managing to live independently where you are?**

#### ASK SUPPLEMENTARY QUESTIONS

1. **In general, how do your finances work out at the end of the month?**
2. **Are you able to manage your money and financial affairs?**
3. **Would you like to advice about financial allowances or benefits?**

---

#### Review ways to enhance

- Close social connections (spouse, family, friends, pets)
- Use of local community resources (clubs, faith groups, day centres, sports, leisure, education)
- Opportunities to contribute (volunteering, employment)
- Connectivity using communication technology

#### ASK SUPPLEMENTARY QUESTIONS TO IDENTIFY THE BARRIERS:

You are not able to pursue because of:

1. **cost**, 2. distance, 3. transport, 4. lack of opportunities, 5. others?

- Provide a list of local community services available to older people, such as leisure facilities and clubs, adult educational providers, volunteering and employment advisory services
- Encourage the older person to use these services to increase their participation

---

*Observational information based on the behaviour of the older person, the behaviour of their caregivers or relatives, or from signs of physical abuse should be used to identify potential abuse.*

---

*World Health Organization*
Annexure 3: WHO simple eye chart
WHO simple eye chart

WHO simple Eye-chart with 4 small Es for near vision

WHO simple Eye-chart with 4 large Es for distance vision
Annexure 4: PowerPoint presentation slides
Talking points

Module 1: Integrated care for older people (ICOPE)

Slide 1:
In this module, we will discuss about a new way of managing an older patient with complex health problems.

Slide 2:
This module, has three learning objectives. Read them out explaining each point from reference manual.

Slide 3:
The new ICOPE approach of WHO reflects a community-based strategy. This approach will help to reorient health and social services towards a person-centered and coordinated model of care to support optimization of functional ability for older people to face the environmental challenges.
Slide 4:

Older people are frequently faced with:

1. Numerous healthcare workers may be involved with one person’s care, and many existing health systems manage health issues in a fragmented way, and there is a lack of coordination across care providers and settings, which may lead to polypharmacy. Healthcare and social care are typically fragmented from one another.

2. Older people find difficult to use services even when they are available. 60% of older people in low income countries did not access health care, because of the cost of the visit, the absence of transportation or the inability to pay for transportation.

3. When they manage to access services, they encounter negative attitudes of health care providers. Decline in intrinsic capacity is expressed very frequently as common impairments. For example, I cannot hear well. Or see well. I forget things more often. Or have difficulties with walking. Early markers of decline in intrinsic capacity, such as decreased gait speed or reduced muscle strength, are often not identified, treated or monitored. These ‘problems’ are often overlooked and interpreted as signs of “normal” ageing by health professionals, although this is crucial if they are to be reversed or delayed. The majority of health professionals lack guidance or training to recognize and manage impairments in older age.

4. There is a lack of interventions to optimize intrinsic capacity and functional ability. Health professionals in clinical settings would need to be able to detect ‘declines’ in Intrinsic Capacity and deliver effective interventions to prevent and slow/stop its progression towards negative outcomes associated with care dependency in older age.

   ✓ These all can lead to older people disengaging from services, not adhering to treatment or not admitting themselves to primary health care clinics based on the belief that there is no intervention available for their problems.

   ✓ There is a pressing need to develop comprehensive community-based approaches and introduce interventions to prevent declines in capacity.
Slide 5:

Here are the principles of ICOPE person-centered care.

The aim is to maximize intrinsic capacity and functional ability.

» It is essential older person is involved in decision making and goal setting and those goals are set and prioritized according to the person’s value, needs and preferences and then develop the personalized care plans

» Opportunities to involve the communities in supporting care must be explored. Multicomponent interventions, should be delivered at home and in the community. Such as strength and resistance exercise, oral supplemental nutrition, home adaptation to prevent falls, and cognitive stimulation

» Assessment and management should involve multi-disciplinary health and social care workers

» Support for self-management includes providing older people with information, skills and tools, respecting their autonomy and abilities to direct their own care (mAgeing)

» Supporting caregivers includes to provide basic information about the older person’s health conditions and training to develop practical skills, and explore opportunities to involve communities and neighborhood

» Strong referral pathways to specialized care are important such as geriatric care, acute care in case of unforeseen events, and palliative care. Furthermore, regular follow up is essential, as it promotes early detection of changes in functional status.

Slide 6:

The concept of Intrinsic capacity was launched by WHO in World Report on Ageing and Health which defines the healthy ageing focuses on the goal of maintaining functional ability, across the life course. There are two key words related to healthy ageing concept: intrinsic capacity and functional ability. WHO defines intrinsic capacity as a combination of individuals physical and mental capacities. Functional ability is the Combination and interaction of intrinsic capacity with the environment a person inhabits.
For example, my visual acuity is low which is my intrinsic capacity, but with contract lenses or glasses, my functional ability for vision is fine.

As people age, their intrinsic capacity become more chronic and complex. Multimorbidity – the presence of multiple chronic conditions at the same time – is increasingly prevalent with age. The health and social needs of older people are typically complex and long-term. There are limitations of traditional models of care.

**Slide 7:**
Person centered assessment is a modification of the existing way of assessing an older patient. Read out each point and discuss with examples if possible.

**Slide 8:**
The first step in person centered approach is screening; which in case of ICOPE has been put in different domains.

**Slide 9:**
If a person cannot answer one of the two questions about the orientation, OR cannot remember all three words; this is considered abnormal and step 2 assessment is required.
**Slide 10:**

Mobility is tested by asking the person to stand up from sitting position on a chair five times while recording the time on stopwatch. If the person takes more than 14 seconds for 5 stand ups, a deficit in mobility is diagnosed. For further assessment he/she needs to be referred to step 2 assessment.

**Slide 11:**

To assess deficit in nutritional status two questions will be asked related to weight loss and loss of appetite. If the answer is yes to any of the questions; malnutrition has to be assessed in step 2.

**Slide 12:**

For vision, two questions; one on seeing far or reading objects; and the second on a few common medical problems needs to be asked.

**Slide 13:**

For assessment of hearing, three methods are there. A person failing in any of the three, has hearing deficit and needs Step 2 assessment. Read all the three options and explain them in detail.
Slide 14:

There are two questions for depression. ‘Yes’ response to any of these indicates depression and requires Step 2 assessment. Read both the questions and discuss about depression.

Slide 15:

This slide is summary of all screening tests. Read them loud and emphasize on positive screening tests.

Slide 16:

Explain the need for screening followed by assessment. Emphasize on all the three points.

Slide 17:

Emphasize screening tests. Discuss on step 2 tests. Talk about the next step of intervention for each diagnosis.
Slide 18:
Explain each step with examples.

Slide 19:
Explain each step with examples. Some points may not be culturally/socially adaptable in your country. Give their alternative if possible.
Talking points

Module 2: Functional assessment of older people

Slide 1:
The core content of assessment of an older person revolves around functional assessment. In this module the concept and practice of functional assessment will be discussed.

Slide 2:
At the end of this module, trainees will be able to enumerate the relevance of conserved functional status and will be able to carry out its assessment.

Slide 3:
Define functional status as provided in the slide and discuss its clinical significance.

Slide 4:
ADLs indicate their importance in life process. While BADLs are the most essential AADLs provide meaning to life.
Slide 5:
Explain each activity.

Slide 6:
This slide provides the importance of BADL and IADL. Give examples of BADL and IADL to explain the meaning of loss of functionality.

Slide 7:
In this slide, discuss the clinical utility of BADLs and IADLs in old age care. Read out each line and explain.

Slide 8:
This is an example of BADL assessment scale. Read out each activity and discuss.
Slide 9:

This is an example of IADL assessment scale. Read out each activity and discuss.

### LAWTON – BRODY INSTRUMENTAL ACTIVITIES OF DAILY LIVING SCALE (I.A.D.L)

Scoring: For each category, circle the item description that most closely resembles the client's highest functional level (either 0 or 1).

<table>
<thead>
<tr>
<th>Category</th>
<th>Description</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>I. Ability to use telephone</td>
<td>1. Operates telephone on own initiative (looks up and dials numbers)</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>2. Dials a few well-known numbers</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>3. Answers telephone, but does not dial</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>4. Does not use telephone at all</td>
<td>0</td>
</tr>
<tr>
<td>V. Laundry</td>
<td>1. Does personal laundry completely</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>2. Launders small items, rinses socks, stockings, etc.</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>3. All laundry must be done by others</td>
<td>0</td>
</tr>
<tr>
<td>II. Shopping</td>
<td>1. Takes care of all shopping needs independently</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>2. Shops independently for small purchases</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>3. Needs to be accompanied on any shopping trip</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>4. Completely unable to shop</td>
<td>0</td>
</tr>
<tr>
<td>VI. Mode of transportation</td>
<td>1. Travels independently on public transportation or drives own car</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>2. Arranges own travel via taxi but does not otherwise use public transportation</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>3. Uses public transportation when assisted or accompanied by another</td>
<td>1</td>
</tr>
<tr>
<td>III. Food preparation</td>
<td>1. Plans, prepares, and serves adequate meals independently</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>2. Prepares adequate meals if supplied with ingredients</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>3. Heats and serves prepared meals or prepares meals but does not maintain adequate diet</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>4. Needs to have meals prepared and served</td>
<td>0</td>
</tr>
<tr>
<td>IV. Housekeeping</td>
<td>1. Maintains house alone or with occasional assistance (e.g. heavy work)</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>2. Performs light daily tasks such as washing dishes and making beds</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>3. Performs light daily tasks, but cannot maintain acceptable level of cleanliness</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>4. Needs help with all home maintenance tasks</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>5. Does not participate in any housekeeping tasks</td>
<td>0</td>
</tr>
<tr>
<td>VIII. Ability to handle finances</td>
<td>1. Manages financial matters independently (makes budgets, writes cheques, pays rent and bills, goes to bank), collects and keeps track of income</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>2. Manages day-to-day purchases, but needs help with banking, major purchases, etc.</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>3. Incapable of handling money</td>
<td>0</td>
</tr>
</tbody>
</table>

Total score:_________________________________

A summary score ranges from 0 (low function, dependent) to 8 (high function, independent) for women and 0 through 5 for men to avoid potential gender bias.

Patient Name: __________                                                       Date: _________
Patient ID # ________
Talking points

Module 3: Health promotion and disease prevention in old age

Slide 1:
The Primary Care Physician has an important role in the health system as the most effective health educator. Health can improve and diseases can be prevented as each. In this module various strategies for health promotion and diseases prevention will be discussed.

Slide 2:
At the end of this module, the trainees will be carrying out health promotion and disease prevention interventions in older population.

Slide 3:
Define health promotion and discuss each of the clauses: enabling, control and improve.

Slide 4:
Discuss each of the three engagements with examples.
Slide 5:
Discuss age related changes in gastrointestinal tract that affects nutrition. Read out each point and discuss.

Slide 6:
This slide provides information on impact of poor nutrition on various aspects of body structure and function. Discuss each point.

Slide 7:
This slide provides a practical strategy for nutritional assessment and management.

Slide 8:
This slide provides management strategy as per mini nutritional assessment.
Slide 9:
This slide provides detailed dietary advice to be carried out by a dietician if available. General advice by the physician can be on the basis of food pyramid provided on the slide.

Slide 10:
This slide provides information on exercises for older people. Discuss in detail.

Slide 11:
This slide provides information on various types of exercises for older people. Discuss in detail.

Slide 12:
Read out and discuss in detail with examples.
Slide 13:
This slide indicates strategies for disease prevention. Discuss on each of the five points with examples and strategies.

Slide 14:
Discuss each box with examples.

Slide 15:
Discuss each vaccine.
Talking points

Module 4: Cardiovascular system

Slide 1:
Cardiovascular diseases are commonest causes of physician consultation with serious illness, hospitalization and death. Every physician must be aware of management of hypertension, acute coronary syndrome and heart failure.

Slide 2:
At the end of this module, the trainee should be able to provide basic management for common heart diseases.

Slide 3:
Discuss these age related changes with examples of outcome.

Slide 4:
Discuss the slide in detail about each box with examples.
**Slide 5:**
Read out and explain. Also add to list any other condition common in your geographic region.

**Slide 6:**
Read out and discuss.

**Slide 7:**
Discuss management strategy with additional health issues.

**Slide 8:**
Read out and discuss. Add anything that you think is important.

---

### Hypertension

- Commonest health problem
- 50-70% of older population
- Majority undiagnosed or uncontrolled
- Systolic BP – greater predictive value than Diastolic BP
- Not diagnosed on basis of single measurement (3 different measurements on 2 separate visits)

### Case Scenario

76-year-old male while being evaluated for knee pain is noticed to have BP 190/80.

### Hypertension

- Primary or essential hypertension is the commonest cause
- Atherosclerotic reno-vascular hypertension, while rare, is more common in the older adults.
- Hypertension being a silent disease diagnosis; every older patient must be subjected to blood pressure measurements at each consultation or visit to the physician.

---

### Common Cardiovascular Diseases

- Hypertension - Isolated Systolic Hypertension
- Coronary Artery Disease
- Heart Failure
- Atrial Fibrillation
- Peripheral Arterial Diseases
Slide 9:
Discuss with examples and strategies.

**Diagnosis and management of hypertension**

- SBP is ≥140 mmHg/DBP is ≥90 mmHg: one to four weeks after the first measurement.
- SBP ≥160 mmHg or DBP ≥100 mmHg may be indicated for immediate treatment.

**Special consideration**

<table>
<thead>
<tr>
<th>SBP ≥160 mm Hg or DBP ≥100 mm Hg</th>
<th>Immediate treatment and refer to higher centre</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prior heart attack/stroke/high risk CVD</td>
<td>LVEDP and/or</td>
</tr>
<tr>
<td>Prior heart attack/ ischemic stroke</td>
<td>add Aspirin (low dose)</td>
</tr>
<tr>
<td>Renal failure</td>
<td>check GFR and starting BP</td>
</tr>
<tr>
<td>SBP persists ≥130 mm Hg</td>
<td>decrease dose or number of BP medicines</td>
</tr>
<tr>
<td>Amlodipine</td>
<td>OD/100mg</td>
</tr>
<tr>
<td>Avoid triple therapy</td>
<td>ACEI, ARB's and Diuretics</td>
</tr>
<tr>
<td>ACE with aldosterone antagonist (spironolactone)</td>
<td>HyperK+Thiazides + Loop diuretics</td>
</tr>
<tr>
<td>Beta blockers</td>
<td>not to use as 1st line agents</td>
</tr>
</tbody>
</table>

**Medicine and dosage for hypertension**

<table>
<thead>
<tr>
<th>Class</th>
<th>Medication</th>
<th>Starting dose</th>
<th>Intensification of dose</th>
</tr>
</thead>
<tbody>
<tr>
<td>Calcium Channel Blocker</td>
<td>Amlodipine</td>
<td>5 mg</td>
<td>10 mg</td>
</tr>
<tr>
<td>Angiotensin Converting Enzyme Inhibitor</td>
<td>Enalapril</td>
<td>5 mg</td>
<td>10 mg</td>
</tr>
<tr>
<td></td>
<td>Ramipril</td>
<td>2.5 mg</td>
<td>5 mg</td>
</tr>
<tr>
<td>Angiotensin Receptor Blocker</td>
<td>Lisinopril</td>
<td>20 mg</td>
<td>40 mg</td>
</tr>
<tr>
<td></td>
<td>Telmisartan</td>
<td>25 mg</td>
<td>50 mg</td>
</tr>
<tr>
<td>Thiazide</td>
<td>Hydrochlorothiazide</td>
<td>12.5 mg</td>
<td>25 mg</td>
</tr>
<tr>
<td></td>
<td>Chlorthalidone</td>
<td>12.5 mg</td>
<td>25 mg</td>
</tr>
</tbody>
</table>

**Protocol for Hypertension Drug Management**

**Slide 10:**
Discuss each point.

**Slide 11:**
Discuss each drug.

**Slide 12:**
Discuss each step.
Slide 13:
Read out and discuss in detail.

Slide 14:
Read out and discuss in detail.

Slide 15:
Read out and discuss in detail.

Slide 16:
Read out and discuss in detail.
Cardiac syncope
Impaired cardiac output due to arrhythmias or structural heart disease with outflow obstruction

Reflex or neurally-mediated syncope
Most frequent cause of syncope in the older people (44% of cases)

Vasovagal syncope
Meditated by the vasovagal reflex

Situational syncope
Occurs in conditions that trigger the Valsalva manoeuvre, such as urination, defecation, coughing, and swallowing

Carotid sinus hypersensitivity
Sudden head turning and wearing tight clothing around the neck

Orthostatic hypotension (OH)
Sustained reduction in systolic blood pressure of at least 20 mmHg or in diastolic blood pressure of 10 mmHg, within 3 minutes of standing

Types of syncope in elderly

Evaluation of dizziness and syncope

• Physical examination
• Check for postural drop in blood pressure
• Perform ECG (if available)
• Evaluate for volume depletion
• Review medications
Talking points

Module 5: Respiratory system

Slide 1:
Respiratory diseases are common in old age. Smoking is an important cause of many chest diseases. TB continues to be a killer in many Member States and pneumonia is a common terminal event in many unrelated disease states.

Slide 2:
After end of this module, trainees will be able to distinguish age related changes from pathological conditions and diagnose and provide first line treatment and referral advice.

Slide 3:
Discuss the age related changes and explain their clinical significance.

Slide 4:
Read and discuss with examples.
Slide 5:
Read and discuss atypical features.

Atypical Features of Pneumonia in Elderly
• Confusion, incontinence, immobility
• Signs of inflammation like fever, tachycardia and leucocytosis may be absent
• Progression and resolution of pneumonia are slower – prolonged hospitalization

Slide 6:
Read and discuss each box.

Assessment of severity and prognosis of pneumonia in Older people

Slide 7:
Discuss each of the points in detail.

Empirical Treatment of Pneumonia

- **OPD:**
  - Previously healthy patient who has had no antibiotics in previous 3 months
  - Azithromycin 500 mg orally, once a day for 5 days or doxycycline 100 mg orally, twice a day for 5 days
  - Has comorbidities such as chronic heart, lung, liver or renal disease, diabetes, epilepsy, immunocompromising conditions, recent HIV infection, recent hospitalization or antibiotic within previous 3 months
  - Amoxycillin-clavulanate 625 mg orally, three times a day or Cefuroxime 500 mg orally, twice a day for 5-7 days
  - Azithromycin 500 mg orally, once a day for 5-7 days

- **IPD:**
  - Non-ICU
  - Injection Ceftriaxone 1 g intravenous twice daily + Azithromycin 500 mg orally or intravenous, once daily for 5-7 days

Slide 8:
Discuss the x-rays.

Tuberculosis

- Centrally located nodule
- Diffuse, cavity, opacity in L/L lung
Slide 9:
Read out and add anything extra you want.

Slide 10:
Read out and explain each point with examples.

Slide 11:
Discuss TB Strategies as per Country TB Control program if it exists.

Slide 12:
Read out and add anything extra you want.
Slide 13:
Read out and add anything extra you want.

Slide 14:
Read out and add anything extra you want.

Slide 15:
Read out and add anything extra you want.

Slide 16:
Discuss in detail.
Slide 17:
Read out and add anything extra you want.

Slide 18:
Read out and add anything extra you want.
Talking points

Module 6: Digestive system

Slide 1:
Symptoms related to gastrointestinal tract are extremely common among older patients in primary care. Further digestive tract dysfunction can lead to malnutrition and its accompanying health problems.

Slide 2:
After end of this module, trainees will be able to distinguish age related changes from pathological conditions and diagnose and provide first line treatment and referral advice.

Slide 3:
Read out and discuss their clinical implications.

Slide 4:
Read out and discuss their clinical implications.
Slide 5:
Read out and discuss each condition briefly. Add additional points if you want.

Slide 6:
Read out and discuss additional clinical issues.

Slide 7:
Read out and discuss additional clinical issues.

Slide 8:
Read out and discuss additional clinical issues.
Slide 9:
Read out and discuss additional clinical issues.

Gastroopathy and peptic ulcer
- NSAIDs increase the risk for peptic ulcer
- Increase with age
- Symptoms: change in bowel habits, constipation or diarrhea, decreased size of stool, blood in the stool, loss of appetite, wasting and weight loss.
- Peptic ulcers induced by NSAIDs, H. pylori or other causes tend to be very virulent
- May present with anaemia, fatigue and weight loss
- UGIS should be done
- Treatment: PPI for 8 weeks.

Slide 10:
Read out and discuss additional clinical issues.

Cancers of the gastrointestinal tract
- Cancer of the colon is more common among women than men, while cancer of the rectum is more common among men.
- Symptoms: change in bowel habits, new onset of constipation or diarrhea, decreased size of stool, blood in the stool, loss of appetite, wasting and weight loss.
- A high index of suspicion and referral to a specialist can go a long way in improving the prognosis.

Slide 11:
Read out and discuss additional clinical issues.

Constipation
- More frequent than younger people

Causes of constipation in old age
- Diet low in fibres
- Less Fluid Intake
- Mental Health Problems
- Lack of physical exercise
- Functional disability and chronic debilitating disease

Slide 12:
Read out and discuss additional clinical issues.

Management of constipation
- Impacted stool may need to be removed manually.
- Stool softeners
- Increasing fluid intake
- Exercise and bowel training regimens
- Osmotic agents
- Bulk-forming agents or stool softeners may be used as first-line therapy.
- Osmotic agents like milk of magnesia and lactulose may be tried if the initial agents do not work.
- The long-term use of stimulatory agents like senna or bisacodyl is best avoided.
Slide 13:
Read out and discuss additional clinical issues.

- Acute diarrhoea among older people is usually caused by viral gastroenteritis, which is a self-limiting
- Oral rehydration therapy with early refeeding is the preferred treatment for dehydration
- In case of severe dehydration or other related complication, patient refer to higher center
- Irritable bowel syndrome is the most common cause for chronic diarrhea in older people

Diarrhoea among older people

Slide 14:
Read out and discuss each condition.

When to refer:
- Appearance of jaundice
- Stool positive for occult blood
- Unexplained loss of appetite
- Sensation of early satiety
- Persistent sensation of fullness of abdomen
- Persistent vomiting
- Appearance of jaundice
- Acute onset alteration of bowel habit for > 2 weeks
- Nocturnal diarrhoea
- Recurrent abdominal pain
Talking points

Module 7: Endocrine system

Slide 1:
The ageing process is marked by several endocrine dysfunction and diseases of thyroid and diabetes are important diseases of old age.

Slide 2:
After end of this module, trainees will be able to develop care plans for common endocrine disorders.

Slide 3:
Read out each point and discuss with examples.

Slide 4:
Discuss each point with examples.
Integrated Care for Older People: A manual for primary care physicians (Facilitator’s Guide)

Slide 5:
Discuss diagnosis of diabetes with clinical features.

<table>
<thead>
<tr>
<th>Diagnostic criteria for diabetes</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Diagnosis</strong></td>
</tr>
<tr>
<td>Diabetic</td>
</tr>
<tr>
<td>Pre-diabetic</td>
</tr>
</tbody>
</table>

Slide 6:
Discuss each point with examples. Emphasize on difference in management strategy depending on over all clinical status of the patient.

<table>
<thead>
<tr>
<th>Slide 6: Target for diabetes management depending on health status</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Patient characteristics/health status</strong></td>
</tr>
<tr>
<td>Healthy (few coexisting chronic illnesses, intact cognitive and functional status)</td>
</tr>
<tr>
<td>Complex/Intermediate health (multiple coexisting chronic illnesses or 2+ instrumental ADL impairments or mild-to-moderate cognitive impairment)</td>
</tr>
<tr>
<td>Very complex/poor health (older adult in long term care or with end stage chronic illnesses or moderate to severe cognitive impairment or 2+ ADL dependencies)</td>
</tr>
</tbody>
</table>

Clinical Practice Recommendations
- Provide counseling around lifestyle changes.
- Prescribe once-daily less expensive and longer-lasting of medicine whenever possible.
- Explain potential adverse effects of the medications and what to do if the patient experiences them (e.g., hypoglycemia), especially to the caregivers.
- Measure blood pressure at every visit.
- Measure weight and calculate body-mass index (BMI) at every visit.
- Conduct foot exam.
- Conduct annual urine protein dipstick.
- Conduct retinal exam by fundoscopy every two years if available.

Slide 7:
Discuss each point with examples.

Slide 8:
Discuss each point with examples. Emphasize the gravity of hypoglycaemia over hyperglycaemia.

Risk factors:
- Autonomic dysfunction with ageing,
- irregular/poor diet,
- cognitive impairment,
- alcohol use,
- polypharmacy,
- chronic diseases of liver/kidney,
- use of sulphonylureas/insulin.
Management of Hypoglycemia

- Hypoglycemia can be life-threatening, but prompt recognition and management of hypoglycemia is rewarding for the primary care physician.
- If the patient is conscious and oriented, one should give sugary drinks/sweets.
- If the patient presents with neuroglycopenic symptoms, administer a bolus of 50 ml of 50% intravenous dextrose solution. Patients often recover with a single bolus dose.
- The older adult as well as the caregivers should be educated.
- Hypoglycemic unawareness (neuroglycopenic symptoms preceding the autonomic symptoms) may occur in older adults.

Slide 9:
Discuss each point in detail with additional clinical inputs.

Hyperglycaemic hyperosmolar state

- Serum glucose level rises to 600 mg/dl or above.
- Mortality rate is high.

Management at the primary healthcare level:
- The signs (severe hyperglycaemia) and symptoms must be recognized promptly, and
- Set up an intravenous drip of 0.9% NaCl and then refer to a hospital.
- Set up an intravenous drip of 0.9% NaCl and then refer to a hospital.

Slide 10:
Discuss each point in detail with additional clinical inputs.

Protocol for diabetes management

Slide 11:
Discuss each box in detail with additional clinical inputs.

Diabetic Foot Disease

- Common long-term complications of diabetes mellitus and carries a high risk of disability.
- Risk factors: Calluses, edema, sensory neuropathy and peripheral vascular disease.
- Foot ulcer evaluation should include assessment of neurological status, vascular status, and evaluation of the wound itself.
- The primary care physician should:
  - Evaluate the feet as well as the foot-wares of patients at every visit in patients at high-risk of diabetic foot ulcers.
  - Refer the patient to a higher center on development of diabetic ulcers.

Slide 12:
Discuss each point in detail with additional clinical inputs.
Slide 13:
Discuss each point in detail with additional clinical inputs. Emphasize atypical presentation and similarity with ageing process.

Hypothyroidism
- Common problem among older people and more so among women
- Management of hypothyroidism involves the establishment of the diagnosis with the demonstration of high serum TSH levels (>10 mU/L), with low free T3 and free T4.
- TSH level should be periodically assessed, every four to six weeks
- Subclinical hypothyroidism, in which abnormalities of lipid metabolism may be the only manifestation, is not an uncommon problem in old age.

Slide 14:
Discuss each point in detail with additional clinical inputs. Emphasize atypical presentation and cardiovascular manifestations.

Hyperthyroidism
- Clinical presentation is rarely classical
- Older people may present with “apathetic hyperthyroidism”: the features of which are weakness, lethargy, listlessness, depression and chronic wasting.
- The features of hyperactivity, irritability and restlessness, which are common in younger age groups, are absent
- Diagnosis: Requires the demonstration of high levels of circulating T3 and T4, with undetectable TSH values in the blood.

Slide 15:
Discuss each point in detail with additional clinical inputs.

Management of hypothyroidism
- Demonstration of high serum TSH levels (>10 mU/L), with low free T3 and free T4.
- Replacement of L-thyroxin
- Among older patients, replacement should start with a very low dose (25 mcg) and should be increased slowly to avoid cardiovascular toxicity.
- The TSH level should be periodically assessed, every four to six weeks, until a normal TSH level is reached. Thereafter, it can be assessed every three months.

Slide 16:
Discuss each point in detail with additional clinical inputs.

Management of hyperthyroidism
- The management of hyperthyroidism in old age requires early control of cardiovascular manifestations with β-adrenergic blocking agents, and the control of toxic symptoms with antithyroid medicines (propylthiouracil, carbimazole).
- The primary care physician monitor the free T4 levels every four to six weeks and accordingly titrate the dosage of medications, following the standard guidelines.
Talking points

Module 8: Musculoskeletal system

Slide 1:
Bones, joints and muscles are responsible for our mobility and carry our weight throughout life. As a result they are very susceptible to the impact of ageing process. With age bone and muscles lose their strength and power and ligaments and cartilages become stiff and lose their flexibility. The net result of these changes are loss of mobility and dependence.

Slide 2:
After this module, the trainees will be able to identify the basis of loss of locomotor functionality in older people and develop care plans for symptom relief and regaining functional ability.

Slide 3:
Discuss each point with their clinical relevance.
Slide 4:
Discuss each point with their clinical relevance.

Consequences of age-related changes in the musculoskeletal system

- The marked loss of muscle quality as well as quantity leads to functional impairment
- The range of movement of the spine and peripheral joints decreases
- Changes in the vertebrae lead to kyphosis and a loss of height
- These changes lead to joint and periarticular pain, as well as difficulty in initiating movement

Slide 5:
Discuss each point in detail.

Locomotor capacity in older people

- Mobility is a critical determining factor for healthy ageing
- Locomotor capacity should be assessed through ICOPE

Slide 6:
Discuss each point in detail.

ICOPE Care pathways for locomotive capacity

- Screen the patient for losses in mobility, using the "chair-rise test".
- If screening is positive for losses, assess the patient’s mobility using the short physical performance battery (SPPB).

Slide 7:
Discuss each point with their clinical relevance.

Care pathways for locomotive capacity

- Advise multimodal exercise (strength/resistance training, aerobic/cardiovascular training, balance training, flexibility training) with close supervision.
- Assess and manage associated conditions.
- Assess and manage the person's social and physical environments to reduce the risk of falls.
Slide 8:
Discuss each point with their clinical relevance. Add additional inputs if any.

Slide 9:
Discuss each point in detail and add additional facts.

Slide 10:
Discuss each point in detail and add additional facts.

Slide 11:
Discuss each circlet in detail and add additional facts.
Slide 12:

BMD is measured by DEXA, which is usually available in tertiary care centres.

Slide 13:

Discuss each point in detail and add additional facts.

Falls are the second leading cause of accidental death. Of the older adults who sustain a hip fracture and are hospitalized as a result of a fall, one-third die within a year.

Approximately 35–40% of persons of the age of 65 years and above fall in a given year. Half of those who fall do so more than once.

Approximately 50% of persons of the age of 80 years and above fall in a year.

Women are more likely to fall than men.

More than half of all falls in the community occur at home.

Slide 14:

Discuss each point in detail and add additional facts.

Management of osteoporosis

• Exposure to sunlight: The best source of vitamin D is exposure to natural sunlight
• Nutrition: osteoporosis-friendly diet, with medications
• Exercising: exercises, including resistance training, jogging, jumping and walking, are considered effective against osteoporosis.
• Calcium and Vit D supplementation: Older males should supplement their dietary intake of vitamin D with 600 IU of vitamin D a day, while postmenopausal females should take 800 IU/day.
• Bisphosphonate therapy

Slide 15:

Discuss each point in detail and add additional facts.

Falls and fractures

Seventy-five per cent of all falls occur in older population.

Women are more likely to fall than men.

More than half of all falls in the community occur at home.

Falls not only affect the quality of life of the individual, but also influence the caregiver and family.

Fear leads to inactivity and loss of confidence. This, in turn, produces a cycle of fear, loss of self-confidence and inactivity, which decreases the quality of life and increases the risk of a fall.
Slide 16:
Discuss each point in detail and add additional facts.

Slide 17:
Discuss each box in detail and add additional facts. Try to correlate each box with the other to provide a clear clinical picture.

Slide 18:
Discuss each point in detail with clinical relevance and add additional facts if any.

Slide 19:
Discuss each point in detail and add additional facts.
Talking points

Module 9: Genitourinary system

Slide 1:
Ageing of the kidney is a silent process. It only unfolds when there is an acute stress or as adverse effect of multiple drugs. While loss of control over overflow of urine is very common in old age in women, men have difficulty in passing urine due to enlarged prostate. But both older men and women have high risk of urinary tract infection with increasing age which can be life threatening.

Slide 2:
At the end of this module, the trainees will be to identify common genito-urinary problems and develop care plans for management.

Slide 3:
Discuss each point in detail with clinical relevance.
Integrated Care for Older People: A manual for primary care physicians (Facilitator’s Guide)

Slide 4:
Discuss each point in detail with additional clinical inputs.

Common diseases

Urinary tract infection:
Factors for the growth and persistence of infection in the urinary tract are:
• Structural abnormalities
• Vascular insufficiency
• Declining immunity
• Diabetes mellitus
• In-dwelling catheters

Factors for the growth and persistence of infection in the urinary tract are:

Slide 5:
Discuss each point in detail with additional clinical inputs.

Urinary Tract Infection

• Clinical symptoms: frequency and dysuria.
• Can also present with delirium in the older adults.
• Prevalence of bacteriuria increases with age and it is more common in women.
• Symptomatic UTI - M C E.coli from the community
• However asymptomatic bacteriuria does not require treatment
• Institutionalized UTI - older people, Proteus, Klebsiella and Pseudomonas, Treatment 5-7 days course of oral antibiotics.

Slide 6:
Discuss each point in detail with additional clinical inputs.

Benign prostatic hypertrophy
• BPH is an extremely common problem of advancing age.

SYMPTOMS
• Obstructive: Hesitancy, Poor stream, sense of incomplete voiding
• Irritative: Frequency, urgency, urge incontinence.

DIAGNOSIS:
• a digital rectal examination
• ultrasonographical evaluation of the bladder and the prostate
• Referring to a specialist: physician should refer the older person to a specialist

Slide 7:
Emphasize the new diagnostic and therapeutic modalities for BPH with ultra-sound and endoscopic surgery. Also note that medicines can postpone or obviate the need for surgery.

Medical management of BPH

• Selective alpha-1 adrenergic antagonists
• 5-alpha-reductase inhibitors
• These medicines act by reducing the size of the prostate gland and have demonstrated the potential for a long-term reduction in the prostate volume. They reduce the need for prostate surgery as well.
**Slide 8:**
Discuss each point in detail with additional clinical inputs. Emphasize that prostate cancer is emerging as a leading cancer among ageing males.

**Cancer of Prostate**
- Common malignancy of old age
- Clinical manifestations are either silent or similar to benign hypertrophy in the early stages.
- In late stages when skeletal metastasis is frequent it becomes one of the most painful conditions.
- Unfortunately, a majority of the patients with prostate cancer present with metastatic disease.

**Role of Primary Care Physician**
- When to urgently refer to a urologist:
  - Prostatic symptoms with digital rectal examination revealing a prostate of firm to hard consistency with nodules, loss of medial sulcus with immobile overlying mucosa.
  - Presence of haematuria, painful ejaculation, impotence.
  - New-onset low back pain with fatigue, malaise, weight loss

**Urinary incontinence**
- Involuntary loss of urine in sufficient amount or frequency, to be a social and/or health problem.
- Neglected by the patient as well as the physician
- Prevalence in community varies from 15-20% and in Long term care center its 50%.

**Types of incontinence**

<table>
<thead>
<tr>
<th>Name</th>
<th>Features</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stress</td>
<td>Involuntary loss of urine due to an increased intra-abdominal pressure during coughing, sneezing, laughing or other activities that increase intra-abdominal pressure.</td>
</tr>
<tr>
<td>Urge Incontinence</td>
<td>Involuntary loss of urine associated with a strong desire or need to urinate. It is usually associated with premature detrusor muscle contractions.</td>
</tr>
<tr>
<td>Mixed</td>
<td>Combination of stress and urge incontinence. It is most common in older women.</td>
</tr>
<tr>
<td>Overflow</td>
<td>Involuntary loss of urine resulting from an over-distended bladder. It may have a variety of presentations, including frequent or constant dribbling, or urge or stress incontinence symptoms.</td>
</tr>
<tr>
<td>Transient</td>
<td>Result of a reversible medical condition.</td>
</tr>
<tr>
<td>Functional</td>
<td>Caused by factors outside the lower urinary tract such as impairment of physical or cognitive functioning, or both.</td>
</tr>
</tbody>
</table>

**Slide 9:**
Discuss each point in detail with additional clinical inputs.

**Slide 10:**
Discuss each point in detail with additional clinical inputs.

**Slide 11:**
Discuss each point in detail.
Slide 12:
Discuss each point in detail with additional clinical inputs.

Slide 13:
Discuss each point in detail with additional clinical inputs. Emphasize that drug or surgical treatment for incontinence is yet to be established.

Slide 14:
Discuss each point in detail with additional clinical inputs.

Slide 15:
Discuss each point in detail with additional clinical inputs.
Talking points

Module 10: Neurological diseases of old age

Slide 1:
Older people are at higher risk of certain diseases which occurs very infrequently in younger population. Parkinson’s disease and Stroke are some of the common disabling conditions in old age.

Slide 2:
After this module, the trainees will be able to detect and develop care plans for common neurological problems such as stroke and Parkinson’s disease.

Slide 3:
Explain and discuss each of the points related to age related changes in brain.

Slide 4:
Discuss the cartoon with examples.
Clinical manifestations

- Numbness or weakness of face, arm or leg, especially on one side of the body
- Confusion, trouble speaking or understanding
- Trouble seeing with one or both eyes
- Trouble walking, dizziness, loss of balance or coordination
- Severe headache with no known cause

**Idiopathic Parkinson’s Disease**

- Parkinson’s disease (PD) is an insidious and asymmetric disease with a progressive course.
- Causes severe disability and all treatment strategies provide only limited relief

**Post-stroke rehabilitation**

A multidisciplinary activity which focuses on problem-solving and educating the patient on the disability.

The basic principles of rehabilitation:

- Documentation of the impairment and disabilities
- Maximization of independence and minimization of dependency
- Should address several sequelae which affect the patient’s quality of life

**Role of primary care physicians in stroke management**

- Recognize the above-mentioned symptoms and refer to a specialized stroke unit.
- Help in post-stroke rehabilitation to maintain independence after the patient is discharged from hospital.
- Help in secondary prevention of stroke.

**Slide 5:**

Explain and discuss each of the points related to stroke.

**Slide 6:**

Explain and discuss each of the points related to stroke management.

**Slide 7:**

Explain and discuss each of the points related to stroke rehabilitation.

**Slide 8:**

Explain and discuss each of the points related to Parkinson’s disease.
**Slide 9:**
Explain and discuss each of the points related to diagnosis and management of PD.

**Slide 10:**
Emphasize the difference between tremor and PD.

**Slide 11:**
Emphasize the difference between tremor and PD.

**Slide 12:**
Discuss in detail.

---

**Diagnosis of Parkinson’s disease**
- The diagnosis of PD is clinical.
- It is diagnosed by the presence of bradykinesia with at least one of the following symptoms:
  - Rigidity
  - Resting tremor (often unilateral to begin with)
  - Postural instability (often the late manifestation).

The management of PD requires specialist care and the patient should be referred promptly for diagnosis and treatment.

**Essential tremor**
- Essential tremor (ET) is the most common movement disorder.
- It is often inherited and generally starts at an advanced age.
- It usually involves the upper limbs. The patient experiences the symptoms when the arms are held up (such as when reading the newspaper) or when the hands are used for any activity (writing, holding food for eating, holding a glass).
- Tremor may involve head, voice, tongue, legs.
- Condition worsens with stress

**Clinical features Parkinson’s disease tremor**

<table>
<thead>
<tr>
<th>Character</th>
<th>Parkinson’s Tremor</th>
<th>Essential Tremor</th>
</tr>
</thead>
<tbody>
<tr>
<td>Family history</td>
<td>Around 10-15%</td>
<td>Around 50%</td>
</tr>
<tr>
<td>Symmetry</td>
<td>Often asymmetrical</td>
<td>Often symmetrical</td>
</tr>
<tr>
<td>Distribution</td>
<td>Hands, legs, chin, tongue</td>
<td>Hands, head, voice</td>
</tr>
<tr>
<td>Associated features</td>
<td>Bradykinesia, rigidity, postural instability, micrographia</td>
<td>Gait disorder often absent</td>
</tr>
</tbody>
</table>

**Management**

Nonpharmacological treatment of ET
- The application of weight on the affected limbs (at the wrist)
- Biofeedback techniques to relieve anxiety
- The role of primary care physicians is to assure the patient that the condition is of a benign nature. They should refer to the specialist for a confirmation of the diagnosis and advice on further management.
Acute confusional state (Delirium)

- Acute confusional state is a common, serious and often unrecognized neuropsychiatric disturbance among older patients.
- The prevalence rates range from 10–30% and incidence rates from 4–53% in the hospital setting.
- The rates are the highest among frail patients and those with dementia.

**Pharmacological management**

**Haloperidol**
- Low-dose haloperidol (0.5–1 mg) may be prescribed on an SOS basis. Haloperidol can be administered orally, intramuscularly or intravenously. After intravenous administration, it may start to act within just 5–20 minutes.

**Risperidone**
- A dose of 0.5 mg od may be administered. If there is no improvement, it could be increased to 0.5 mg bd.

**Diagnosis of delirium**

The older people should fulfill all the first 3 criteria along with criterion 4 or 5 of the confusion assessment method.

<table>
<thead>
<tr>
<th>Criteria</th>
<th>Symptoms</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Acute change in mental status</td>
</tr>
<tr>
<td>2</td>
<td>Symptoms that fluctuate over minutes or hours</td>
</tr>
<tr>
<td>3</td>
<td>Inattention</td>
</tr>
<tr>
<td>4</td>
<td>Altered level of consciousness</td>
</tr>
<tr>
<td>5</td>
<td>Disorganized thinking</td>
</tr>
</tbody>
</table>

**Management of delirium**

- Identification of the precipitating cause
- Management of the cause
- Control of the behavioral symptoms
Slide 17:
Discuss each point in management of delirium in detail.

Non-pharmacological management
- Mild confusion and agitation may improve with interpersonal and environmental manipulations
- Frequent reassurance, touch and verbal orientation can reduce disruptive behavior
- Helping the patient to get a good night’s sleep
- Avoid sensory over-stimulation, especially at night

Provide and maintain eye glasses and hearing aids
Speak clearly using simple sentences
Use clocks and calendars to help with orientation
Encourage regular physical activity
Promote good sleep habits
Provide plenty of fluids and a healthy diet

Role of a primary care physician in delirium management
- Diagnose delirium using the CAM score
- Urgently refer the patient to a Specialist

Slide 18:
Discuss in detail.
Talking points

Module 11: Brain ageing and cognitive impairment

Slide 1:
Like all organs, our brain also ages; becomes smaller in size and less efficient in functioning. As a result several finer functioning of the brain declines. In this session we will discuss issues related to ageing brain and its clinical implications.

Slide 2:
After this module, the trainee will be able to recognise effects ageing on brain in a clinical context and develop care plans for its management.

Slide 3:
Discuss all the points in detail.

Slide 4:
Discuss all phrases in the statement in detail.

Learning objectives
- To enumerate age-related changes in cognition
- To screen for and identify cognitive impairment
- To assess and develop care plans for older patients with dementia

Age-related changes in cognition
If the age-related changes in the brain are excessive, it leads to significant functional impairment, termed as 'cognitive impairment'. Cognitive decline is manifested as increasing forgetfulness, loss of attention and a reduced ability to solve problems.

Declines in cognitive can be minimized and reversed by a healthier lifestyle, cognitive stimulation and social engagement.
Slide 5:
Discuss age related brain changes and their clinical correlates with explanation.

<table>
<thead>
<tr>
<th>Normal age-related memory changes</th>
<th>Symptoms suggestive of cognitive impairment/dementia</th>
</tr>
</thead>
<tbody>
<tr>
<td>Able to function independently and pursue normal activities, despite occasional memory lapses</td>
<td>Difficulty performing simple tasks and forgetting how to do things that one has done many times in the past</td>
</tr>
<tr>
<td>Able to recall and describe incidents of forgetfulness</td>
<td>Unable to recall or describe specific instances in which memory loss caused problems</td>
</tr>
<tr>
<td>May pause to remember directions, but does not get lost in familiar places</td>
<td>Gets lost or disoriented even in familiar places, unable to follow directions</td>
</tr>
<tr>
<td>Occasional difficulty finding the right word, but no trouble holding a conversation</td>
<td>Words are frequently forgotten, misused or garbled; repetitive in conversation</td>
</tr>
<tr>
<td>Judgment and decision-making ability intact</td>
<td>Trouble making choices; poor judgment or socially inappropriate behavior</td>
</tr>
</tbody>
</table>

Differences between normal age-related memory changes and cognitive impairment/dementia

Slide 6:
Define dementia and explanation the deficits domain wise as demonstrated in the diagram.

Dementia
Dementia is an acquired brain syndrome characterized by a decline in the previous level of cognitive functioning. It is associated with impairment in two or more cognitive domains, such as memory, executive functions, attention, language, social cognition and judgment, psychomotor speed and visuo-perceptual or visuospatial abilities.

Domains of dementia
- Memory
- Executive functioning
- Attention
- Language
- Visual-Spatial Perception
- Ability

Aetiology of dementia

Irreversible causes
- Degenerative disease
  - Alzheimer’s dementia
  - Dementia with Lewy bodies
  - Frontotemporal dementia
  - Parkinson’s associated dementia
- Vascular
  - Multi-infarct dementia
  - Lacunar infarct
  - Small vessel disease
- Infectious
  - AIDS dementia complex
  - Creutzfeld-Jakob disease

Reversible causes
- Side-effects of medication
- Vitamin deficiencies
- Subdural hematoma
- CNS tumors
- Hypothyroidism
- Obstructive sleep apnoea
- Leucoencephalopathy
- Chronic kidney disease
- Liver disease
- Infections

Clinical manifestations of dementia
- Cognitive and other problems in dementia
  - Memory loss
  - Poor concentration
  - Visuospatial difficulties
  - Speech and language defects
  - Inability to recognize self and others
  - Incongruities
  - Disturbances of gait

- Behavioural and psychological problems
  - Agitation
  - Personality change
  - Abnormal eating behaviour
  - Murdering
  - Mood disorder, depression
  - Anxiety, phobias, fear
Integrated Care for Older People: A manual for primary care physicians (Facilitator’s Guide)

Slide 9:
Emphasize the role as a doctor who will be approached by the family of the dementia patient for all behavioural problems and co-morbidities.

Slide 10:
Discuss the steps in detail with examples.

Slide 11:
Discuss the steps in detail with examples.

Slide 12:
Discuss the interventions in detail with examples.

To improve the patient’s cognitive functioning, carers must be encouraged to:
• Regularly provide information to orient the patient (day, date, time, names of people).
• Use materials such as newspapers, radio or TV programmes, family albums and household items to promote communication.
• Use simple short sentences to make verbal communication clear.
• Listen carefully to what the person has to say.
• Keep things simple, avoid changes to the patient’s routine.

Interventions to improve cognitive functioning
Carer support

- Assess the impact providing care on the Carer’s needs to ensure that they have the support and resources necessary for their family life, employment, social activities and health.
- Acknowledge that it can be extremely frustrating and stressful to take care of people with dementia.
- Carer need to be encouraged to respect the dignity of people with dementia and avoid hostility towards, or neglect of, them.
- Encourage Carer to seek help if they are experiencing difficulty or strain in caring for their loved one.
- Provide the Carer with training and support in specific skills, e.g. managing difficult behaviour, if necessary. It would be most effective to elicit active participation, e.g. role play.

Slide 13:
Read each point and discuss in detail.
Talking points

Module 12: Mental health

Slide 1:
Older people have multiple stresses arising out of their life situation as well as the social environment in which they live. In addition the likelihood of developing dementia also increases with age. Multiple co-morbidities also contribute to poor mental health. Assessing mental health issues during routine consultation and addressing them through non-pharmacological or pharmacological strategies; or referral to specialist for complexity of the clinical problem.

Slide 2:
At the end of this module, trainees will be able address mental health issues of old age with diagnosis and care planning.

Learning objectives
• To enumerate the common stresses of old age
• To enumerate the social and cultural barriers to seeking mental health services
• To identify common mental health problems among older patients and develop care plans

Slide 3:
Enumerate the stress of old age listed in the slide with examples and discuss.

Common stresses that older people have to cope with
- Widowhood and the death of other significant friends and relatives
- Caregiver stress
- Fear of death
- Financial difficulties
- Loss of independence
- Changes in living arrangements and previous roles
- Social isolation
- Chronic diseases
Slide 4:
Emphasize that while mental health problems are common and well recognized; there is hesitation in seeking and accepting mental health care. Discuss the points provided in this slide with examples.

Barriers to accepting mental health problems in old age
- Feel these problems are shameful
- The problem as retribution for the bad deeds done in an earlier life
- Convinced that the cure of illnesses is in god's hands
- Suffering should be endured
- They want to appear in control in order to maintain their dignity motional control is valued in society and admitting the need for help suggests that one is not in control

Slide 5:
Discuss sleep problems of old age and their genesis with examples.

Sleep
- The duration of sleep is shortened, and the quality of sleep also becomes poorer with ageing.
- The sleep pattern changes as the person ages.
- Sleep disturbances are common among older people and are related to various factors:
  - Use of caffeine, tobacco and alcohol,
  - Multiple co-morbid diseases,
  - Poly-pharmacy

Slide 6:
Discuss each point with examples.

Manifestations of insomnia among older people
- Difficulty in initiating sleep (sleep onset insomnia)
- Difficulty in maintaining sleep (sleep maintenance)
- Waking up earlier than desired
- Resistance to going to bed according to the appropriate schedule
- Difficulty sleeping without the caregiver’s intervention

Slide 7:
Discuss each point with examples.

Role of primary care physicians
- Educate the older person as well as the caregivers on sleep hygiene
  If the older person insists that he/she wants sleep-inducing medications, the primary care physician may:
  - Prescribe the following for the shortest possible duration.
  - For sleep onset insomnia: zolpidem (immediate-release) 5 mg before bed
  - For both sleep initiation and maintenance insomnia: zolpidem (extended-release) 6.25 mg before bed
  - Refer to specialist if the problem persist despite behavioural and environmental modifications
Slide 8:
Discuss each point with examples.

Sleep hygiene rules for older people

<table>
<thead>
<tr>
<th>Rule</th>
</tr>
</thead>
<tbody>
<tr>
<td>Limiting daytime naps to 30 minutes</td>
</tr>
<tr>
<td>Avoiding stimulants such as caffeine and nicotine close to bedtime</td>
</tr>
<tr>
<td>Exercising to promote good quality sleep</td>
</tr>
<tr>
<td>Lite dinner</td>
</tr>
<tr>
<td>Ensuring adequate exposure to natural light</td>
</tr>
<tr>
<td>Establishing a regular relaxing bedtime routine</td>
</tr>
<tr>
<td>Making sure that the sleep environment is pleasant</td>
</tr>
</tbody>
</table>

Slide 9:
Discuss each disease briefly.

Psychiatric diseases of old age

- Depression
- Personality disorders
- Anxiety disorders
- Post-traumatic stress disorder
- Bereavement
- Somatoform disorders
- Late-life delusional disorders
- Obsessive compulsive disorders
- Self-neglect
- Alcoholism.

Slide 10:
Discuss each point in detail.

Depression

- The point prevalence of major depressive illness among community-dwelling older people ranges from 1 to 9%.
- 36–46% in acutely ill hospitalized older people.
- It is about 10–22% among older people in long-term care facilities.

Slide 11:
Discuss each point with examples.
Slide 12:
Discuss commonly used drugs with side effects.

<table>
<thead>
<tr>
<th>Medication</th>
<th>Dosage</th>
<th>Side effects</th>
<th>Contraindications</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fluoxetine (should be preferred in obese patients)</td>
<td>Start at 10 mg per day, increase to 20 mg after 1 week</td>
<td>Common: sedation, insomnia, headache, dizziness, gastrointestinal disturbances, sexual dysfunction</td>
<td>Serious: bleeding abnormalities in those using aspirin or other NSAIDs, hyponatremia</td>
</tr>
<tr>
<td>Escitalopram (should be preferred in thin build patients)</td>
<td>Start at 5 mg per day, increase to 10 mg after 1 week</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sertraline (should be preferred in patient with cardiac problems)</td>
<td>Start at 25 mg per day, increase to 50 mg</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Slide 13:
Discuss each point in detail.

Generalized Anxiety Disorder

- Generalized anxiety disorder (GAD) suffer constant worries, and there may be nothing or little to cause these worries.
- Older people with GAD have difficulty relaxing, sleeping and concentrating, and get easily startled.
- Untreated anxiety can lead to cognitive impairment, disability, poor physical health, and a poor quality of life.
- SSRIs are effective for the treatment of anxiety disorders.
Talking points

Module 13: Sensory system in old age

Slide 1:
We perceive the environment through our sensory system. Ageing affects our sensory system and thereby affects our health.

Slide 2:
After this module, the trainee will be able to identify and provide guidance for their management.

Slide 3:
Describe the changes in the skin from the slide and give a few clinical examples.

Slide 4:
Describe the changes.

Skin: Age-related changes
- Thickness of the epidermis decreases.
- Stratum corneum loses moisture, making the skin dry and rough.
- The number of melanocytes declines.
- Reduction in the number of skin Langerhans cells
- Wrinkling of the skin
- Vascularity of the skin declines
- Secretions of the sweat and sebaceous glands decrease
- The hair turns grey due to the loss of melanin and there is loss of hair on the scalp.
- The growth of nails slows down.
Slide 5:
Discuss each point in detail.

**Care of skin for older adults**

- Should bathe periodically to relieve dry skin
- Use of coconut oil and emollients: Can help to relieve pruritus induced by dry skin.
- Older adults should be encouraged to wear gloves while doing household or other work.
- Primary care physician: Should examine the skin for any signs of skin cancer.
- Caregivers dealing with older adults in long-term care should be educated on how to prevent bedsores.

Slide 6:
Discuss each point in detail.

**Common disease condition**

- Infections: The common infections among older people are herpes zoster, scales, decubitus ulcer and pyoderma
- Pruritus: This may be caused by dryness or systemic disease. Apply coconut oil, emollients (glycerin, paraffin). Antihistaminics should be avoided or prescribed for short duration (2 to 4 weeks) for intractable pruritis.
- Seborrhoeic dermatitis: Treat this with topical antifungal or cortisone cream
- Medication reactions
- Cancers, e.g. basal cell carcinoma, squamous cell carcinoma and malignant melanoma
- Pressure ulcers.

Slide 7:
Discuss each point in detail.

**Melanoma: Change in colour, size or appearance of a mole that has been there for a while**

Slide 8:
Discuss each point in detail.
### Slide 9:
Discuss each point in detail.

#### Warning signs of skin-damage:
- Skin redness (Earliest sign)
- Discomfort/pain at the site to the patient
- Persistent erythema
- Non-blanching hyperemia
- Blisters (superficial)
- Warm to touch
- Localised edema
- Induration
- Purplish/bluish localised areas in those with dark skin.

### Slide 10:
Discuss each point in detail.

#### Common sites of pressure-ulcers

### Slide 11:
Discuss each point in detail.

#### Grading of pressure ulcers

- **Grade 1**: Non-blanching erythema of intact skin
- **Grade 2**: Partial thickness skin loss involving epidermis, dermis, or both
- **Grade 3**: Full thickness skin loss involving damage to underlying subcutaneous tissue
- **Grade 4**: Extensive destruction, tissue necrosis, or damage to muscle, bone

### Slide 12:
Discuss each point in detail.

#### Local infection in a pressure ulcer
- Lack of signs of healing for two weeks
- Friable granulation tissue
- Malodor
- Increased pain in the ulcer
- Increased heat in the tissue around the ulcer
- Increased drainage from the wound
- An ominous change in the nature of the wound drainage (e.g., new onset of bloody drainage, persistent drainage)
- Increased necrotic tissue in the wound bed
- Peculiar or bridging in the wound bed.
**Slide 13:**
Discuss each point in detail.

**Management of existent pressure damage**
- Assessment of the pressure sore:
  - Site/location
  - Grading
  - Pain
  - Exudate amount and type
  - Local signs of infection
  - Wound/surrounding skin
  - Consider undermining, tracking, sinus or fistula
  - Size – length, width and depth.
- Use baseline photographs for serial monitoring of the healing process. (Using phone-camera)
- Wound-dressing and debridement.

**Slide 14:**
Discuss each point in detail.

**Wound dressing: Pressure ulcers**
- Cleanse the pressure ulcer at the time of each dressing change.
- Cleanse most pressure ulcers with normal saline.
- Consider using cleansing solutions with surfactants and/or antimicrobials to clean pressure ulcers.
- Cleanse pressure ulcers with sinus tracts/tunneling/undermining with caution.
- Apply cleansing solution with sufficient pressure to cleanse the wound without damaging tissue or driving bacteria into the wound.
- Cleanse surrounding skin.

**Slide 15:**
Discuss each change and explain its clinical implication.

**Normal Ageing changes: Eyes**
- Eyelids become lax.
- Decrease in secretion by the lacrimal gland: Dry eyes.
- Subconjunctival haemorrhage.
- Accumulation of fluid in the endothelial cells of the cornea.
- Deposition of fluid in the periphery of the cornea: Arcus senilis.
- Distortion of the anterior aspect of the uveal tract: Chronic close-angle glaucoma.
- Lens becomes rigid and there is a loss of accommodation (presbyopia).
- Denaturation of lens protein: Cataract.

**Slide 16:**
Show the white ring on outer aspect of cornea.
Slide 17:
Discuss each box and its implication on day to day life.

Slide 18:
Discuss each point in detail. Emphasize on referral for surgery.

Slide 19:
Discuss each point in detail. Emphasize on referral for management.

Slide 20:
Discuss each point in detail.
Slide 21: Discuss each point in detail.

Slide 22: Discuss each point in detail.

Slide 23: Discuss each point in detail.

Slide 24: Discuss each point in detail. Emphasize on referral for hearing aid.
Talking points

Module 14: Cancer and palliative care

Slide 1:
Age is a strong risk factor for cancer. Cancer is the second most common cause of death among older people. However, most of these patients in low and middle income countries are diagnosed at an advanced stage of disease when definitive or curative treatment is not possible. Older cancer patients are thus in great need of palliative care. This module will provide a comprehensive account of cancer in old age useful for primary care physicians.

Slide 2:
After this module, the trainees will be able to provide initial treatment and referral to older patients with cancer and manage the terminal phase with palliation of distressful symptoms.

Slide 3:
Discuss about facts of cancer in old age. Read all points and discuss with examples.
Integrated Care for Older People: A manual for primary care physicians (Facilitator's Guide)

Slide 4:
Read all points and discuss with examples.

Causes for delay in diagnosis
- People are not particularly interested in screening for cancer.
- There is a lack of awareness of the problem.
- Older patients are usually under-treated due to a widely prevalent misconception that they are less eligible for surgery and they tolerate radiotherapy and chemotherapy poorly.

Slide 5:
Read all points and discuss with examples.

Signs and symptoms of suspected malignancy

<table>
<thead>
<tr>
<th>General signs</th>
<th>Changes specific to certain cancers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Continuous fever</td>
<td>Changes in bladder and bowel habits</td>
</tr>
<tr>
<td>Fatigue</td>
<td>Non-healing sores</td>
</tr>
<tr>
<td>Unexplained weight loss</td>
<td>White patches in the mouth or on tongue</td>
</tr>
<tr>
<td>Loss of appetite</td>
<td>Unusual bleeding or discharge</td>
</tr>
<tr>
<td>Pain</td>
<td>Lump in any part of the body,</td>
</tr>
<tr>
<td>Skin changes</td>
<td>Indigestion or difficulty in swallowing</td>
</tr>
<tr>
<td></td>
<td>Recent change in warts or moles</td>
</tr>
<tr>
<td></td>
<td>Nagging cough or hoarseness of voice</td>
</tr>
</tbody>
</table>

Role of primary care physician in management of cancer in the community
- Screening for cancer and detecting cancer at an early stage
- Referring the patient to a specialized unit involved in the management of cancer addressing pre-treatment health issues
- Detecting and managing comorbidities, and making the necessary referrals
- Detecting and managing post-treatment health problems
- Providing palliative care
- Providing care in the terminal stage

Slide 6:
Read all points and discuss with examples.

Palliative care

"An approach that improves the quality of life of patients and their families facing the problem associated with life-threatening illness, through the prevention and relief of suffering by means of early identification and impeccable assessment and treatment of pain and other problems, physical, psychosocial and spiritual." - WHO

The majority of adults in need of palliative care have chronic diseases, such as cardiovascular diseases (38.5%), cancer (34%), chronic respiratory diseases (10.3%), HIV/AIDS (5.7%) and diabetes (4.6%)

Slide 7:
Define palliative care with emphasis on each of the phrases. Point out the co-morbidities. Discuss their clinical impact.
Slide 8:
Read all points and discuss their importance with examples. Discuss on their management.

Slide 9:
Read all points and discuss their importance with examples.

Slide 10:
Discuss pain management as a part of palliative care in detail.

Slide 11:
Discuss the slide in detail. Also talk about availability of morphine in your country.
Talking points

Module 15: Elder abuse

Slide 1:
Older persons are easy targets for abuse and violence as they do not have physical strength to retaliate. This is a universal phenomenon and occurs in every society in various forms. Though it is not a direct health issue, the health care worker is in a most suitable position to detect it.

Slide 2:
After this module, the trainee will be able to detect elder abuse and prepare plans to prevent it.

Slide 3:
Read out the definition and discuss each of the phrases in detail with examples.

WHO defines elder abuse as "a single, or repeated act, or lack of appropriate action, occurring within any relationship where there is an expectation of trust which causes harm or distress to an older person".

Learning Objectives

• To enumerate the concept and health consequences of elder abuse
• To enumerate measures to prevent elder abuse
Slide 4:
Discuss each type of abuse with explanation and examples.

Slide 5:
Discuss various characteristics of the abuse with example. Emphasize that poverty is not a determinant of abuse.

Slide 6:
Discuss various signs of abuse with examples. The last picture is extreme malnutrition due to no access to food from the caregiver.

Slide 7:
Discuss various signs of abuse with examples.
Signs and Symptoms of Elder Abuse
- Bedsores, unattended medical needs, poor hygiene, and unusual weight loss are indicators of possible neglect.
- Behavior such as belittling, threats and other uses of power and control by spouses are indicators of verbal or emotional abuse.
- Strained or tense relationships, frequent arguments between the caregiver and older person are also signs.
- Changes in personality or behavior in the elder.

Management and prevention of abuse
- The management of the abuse of elders requires the involvement of multidisciplinary team like nurse, doctors, physiotherapist, counselor, social worker.
- The physician should use tact and discretion while dealing with the problem.

The steps involved are:
- Assessment of the elder person's physical and mental capacity
- Counselling of the abuser
- Documentation, liaison and interaction with other professionals
- Admission to sheltered accommodation, such as an old age home or nursing home, if the abuse cannot be prevented
Talking points

Module 16: Long-term care and caregiver issues

Slide 1:
At some point of time or the other, many older people will lose their autonomy and independence, and will be dependent for activities of daily living. This dependence can be for variable period of time. While caring for short periods is usually managed by the caregivers without much problem, providing care for long period of time is a major challenge for the family and the health and social welfare system.

Slide 2:
After the end of this module, trainees will be able to conceptualize long-term care, its components and the challenges associated with it.

Slide 3:
In this slide, define long-term and explain its components. Discuss the profile of caregivers and their characteristics with examples.

Slide 4:
Discuss the social issues in care-giving. Describe the profile of care receiver with various health problems.
Slide 5:
In this slide, the role of primary care physician will be discussed. Read out each point with examples and discuss in detail.

Slide 6:
There are two types of setting for long-term care: institutions of long-term care and home and community sites. Discuss each of these sites with examples.

Slide 7:
In this slide, discuss types of care receivers in institutional care in detail with examples.

Slide 8:
In this slide, discuss types of care receivers in institutional care from length of stay point of view. Discuss in detail with examples.
Integrated Care for Older People: A manual for primary care physicians (Facilitator’s Guide)

Slide 9:
In this slide, discuss challenges of care giving and problems of caregivers.

Caregiving
- Older people with physical or cognitive disability require continuous care from formal or informal caregiver.
- Caregiver Burden: Long-term care of a frail and physically dependent older person causes the caregiver to feel a variety of stresses, such as physical, emotional, social and financial
- The caregiver is usually the “hidden patient” and the health-care worker must direct some attention towards his/her needs

Slide 10:
In this slide, discuss about assessment of caregiver stress. Read out each point and discuss in detail.

Assessment of caregiver stress
- The older person’s capacity to care for himself/herself
- The type of care required by the older person (feeding, dressing, bathing, toilet)
- The amount of extra time the caregiver needs to spend on caring for the older person
- Arrangements for rest and relaxation for the caregiver
- Resources and support systems available to the caregiver
- Vague physical health-related complaints by a caregiver, which should make one suspect that he/she needs more assistance at home.

Slide 11:
In this slide, discuss ways and means of supporting the caregiver with examples.

Supporting the caregiver
- Maintain her/his physical and mental health
- Avoid the development of an abusive situation
- Reduce the risk of institutionalization
- Promote a good quality of life for the entire family

Slide 12:
Discuss the role of primary care physician. Read out each point with examples.

Role of the primary care physician
- Educate the caregiver and the family members on ways to recognize danger signs in the person receiving care
- Teach the caregivers at home about the prevention of complications, such as bedsores, aspiration pneumonitis, catheter-related infections and deep-vein thrombosis
- Consult a psychiatrist, as psychiatrist services are very important in organizing day hospitals, day-care centres and centres for seniors that provide engagement and food
- Should be involved in outpatient and inpatient care for the investigation of major problems
Integrated Care for Older People: A manual for primary care physicians (Facilitator’s Guide)

Talking points

Chapter 2: Health of older people and geriatric medicine

Slide 1:
I welcome you all to this training program on health and health care in old age. The program will include presentations on various aspects of health. Disease and disabilities of old age and strategies to manage them. In this discussion, we will discuss various concepts in geriatrics or old age medicine.

Slide 2:
There are four learning objectives of this session. These include diseases and disabilities of old age, concepts and principle of geriatric medicine; comprehensive geriatric assessment; and role of primary care physician in old age care.

Slide 3:
Define old age; the impact of ageing on body and mind and age cut off by UN agencies. Impress that the 60 year cut off is to ensuring uniformity in policy formulation for support and services. The cut offs are not indicator of health status or retirement policy.
Integrated Care for Older People: A manual for primary care physicians (Facilitator’s Guide)

Slide 4:
Speak on origin of non-communicable diseases from the three format with examples: Biological decline- cataract, sensory neural deafness; prostate enlargement; Lifestyle - related - hypertension, diabetes, heart disease; and Environmental exposure: cancer; COPD. Discuss about multiple diseases leading to multiple disabilities and complex symptoms termed as geriatric syndromes. Emphasize on NCDs as important health problems in old age in terms of burden of care requirement and death.

Slide 5:
In this slide, discuss about distinction between normative changes of ageing and pathological states.

Slide 6:
Discuss about geriatric medicine here as provided in this slide.

Geriatric Medicine
- Geriatric Medicine: A branch of medicine that concerns itself with the ageing process; the prevention, diagnosis and treatment of health-care problems in the aged; and the social and economic conditions that affect the health care of the older people.
- Goal of geriatric medicine: Maximize the positive aspects of ageing, delaying the onset of chronic disease and maximizing function despite the disease.
- The key strategies are: To break down the complex issues into multiple simple problems, and to address them individually in terms of diagnostic tests, therapeutic interventions or rehabilitation.
Slide 7:
Read out and discuss about each of the concepts with adequate examples.

Slide 8:
Explain the concept of frailty.

Slide 9:
Discuss each bullet point.

Slide 10:
Define this entity to health professionals.
Acute care in old age

• Older people come to the acute care set-up with common conditions like respiratory failure, sepsis, acute abdomen, acute coronary syndromes and cerebrovascular accidents.

• Atypical presentation of diseases in old age and multimorbidity, further complicated by geriatric syndromes, can make the diagnostic and management process very complicated.

• The primary care physician needs to recognize these conditions and initiate emergency treatment.

• Eliciting a detailed medical history in acutely ill old age patients is sometimes difficult, with their cognitive and physical deficits.

• Past medical and surgical problems, along with the history of medications and subtle physical signs, make the challenge greater.

Role of primary care physician in care of older people

• In geriatric care, particularly in the prevention, early detection and management of most diseases or geriatric syndromes

• Perform screening and provide preventive care for geriatric conditions and syndromes

• In detecting early functional decline and dependence by using simple screening tools.

• Initiate early intervention and does appropriate referral

• In the long-term management of chronic diseases

• In the detection of new health risks

• Promotion of the health of older people

Comprehensive Geriatric Assessment

The Comprehensive Geriatric Assessment (CGA) refers to the multifaceted approach of diagnosing and managing complex physical, psychological and functional problems in older people.

The aims is to promote cost-effective use of services, keep the patient active and provide a good quality of life.

The domains covered in a CGA

• Taking the medical history and performing a physical examination
• Reviewing the medications
• Assessing geriatric syndromes
• Assessing the intrinsic capacity
• Assessing the functional status
• Assessing support provided by caregivers
• Assessing the emotional status of the patient and caregivers

Discuss each of the concepts with examples.

Define Comprehensive Geriatric Assessment and discuss its importance.

Discuss each point with examples from the reference manual.

Discuss each point with example.