PORTFOLIO

Evidence-based programs for a person-centered, integrated care for older people at the primary health care level

PAHO
Pan American Health Organization
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FOREWORD

A great challenge for public policies is to transform the current demographic transition into opportunity. Longer lives call for new paradigms and concepts in the field of health and care. More than living without diseases, individuals have the right to live longer with abilities and capacities that enable them to be and do what they have reason to value, that is, maintaining functional ability.

The World Health Organization (WHO) defines healthy aging as "the process of developing and maintaining the functional ability that enables well-being in older age."[1] It is determined by the intrinsic capacity (the combination of all the individual's physical and mental capacities), the environments the individual inhabits (understood in the broadest sense and including physical, social and policy environments), and the interaction between these. Although the demographic shift is a reality, there is no evidence to support that older adults are living with better health. In fact, data have shown that there is a large gap between life expectancy and healthy life expectancy in the Latin American and Caribbean Region.

To promote older adults' health, independence and autonomy, WHO has supported the Decade of Healthy Aging (2021-2030), which is aligned with the agenda of the Sustainable Development Goals of the United Nations. The four main areas of action for the Decade are: change how we think, feel and act towards age and ageing; ensure that communities foster the abilities of older people; deliver person-centered integrated care and primary health services responsive to older people; and provide access to long-term care for older

1 World Health Organization. World report on ageing and health. Geneva: WHO; 2015. Available from: https://apps.who. int/iris/handle/10665/186463

people who need it. These four areas will ultimately provide an opportunity to align action and collaborate across sectors to foster healthy aging.

Public health responses, aiming at healthy aging, might then consider not only approaches to controlling diseases and ameliorating losses associated with older age, but also to reinforcing recovery, adaptation and psychosocial growth. Health care models must be adapted and aligned with the new concept of healthy aging, especially in view of the increased prevalence of chronic diseases in older adults, which frequently lead to higher dependency rates.

The Decade of Healthy Aging fosters integrated person-centered care for older adults, and having older people active in developing care planning and self-care. Systems must therefore be prepared to deliver such services, in which older adults feel they are responsible for their own health and health decisions, in a continuum of care. Integrated Care for Older People (ICOPE) is a WHO strategy to improve older adults' care at the community level. It brings an approach that helps to reorient health systems toward more person-centered and integrated care for older people, to better address their own health and social needs, as well as from their caregivers.

There is a strong rationale for introducing effective interventions to optimize intrinsic capacity, which underpins the ICOPE approach, such as evidence-based community programs. That is, interventions tested in a research-controlled environment and afterwards applied in the community with positive outcomes. Evidence-based programs are considered best-practice strategies for promoting community health.

Several evidence-based programs have been designed to improve older adults' intrinsic capacity and ultimately health during the aging process. Even though programs are developed to achieve a specific objective, a program can usually improve more than only one domain of older adults' health. Some of these programs, with strong evidence and large dis-semination, are presented in this portfolio which has been developed by the Pan American Health Organization (PAHO).

INTRODUCTION

For nearly two decades, the World Health Organization has included the terms "self-management", "self-care" and "self-management support" in their documents. The 2015 World Report on Aging and Health specifically states that "offering support for self-management is another tool for providing person-centered and integrated care to older adults." WHO defines offering support for self-management as "... providing them [patients] with information, skills, and tools that they need to manage their health conditions, prevent complications, maximize intrinsic capacity and maintain their quality of life".[2]

This publication presents a number of interventions/programs that are evidence-based, and offer support for self-management, as defined by WHO. The objective of the programs is to improve or maintain older adults' intrinsic capacity at the community level. These "tools" have been proven to deliver positive outcomes and therefore should become part of any primary care tool kit designed to promote and improve healthy aging in the community. Older adults require an integrated approach and a continuum of care with adequate support and transitions from one level to another, depending on their specific needs. Strengthening primary care is one strategy to prepare and align health systems to an aging society.

In order to overcome barriers and myths regarding the benefits of adopting evidence-based programs that support self-management and engage older persons in their self-care, we need to debunk much misinformation still permeating our culture.

2 World Health Organization. World report on ageing and health. Geneva: WHO; 2015:105

Myth 1: Self-management education is what nurses and doctors do when they tell patients what to do for their personal care. Self-management, or health education, is always included as part of a chronic care visit.

Reality: Although different members of the health care team can contribute to self-management education, it is important for primary health care settings to create a referral process to ensure that older adults receive:

a. knowledge,

b. tools to build skills, and

c. the necessary support to improve and/or maintain intrinsic capacity.

Self-management education takes time and includes principles of behavior change necessary for dealing with the challenges of living well as people age.

Myth 2: The role of older patients is simply to obey the recommendations given to them by the doctor, who after all is the expert.

Reality: While knowledge is necessary to gain skills, it is not sufficient in and of itself. Knowing what my doctor wants me to do is not the same as knowing how and whether I can and want to do it. In order for the doctor to see improved results in a care plan, the patient must be either an activated person or be able to acquire the understanding and receive the skills necessary for maintaining a productive relationship with the health care provider. Evidence-based programs in this portfolio have been tested and shown to deliver positive results.

Myth 3: Evidence-based programs are a waste of time because older adults are set in their ways and won't change their behaviors.

Reality: Older persons will indeed change their behaviors – we just often do not use effective behavioral change strategies to help them change. In contrast, evidence-based programs are rooted in the science of behavior change. Evidence-based programs are not heavy-handed and do not tell people what they must do. Rather, they present facts, encourage critical thinking, and enable individuals to tailor strategies to meet their own needs, personalities, and priorities.

Myth 4: Evidence-based programs are not worth the trouble because many older adults aren't curious, have memory problems, and won't retain the new information.

Reality: The aging brain needs stimulation to stay sharp. Novel experiences and interacting with others help to promote a healthy brain. Older adults can retain new information and will do so more effectively if they are able to interact with the material in multiple modalities (e.g. through discussions, generating new ideas, touching objects, moving one's body, offering suggestions to others, or navigating new relationships). Evidence-based programs are rooted in effective teaching techniques that keep participants engaged. The programs are designed to help participants acquire information that they will remember and use.

Myth 5: Local health promoters know best the culture and the needs of older persons in their communities. Evidence-based programs designed in a university or in a foreign country may not be aware of local customs and local talents.

Reality: Community health workers are the first link in the primary health system and their role in providing self-management education and support is well recognized. They need a portfolio of effective tools and teaching methodologies to ensure success in supporting healthy aging in the community. The evidence-based programs included here in this portfolio have been designed to be delivered by community health workers or trained volunteers. The programs have been proven to work in real-life community settings and provide the structure, guidance, and processes needed for effective implementation in any community. The local health promoter adapts the language and brings the knowledge of the community to complement the structured program.

Myth 6: Evidence-based programs are not sustainable. They have too many requirements.

Reality: The value of evidence-based programs is that they have been proven to deliver results. This means they have been tested with a specific "dosage" and with proven methodologies for success. Fidelity to the design of the program is comparable to adherence to a proven prescription. Therefore, in order to make a sound investment in an evidence-based program, the organization must ensure appropriate budget and strategies for sustainability. In most of the evidence-based programs, the initial investment in

training becomes only cost-effective if it also has the budget to ensure that trained personnel are able to deliver the intervention/ program on a regular basis. If the program requires educational materials for participants, a sound investment ensures that funding for these materials is included in the annual budget.

The programs listed in this portfolio were designed to support older people's wants and aspirations in different domains. If adopted, with fidelity, the programs will support healthy aging and promote active participation of older persons in managing their health and improve their self-care, and therefore become important tools for providing person-centered and integrated care to older adults.

This portfolio includes programs/interventions designed to support the following five areas:

- Locomotor and falls prevention
- Self-management support for persons with multiple chronic diseases and specific chronic conditions
- Psychological capacity to manage depressive symptoms
- Cognitive capacity
- Caregivers education and self-management support.

The appendix to the portfolio contains a tool kit with checklists, questionnaires, and suggestions for building the necessary infrastructure to provide, maintain, and adopt selected evidence-based programs to support healthy aging.

1. THE ROLE OF SELF-MANAGEMENT IN AN INTEGRATED CARE FOR OLDER PEOPLE

KEY POINTS

- For the health care system, one of the keys to promoting healthy aging for all people is optimizing self-efficacy for self-care. An active self-manager is better able to work with the health provider in optimizing intrinsic capacities and functional ability.
- It is possible to change a passive self-manager into an active one, thus obtaining broad and lasting health benefits.
- This portfolio offers a list of programs that could be adopted to serve older people with multiple chronic diseases and variable degrees of functional ability. The programs do not replace therapeutic treatments, but can be offered to accompany a person-centered plan of care.
- Support for self-management is an essential component of an integrated, person-centered approach and essential for an effective and efficient integrated approach in primary health care settings.

The concept of healthy aging calls for a new approach to health which requires optimizing people's intrinsic capacity and functional abilities as they age in a person centered and integrated care system.

A person-centered, integrated approach at the primary health care level includes:

1. Assessment of the older person's needs and physical and mental capacities;
2. Setting a Goal of Care and Care Plan to maximize health and function, prevent avoidable disease, decline and injuries, and promote early detection of potentially treatable health problems; and
3. ***Implementation of the care plan using the principles of self-management support in order to achieve broad and last-ing benefits.*** This publication provides guidance on how to complete step 3 in a person-centered plan.

Support for self-management of health consists of providing people with "the ***information, skills and tools*** they need to control their diseases, avoid complications, enhance their intrinsic capacity and maintain their quality of life."[3]

Support for self-management is not simply providing information. Knowing what to do is essential but not sufficient. Knowing what to do needs to be accompanied 1) by the belief that one can make positive changes, and 2) promote specific behavior change strategies to help bring about these changes. Therefore, support for self-management includes strengthening self-efficacy and providing tools for learning how to put in practice therapeutic recommendations and healthy lifestyles needed to manage symptoms and optimize intrinsic capacity and functional ability.

Despite increasing the capacity for diagnosis and treatment of disease in older persons, health services still lack a support system for self-management of health.

This publication will present evidence-based programs that allow self-care to be included as a comprehensive service for older people without increasing the burden on health systems. Most people spend less than 1% of their time receiving direct medical attention. The rest of the time is spent living in the community, where they adopt habits and ways of life that affect health. The portfolio presents five categories of community-based evidence-based interventions/programs that are designed to support self-management:

- Managing multiple chronic conditions;
- Improving locomotor capacity and preventing falls;
- Managing depressive symptoms and decreasing social isolation;
- Cognitive capacity; and
- Supporting caregivers of older adults

Selected programs have demonstrated that, if adopted with fidelity, they deliver results.

3 World Health Organization. (2015). World report on ageing and health. Geneva: WHO; 2015. Available from: https://apps.who.int/iris/handle/10665/186463

The sustainability of a selected program will be directly influenced by several variables:

- Is the goal of the program what the selected population needs?
- Does the program integrate well with the organizational mission and other programs and services offered?
- Does the program have the support of management?
- Does the program have the resources to be implemented with fidelity?
- Does the program have, or can it train, the necessary personnel for implementation?
- Are sustainability strategies identified during the early planning stage and reviewed throughout the implementation phase?
- Can the organization/agency recruit a broad-based set of partners to market, adopt or maintain the program?
- Can the organization/agency document the difference it makes in the population served?

SELECTED PROGRAMS:

- Provide opportunities for a community-based approach and multi-sectoral collaboration.
- Are based on the principle that learning to change any behavior takes knowledge, practice, and support.
- Provide simple, cost-effective measures to teach and support behavior change in order to improve and maintain intrinsic capacity to manage multiple chronic conditions, and function (physically and psychologically).

This manual also includes a series of tools intended to assist in the selection, implementation and evaluation of a program. The tools will assist program managers and decision-makers in deciding if they are ready to adopt one of these programs.

The goal of adopting community and evidence-based programs in integrated primary health care is to ensure that programs and interventions adopted are sustainable and embedded in a person-centered plan.

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2. THE RATIONALE FOR EVIDENCE-BASED PROGRAMS

KEY POINTS

- Evidence-based programs are considered best practice strategies for community health promotion because they have met the test of efficacy and cost-effectiveness.
- Evidence-based programs must have published results of outcomes in a peer-reviewed journal.
- Programs based on research are not the same as evidence-based programs.
- Evidence-based programs demonstrate that they have been proven to be effective and can be implemented in the community with fidelity. This includes standardized training, training materials, program delivery manuals, and dissemination products.
- To support self-management and intrinsic capacity, programs should not only teach what to do but also provide the skills, tools and support to teach *how* to do.

WHO has defined evidence-based as "the use of information derived from formal research and systematic investigation to identify causes and contributing factors to health needs and the ***most effective health promotion actions*** to address these in given contexts and populations."[4] Therefore, an evidence-based program has demonstrated not only that it is 'derived from formal research' but very importantly that it has proven through research to be 'most effective.'

The Evidence-Based Leadership Collaborative (EBLC) explains: "Evidence-based programs are programs that have been rigorously tested in controlled settings, proven effective, and translated into practical models."[5]

4. Smith BJ, Tang KC, Nutbeam D. WHO health promotion glossary: New terms. Health Promot. Int. 2006;21(4):340-345. Available from: https://doi.org/10.1093/heapro/dal033

5. Evidence-Based Leadership Collaborative. What is "evidence-based"? Lawrence, MA: EBLC; 2022. Available from: http://www.eblcprograms.org/evidence-based/what-is-eb/

Evidence-based programs included in this portfolio have been:

- tested in trials using experimental or quasi-experimental designs;
- translated using real life community sites;
- published in peer reviewed journals; and
- disseminated widely with standardized training protocols, structured implementation manuals and support available to the public.

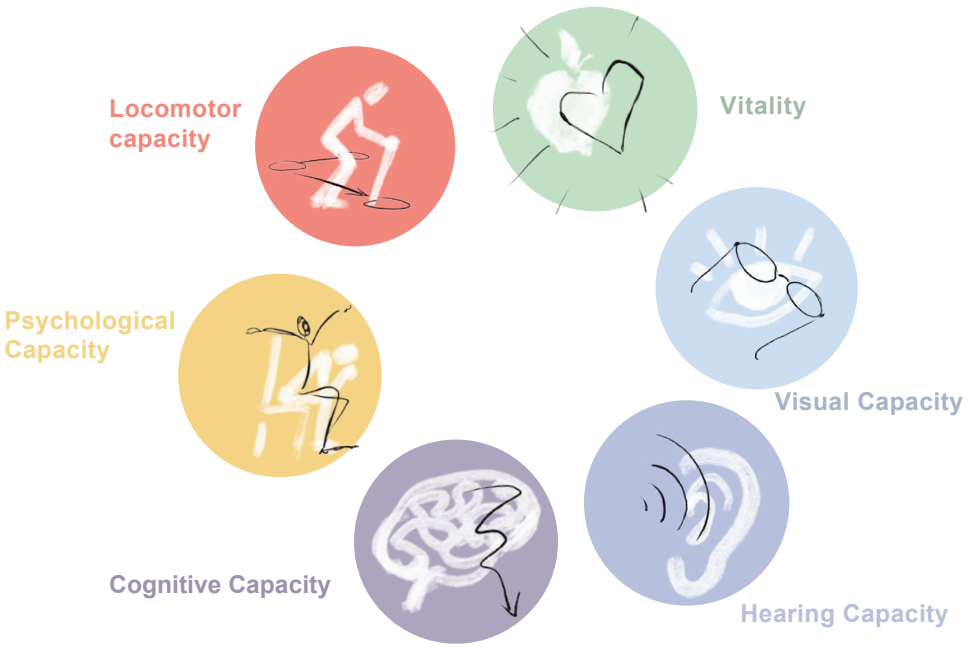
Evidence-based programs designed to support self-management and increase or maintain intrinsic capacity are important tools for health systems to optimize healthy aging in the population and thus ensure the rights of older persons to universal health.

3. BASIS FOR SUPPORTING EVIDENCE-BASED PROGRAMS TO SUPPORT INTRINSIC CAPACITIES

KEY POINTS:

- Healthy aging is the process of developing and maintaining the functional ability that enables well-being in older age.
- Functional ability comprises all health-related attributes that enable people to be and to do what they have reason to value. It is made up of intrinsic capacity, the environment and the interactions between them.
- The intrinsic capacity is all the person's mental and physical capacities, with key main domains.

Figure 1: *Domains of the intrinsic capacity*



The demographic shift, which is reflected by the increase in the older adult population, is accompanied by the epidemiological transition, defined as the change in disease patterns and causes

6. World Health Organization. Integrated care for older people (ICOPE): Guidance for person-centered assessment and pathways in primary care. Geneva: WHO; 2019. Available from: https://www.who.int/publications/i/item/WHO-FWC-ALC-19.1

of death, increasing the prevalence of chronic degenerative diseases. Older adults already suffering from one chronic disease or infectious diseases are especially vulnerable to develop other associated conditions, including frailty. Older adults already suffering from one chronic or infectious diseases are especially vulnerable to develop other associated conditions, including frailty.

To achieve healthy aging, it is crucial to maintain intrinsic capacity and functional ability, even though neither of them remains constant within aging. In general, older adults with chronic diseases face an earlier and steeper slope on functional decline, which is why interventions helping them to delay disability onset and opti-mize functional capacity are fundamental.

For older adults with significant declines in functional ability, supportive environments and self-management support can ensure that they live lives with dignity and continued personal growth. A person-centered, integrated care for older people (ICOPE) at the primary health care level would not have the desired positive outcomes without creating a system to support self-management, falls prevention, exercise, and depression management. In an integrated program, both the individual and the community play a key role in improving health and containing health care costs, and both need tools and skills to prepare them to be partners in care.

In the ICOPE model, health care providers assess, diagnose, and develop a care plan with multiple interventions. For example, a person may receive a number of prescribed medications or therapies, advice for a healthy diet, recommendations for physical activity, etc. Unless the person also receives self-management support, it is likely that the move from ***knowing what to do to having con idence that one can accomplish a specific action or change a specific behavior*** may never occur.

EPIDEMIOLOGICAL BASIS TO SUPPORT SELF-MANAGEMENT PROGRAM DEVELOPMENT AND IMPLEMENTATION

Definitions:[7]

a. Self-management relates to the tasks that an individual must undertake to live well with one or more chronic conditions. These tasks include gaining confidence to deal with medical management, role management and emotional management.

b. Self-management support is the systematic provision of education and supportive interventions by health staff to increase patients' skills and confidence in managing their health problems, including regular assessment of progress, goal setting, and problem-solving support.

- Two in three older persons have a chronic condition, including arthritis, asthma, chronic respiratory conditions, diabetes, heart disease, hypertension. The prevalence of two or more concurrent chronic conditions increases with age. As the number of chronic conditions in an individual increases, so do the risks of poor functional status and unnecessary hospitalizations.
- A significant number of adults and older adults will live with a chronic condition for an average of 30 to 40 years.
- Approximately 80% of declines in functional ability due to chronic conditions are preventable, usually using easy and affordable alternative care models.
- Mental health conditions are among the leading factors that contribute to morbidity, disability, injuries, premature mortality, and increased risk for other health conditions. The prevalence of these disorders in the Americas ranges between 18.7% and 24.2%.
- Treatment adherence among patients suffering from chronic diseases averages only 50%. The magnitude and impact of poor adherence in developing countries is assumed to be even higher, given the paucity of health resources and the inequities in access to health care.[8]

7. Adams K, Greiner AC, Corrigan JM (editors). Institute of Medicine (US) Committee on the Crossing the Quality Chasm: Next Steps Toward a New Health Care System. The 1st Annual Crossing the Quality Chasm Summit: A Focus on Communities. Washington, DC: National Academies Press (US); 2004. PMID: 25009886.
8. Pan American Health Organization. Health in the Americas 2017. Washington, DC: PAHO; 2017. Available from: https://www.paho.org/salud-en-las-americas-2017/

Why should we aim to improve locomotor capacity?

- 30% of community-dwelling individuals older than age 65 and 50% of people older than age 85 fall at least once a year.
- Significant injuries occur in 4%-15% of falls, and 23%-40% of injury-related deaths in older adults are due to falls; 80% of low-trauma fractures occur in people who do not have osteoporosis and 95% of hip fractures result from falls.
- There is extensive evidence that many falls can be prevented by addressing a wide range of risk factors, including: declines in physical capacity, and difficulties with balance and mobility.
- Falls, back and neck pain, diabetes and osteoarthritis are some of the leading cause of greatest burden of disability in older adults.
- Components of frailty (weight loss, exhaustion, weakness, slowness, and low physical activity) are totally related to mobility. Frailty has been associated with adverse health outcomes, prolonged hospitalizations, increased susceptibility to deconditioning, faster functional decline and higher health care use.
- Community-dwelling older adults are prone to developing frailty. A study shows that among non-frail Individuals 13.6% became frail (3-year follow-up). Among robust individuals 30.9% became prefrail (2.5-year follow-up).[9]

9 Ofori-Asenso R, Chin KL, Mazidi M, Zomer E, Ilomaki J, Zullo AR, Gasevic D, Ademi Z, Korhonen MJ, LoGiudice D, Bell JS, Liew D. Global Incidence of Frailty and Prefrailty Among Community-Dwelling Older Adults: A Systematic Review and Meta-analysis. JAMA Netw Open. 2019 Aug 2;2(8):e198398. doi: 10.1001/jamanetworkopen.2019.8398. PMID: 31373653; PMCID: PMC6681553.

Why to improve psychological capacity through managing depression in older adults?

- Depressive symptoms in older adults are associated to higher risks of cognitive decline and dementia.
- Depression and depressive symptoms have a considerable negative effect on patients' self-rated health.
- About 2%-3% of older adults living in the community suffer from depression. Older people more often suffer from substantial depressive symptomatology without meeting the diagnostic criteria for a depressive disorder. This condition is often referred to as subthreshold depression, and affects nearly one in 10 older adults.
- If underdiagnosed and not managed, depressive symptoms can lead to major psychological disease, functional dependence, isolation, poor quality of life, greater use of health services, and increased risk of death.
- Depressive disorders are one of the leading causes of the greatest burden of disability in older adults.
- The proportion of older people living alone is rising dramatically, which can increase the risk of isolation and depressive symptoms.

4. SELF-MANAGEMENT SUPPORT FOR OLDER PERSONS

SELF-MANAGEMENT

Self-management relates to the tasks that an individual must undertake to live well with one or more chronic conditions. These tasks include gaining confidence to deal with medical management, role management and emotional management.[10]

SELF-MANAGEMENT CAPACITY

"Offering support for self-management is another tool for providing person-centered and integrated care to older adults"[11].

Self-management support consists of providing "the information, skills and tools that they need to manage their health conditions, prevent complications, maximize their intrinsic capacity and maintain their quality of life". Everyone manages their conditions the best they can. The Chronic Disease Self-management Program (CDSMP)

10 Adams K, Greiner AC, Corrigan JM (editors). Institute of Medicine (US) Committee on the Crossing the Quality Chasm: Next Steps Toward a New Health Care System. The 1st Annual Crossing the Quality Chasm Summit: A Focus on Communities. Washington, DC: National Academies Press (US); 2004. PMID: 25009886.

11 World Health Organization. World report on ageing and health. Geneva: WHO; 2015. Available from: https://apps.who.int/iris/handle/10665/186463

teaches that individuals can change from being a poor or passive self-manager to a good or active self-manager.

GOOD SELF-MANAGERS ARE ABLE TO:	POOR SELF-MANAGERS OFTEN:
Solve problems	Take barriers as dead-ends
Make decision	Make decisions passively
Do action planning	Are overwhelmed by big goals

The CDSMP is available in PAHO's official four languages:

English: Chronic Disease Self-Management

Spanish: Tomando Control de su Salud

Portuguese: Assumindo o Controle de sua Saúde

French: Vivre en Santé avec une Maladie Chronique

The program was developed at Stanford University, and is one of the most widely disseminated evidence-based programs. It was specifically developed to provide self-management skills and confidence to people with one or more chronic conditions, including severe mental health conditions such as depression, that can impact their intrinsic capacity. The program makes the assumption that people with different chronic conditions have similar concerns and problems; they deal not only with the disease(s) but also with the impact these have on their daily lives and emotions. Learning to manage these conditions and to maintain a healthy life in spite of disease is the key to self-management.

The program has reached more than a million people, is offered in more than 30 countries and is available in more than 15 languages. It has been evaluated in a randomized efficacy study in the United States, a randomized effectiveness study in England and a longitudinal effectiveness study in the United States.

These studies demonstrated reductions in health care utilization, reductions in symptoms (fatigue and depression), and increases in role function.

They also demonstrated increases in exercise, use of cognitive symptom management, and adherence to medications.

The program has been customized to serve people with specific diseases or conditions.

ENGLISH	SPANISH
Diabetes Self-Management	Manejo Personal de la Diabetes
Chronic Pain Self-Management	Manejo Personal del Dolor Crónico
Cancer: Thriving and Surviving	Cáncer: Triunfando y Sobreviviendo
HIV: Positive Self-Management	Vivir más Sano con VIH

The program has been customized so it can be offered in small groups in community settings, using a virtual group setting (to accommodate for physical distancing during Covid-19), or in a self-guided tool kit.

The self-management suite of programs was developed by the Patient Education and Research Center of Stanford University and are licensed and managed by the Self-management Resource Center, Inc.

For more information on available formats in different languages, visit: https://www.selfmanagementresource.com

SMALL GROUP FORMAT TO BE DELIVERED IN COMMUNITY SETTINGS FOR PERSONS WITH ANY CHRONIC CONDITION THAT CAN IMPACT THE INTRINSIC CAPACITY

Program	Goal	Description	Requirements	Website for program information and evidence
Chronic Disease Self-management (CDSMP) **Tomando Control de su Salud** **Assumindo o Controle de sua Saúde** **Vivre en Santé avec une Maladie Chronique** 	To provide self-management skills and confidence to people with one or more chronic conditions.	The program was developed by Dr. Kate Lorig, DrPH, Professor of Nursing at Stanford University, USA. It is a highly interactive workshop offered in small groups (10-14 people) 2.5 hours once a week for 6 weeks. **Target:** Adults with one or more physical and/or mental health chronic conditions. **Key activities:** Each session is built on three major skills which underlay all self-management: • Action planning (making a weekly commitment to behavior change) • Problem-solving (how to solve problems) • Decision-making (how to make decisions) Each session has 4 to 8 different activities. • Topics included in the sessions are: symptom management (sleep, fatigue, pain, shortness of breath, depression, difficult emotions) • Exercise • Healthy eating • Cognitive symptom management techniques (distraction, positive thinking, relaxation exercises) • Communicating about chronic disease • Medication management.	**Training requirements:** Peer leaders are trained by a pair of certified master trainers in a 4-day group workshop. **Personnel requirements:** Each program is facilitated by a pair of trained peer leaders who teach from a detailed manual. Peers are usually people from the community being served, who also have chronic conditions. They do not need to have past training in health or to be health professionals. **Materials required:** *Peer Leaders need*: • The CDSMP Workshop Leader's Manual (printed locally). • The book, Living a Healthy Life with Chronic Conditions • Flip charts and markers *Participants need:* • The book, Living a Healthy Life with Chronic Conditions (books can be distributed to participants in a lending library to minimize cost of implementation.	https://www.selfmanagementresource.com Health outcomes and evidence supporting health outcomes have been published in various peer reviewed journals. For full bibliography, visit the program website. The Self-management Resource Center (SMRC) provides licenses, training and support for the implementation of the program. PAHO Regional office works directly with SMRC for regional implementation in Latin America and the Caribbean and has a Regional License for PAHO Country Offices. The Chronic Disease Self-management Program has reached more than a million people, is offered in more than 30 countries and is available in more than 15 languages.

OFFERING SELF-MANAGEMENT EDUCATION IN A VIRTUAL VIDEO FORMAT

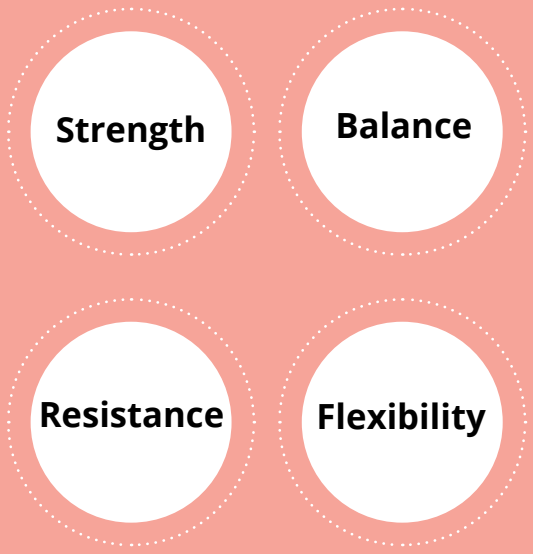
Modality	Description	Requirements	Website for program
Video Platform Workshops for Chronic Disease Self-management (CDSMP) The video platform modality is also available for: Diabetes Self-management; Chronic Pain Self-management; Cancer Thriving and Surviving; and Positive Self-management. It can also be used with the Spanish version of these programs.	The virtual video format is presented for six weeks and uses an adapted CDSMP Leader's Manual. It is exactly the same as the small group in-person workshop but adapted to a video platform during the Covid-19 pandemic. **Target:** Adults with one or more physical and/or mental health chronic conditions.	**Leaders:** must be active in the CDSMP program and have the revised manual for the video platform. **Personal requirement:** Each virtual workshop is led by two active leaders. **Materials required:** • All participants must have a webcam and use it during the workshop. • All participants must have a Living Healthy book and must participate in the video platform, not just by phone. • Workshop size should be between 8 and 12.	https://www.selfmanagementresource.com The video platform can be delivered only by licensed organizations/ agencies and offered to their clients/ patients. The PAHO license includes the virtual modality.

OFFERING SELF-MANAGEMENT EDUCATION IN A SELF GUIDED FORMAT

Modality	Description	Requirements	Website for program
Mailed Tool Kits: **Active Living with Chronic Conditions Tool Kit** **Caja de Herramientas para tener una vida activa con condiciones crónicas.**	The CDSMP Tool Kit for Active Living with Chronic Conditions (English and Spanish) is a self-guided modality that includes all tools in the CDSMP. It offers an alternative method for those who cannot or do not wish to attend a CDSMP workshop in person. **Target population:** Adults with one or more physical and/or mental health chronic conditions.	Since this is a self-guided program, no leader or facilitator is needed. However, participants must be able to read and follow a self-guided program. Each participant receives a tool kit containing the following: • Living a Healthy Life with Chronic Conditions • The Relaxation for Mind and Body CD • An exercise CD • Tip sheets on the most important self-management tools.	https://www.selfmanagementresource.com The program has been tested for effectiveness with positive results. For bibliography, see the self-management resource center website.
Mailed Tool Kits with Weekly Telephone Contact	This mode of delivery utilizes the Active Living with Chronic Conditions Tool Kit and adds weekly telephone contact.	• Participants receive tool kits and are assumed to be able to use the materials with the self-guided brochure. • Weekly conference calls are made by one group leader to a group of 4-6 people. • Leaders follow a scripted format for the phone calls.	

5. LOCOMOTOR CAPACITY PHYSICAL ACTIVITY/EXERCISE/ FALLS PREVENTION

LOCOMOTOR CAPACITY IS THE PERSON'S BODILY CAPACITY TO MOVE FROM ONE PLACE TO ANOTHER



Mobility is a critical determining factor for healthy aging. It is important for maintaining autonomy and preventing dependence on care.

GOOD LOCOMOTOR CAPACITY	POOR LOCOMOTOR CAPACITY
•Ability to perform activities of daily living •Autonomy •Independence	•Falls •Dependence •Poor quality of life

Limited mobility is common among older people but not inevitable.

"Declines in any intrinsic capacity can increase the risk of falls and can also impair other domains, such as cognition."

An exercise program, tailored to individual capacities and needs, is the most important approach to improve or maintain locomotor capacity.

Declines in locomotor capacity can also impair other domains from a person's intrinsic capacity, such as cognition.

This portfolio is intended to showcase specific interventions for improving locomotor capacity and preventing falls. These selections represent just a sampler of available programs that meet the following criteria:

The programs have:

- published data in the peer-reviewed literature
- included community-dwelling adults aged 60 and older
- used a randomized controlled study design
- been specifically designed to improve locomotor capacity and/or reduce falls
- demonstrated statistically significant positive results in improving locomotor capacity and/or reducing falls
- been tested in real-life settings.

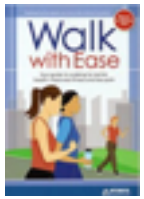
An evidence-based program delivered in groups or with one-on-one supervision is a cost-effective way of providing a structured physical activity program that improves locomotor capacity, reduces risks of falling, and provides self-management support.

CONTENT

The portfolio presents two groups of interventions:

A. One-on-one interventions in community or clinical settings	B. Group interventions in community settings
A.1 Vivifrail	B.1 Active Living Every Day
A.2 Walk with Ease	B. 2 Enhance Fitness
A.3 CAPABLE	B.3 Fit and Strong
A.4 OTAGO	B.4 Matter of Balance
	B.5 Tai Chi for Arthritis/For Fall Prevention

A.1 VIVIFRAIL IS A PROGRAM FOR THE PROMOTION OF PHYSICAL EXERCISE				
Program	**Goal**	**Description**	**Requirements**	**Program Website**
Vivifrail 	To improve functional ability and to promote a gradual increase in activity level to prevent frailty and falls.	Vivifrail was developed by Mikel Izquierdo, Ph.D. and professor of Exercise Physiology at the Public University of Navarra, Spain. It is a 12-week individualized multicomponent program of exercises, with daily rounds of approximately 30-45 minutes of physical activity. **Target:** persons 70 years and older Key activities: • The program starts with an evaluation using the Vivifrail test. The test includes three separate measures: balance, walking speed, getting up from a chair and a fall risk test. • Evaluation results allows the professional to determine the most appropriate type of multicomponent physical program to prescribe for each person using a set of different prescription models (exercise passports). These range from type A for persons with a disability to type D for robust persons.	**Training requirements:** • Professionals and specialists in exercise will be guided through a self-guided training process available on-line at no cost. • No license is required **Personnel requirements:** • The exercise prescription is originated from a health professional or an exercise specialist. • Didactic materials for instructors and for participants are all available in the website at no cost. **Materials required:** • Passport booklet with prescribed exercises for each participant. • Printing of materials is done locally. • Bottles of water are used to support strength training. All materials are available in the public domain in ***Spanish, English,*** and ***Portuguese*** at no cost.	www.vivifrail.com https://diabfrail-latam.eu/ • Health outcomes and evidence supporting health outcomes have been published in various peer-reviewed journals. For full bibliography visit the program website. • A new modality of Vivifrail is Diabfrail. Diabfrail is presently under investigation. This new modality targets persons with Diabetes and is a mix of group education program meeting 2x week for 3-4 weeks. And a 16-week individual exercise program done at home. The program is still in its clinical testing phase and is developed with funding from the from the European Commission (European Union's Horizon 2020 research and innovation program).

A.2 WALK WITH EASE				
Program	**Goal**	**Description**	**Requirements**	**Program Website**
WALK WITH EASE (WWE)   	• The overall goals of the program are: • To promote education about physical activity for adults with arthritis. • To promote education about arthritis self-management and walking safely and comfortably. • To encourage participants to continue their walking program and explore other exercise and self-management programs that deliver proven benefits for adults with arthritis.	The Arthritis Foundation Walk with Ease program was developed in 2007 by Thurston Arthritis Research Center and the Institute on Aging of the University of North Carolina. The Spanish translation and adaptation, Camine con Gusto, was completed in 2011. The program has proven to improve symptoms of arthritis, function, and overall health. **Target:** adults with arthritis or joint pain/stiffness. Participants must be able to stand on their feet for at least 10 minutes. The program is designed so it can be offered in two modalities: **Group program:** • 6 weeks (1 hour/3 times a week). • 12-15 recommended participants per group. Self-directed program including self-paced walks and following the book guidelines covering health-topic related topics • 6 weeks • 30 min, 3 times a week	**Training requirements:** On-line training offered by the Arthritis Foundation or 3-4 hour in person Arthritis Foundation training. **Personnel requirements:** A certified instructor trained to lead the WWE program by the Arthritis Foundation must be also certified in CPR. No license is required. **Materials required:** Walk with Ease Book for the participants (English); Camine con Gusto (Spanish)	https://www.arthritis.org/health-wellness/healthy-living/physical-activity/walking/walk-with-ease Health outcomes and evidence supporting health outcomes have been published in various peer-reviewed journals. For full bibliography, visit the program website.

A.3 CAPABLE (COMMUNITY AGING IN PLACE, ADVANCING BETTER LIVING FOR ELDERS)				
Program	**Goal**	**Description**	**Requirements**	**Program Website**
CAPABLE Community Aging in Place, Advancing Better Living for Elders.	To decrease fall risk and increase mobility, functionality, and capacity to age in place. This program is designed to increase locomotor intrinsic capacity while minimizing hazards in the home environment.	CAPABLE was developed by Sarah L. Szanton, Ph.D. A.N.P at Johns Hopkins University. It is a 4 to 5-month person-centered home-based intervention focusing on medication management, problem-solving ability, strength, balance, nutrition, and home safety. **Target:** Older adults with at least one activity of daily living difficulty, such as difficulty bathing, dressing, walking, or getting off/onto the toilet and who are cognitively able to identify goals. **Key activities:** • 6 visits from an occupational therapist and 4 visits from a nurse. • 1 day of home repairs, modifications, and installation of assistive devices by a Handyman. The nurse and occupational therapist work with the participant to identify their physical and functional limitations and establish individualized self-care goals. The program combines environmental and personal supports.	**Training requirements:** • Six (6) online modules for the CAPABLE nurses and occupational therapists. • Eight (8) hours of training support through Skype or other distance technology. • Follow-up support calls or monthly webinars **Personnel requirements:** • Nurse trained in CAPABLE • Occupational therapist trained in CAPABLE • Handyman and supplies to make home modifications and install assistive devices No license is required. **Materials required:** Materials and equipment individualized to the participant. ***Training for nurses and occupational therapists available in English only.***	Community Aging in Place | CAPABLE | School of Nursing at Johns Hopkins University https://nursing.jhu.edu/faculty_research/research/projects/capable/ Health outcomes and evidence supporting health outcomes have been published in various peer-reviewed journals. For full bibliography, visit the program website.

A.4 OTAGO				
Program	**Goal**	**Description**	**Requirements**	**Program Website**
OTAGO 	To reduce risk of falls through better lower extremity strength and balance.	The Otago exercise program was developed and tested by Dr. John Campbell and Dr. Clare Robertson at the University of Otago, Otago, New Zealand as a homebased exercise program. **Target:** individuals who are frail, adults 80 and older. It can be modified for a community setting such as a clinic. **Key activities:** • A series of warm-up exercises and 17 strength and balance exercises conducted in the home for 30 minutes/day, three times/week (three exercises use ankle weights to provide added resistance). The exercises are selected and progressed by a physical therapist based on the participant's abilities (the participant does not do all 17). • A walking program done for up to 30 minutes/day, three times/week. • 5 PT participant visits over a period of 8 weeks. • Follow-up visit at 6 months and one year • Monthly phone calls during months when there is no face to face interaction.	**Training Requirements:** Instructors are required to complete the Otago Exercise Program Online Training. **Personnel Requirements:** The program can be delivered by a Physical Therapist or Physical Therapy Assistant or a Licensed Exercise instructor who are trained in the Otago Program. **Materials required:** Ankle weights for participants. Individualized packet of handouts containing selected exercises for each participant (printing locally). No license is required. ***Training and materials available in English.*** For those exercising at home there are free videos available at: http://www.med.unc.edu/aging/cgec/exercise-program	https://www.livestronger.org.nz/assets/Uploads/acc1162-otago-exer-cise-manual.pdf http://www.med.unc.edu/agin g/cgec/exercise-pro-gram Health outcomes and evidence supporting health outcomes have been published in various peer-reviewed journals. For full bibliography visit the program website.

B.1 ACTIVE LIVING EVERY DAY				
Program	**Goal**	**Description**	**Requirements**	**Program Website**
Active Living Every Day (ALED)	To teach skills needed to successfully adopt and maintain a physically active lifestyle	ALED is based on the research study Project Active, which was conducted at The Cooper Institute. It offers different options to traditional exercise programs to help participants overcome their barriers to physical activity. **Target audience:** Older adults and adults with arthritis and other chronic conditions. **Key activities:** • The instructor meets for one hour once a week for 12 to 20 weeks for short lecture (scripted in manual) on goal setting, overcoming barriers, and finding physical activities that participants enjoy. • Group discussion. • Participants create plan for physical activity that can be added to daily routines, based on individual lifestyle. • All physical activity happens outside of class.	**Program Requirements:** • One leader per class. No educational or fitness certification is required for the leader, but leader must complete an online course and training. • A license from ALED is required. No cost for license. **Training Requirements:** • Leaders must complete online course for facilitator and successfully complete an online competency exam. **Materials required:** • Didactic materials for instructors: flip charts, markers, handouts, ALED manual and book. • For participants: ALED book, on-line support and step counter. ***Training and materials are available for purchase. See website for actual cost. Available in English only.***	https://us.humankinetics.com/blogs/active-living Active Living Every Day Program Description | Arthritis | CDC https://www.cdc.gov/arthritis/interventions/programs/aled.htm Health outcomes and evidence supporting health outcomes have been published in various peer reviewed journals. For full bibliography, visit the program website.

B.2 ENHANCE FITNESS				
Program	**Goal**	**Description**	**Requirements**	**Program Website**
Enhance Fitness (EF)	To improve the overall functional fitness and well-being of older adults and prevent falls.	Enhance Fitness was developed by a collaboration among Group Health Cooperative, Sound Generations, and the University of Washington Health Promotion Research Center. It is multi-component and can be tailored for specific chronic diseases (e.g., arthritis). **Target population:** Older adults, from the frail to the fit. The class can be taken seated or standing, and instructors are trained in how to modify the exercises to suit the varying abilities of participants. **Program components:** • Warm-up (5-9 minutes) • Cardiovascular workout (20 mins) • Cool-down (3-5 mins) • Upper and lower body strength training with wrap around weights (20 mins) • Flexibility (8-10 mins) • Balance training and posture review are included throughout Outcomes testing is conducted in the first week of classes and repeated every 4 months. Tests include biceps curl, 8 foot Up-and-Go, and Chair Stand.	**Program Requirements:** • One EF instructor per class. • A program license is required from Project Enhance. See website the cost of license and training. **Training Requirements:** • Be either a health professional or certified by a nationally recognized fitness organization. • Attend a 1.5 EF Instructor training. • Current CPR certification **Materials Needed for Class:** • Adjustable ankle and wrist weight cuffs for each participant • Sturdy, armless straight-back chairs **Materials Needed for Measurements:** Stopwatch, 5 and 8 lbs. hand-weights, and tape measurement. ***Training and materials are available for purchase. See website for actual cost. Available in English and Spanish.***	https://projectenhance.org/ Health outcomes and evidence supporting health outcomes have been published in various peer reviewed journals. For full bibliography, visit the program website. EF has permanent sites offering the program in 40 of the 50 States in the USA. YMCA, municipal parks, senior centers, community clinics, and health systems have adopted the program throughout the USA.

B.3 FIT AND STRONG				
Program	**Goal**	**Description**	**Requirements**	**Website for**
Fit and Strong! (FS)	To manage lower- extremity osteoarthritis. **Specific goals:** • Maintain independent functioning • Reduce and manage arthritis symptoms • Learn a variety of exercises • Understand osteoarthritis • Incorporate physical activity into lifestyle • Develop individualized activity program that is sustainable after the program ends	FS was developed by Susan L. Hughes, Ph.D. Professor in the Division of Community Health Sciences, Center for Research on Health and Aging at the University of Chicago. The program is both a physical activity and a behavior change program. **Target population:** Older adults who have lower-extremity joint pain and stiffness related to osteoarthritis. **Program components:** • 60 mins of exercise including: • Warm up and stretching/balance (15 mins) • Aerobic and endurance exercises (20 mins) • Strengthening and resistance exercises using exercise bands and ankle cuff weights (20 mins) • Cool-down exercises (5 mins) A 30-minute group problem solving and health education focusing on issues related to osteoarthritis and physical activity. Before the end of 8th week participants meet with instructor to develop an individualized exercise plan. Outcomes testing is conducted at the beginning and end of the program.	**Program Requirements:** • One FS instructor per class. • A program license is required from FS. See website for cost of license and training **Training Requirements:** • Must be either a health professional or certified by nationally-recognized fitness organization. • Experience leading group-based exercise classes. • Successfully complete an 8-hour Fit and Strong! Instructor training. **Materials Needed for Class:** • One FS manual per participant. (Printed locally) • Resistance equipment per partici-pant including elastic exercise bands and adjustable ankle cuff weights (10 lbs.) • Floor mats for floor-based exercises • Music • Chairs ***Training and materials are available for purchase. See website for actual cost. Available in English, Spanish, and Portuguese***	https://www.fitandstrong.org Health outcomes and evidence supporting health outcomes have been published in various peer-reviewed journals. For full bibliography, visit the program website.

B.4 MATTER OF BALANCE				
Program	**Goal**	**Description**	**Requirements**	**Program Website**
Matter of Balance (MOB) Un Asunto de Equilibrio (ADE)	To reduce the fear of falling and increase activity levels	MOB is based on Fear of Falling, a program developed at the Geriatric Education Center, Boston University and translated to a 'lay coach' model in collaboration with Maine Health Partnership. It is a multi-component cognitive-behavioral intervention offered in small group class (8 to 12 participants Class meets 8 times for 2-hour sessions. Class can meet either twice a week for 4 weeks or once a week for 8 weeks. **Target population:** Older adults, ambulatory, able to problem solve and concerned about falls. **Program components:** Each class includes: • A behavior change component that addresses the fear of falling, teaches how to change/modify risk factors for falls such as adaptations at the home environment • 25 minutes low-to-moderate level exercises to increase flexibility, balance, strength, and endurance. In class no. 7, a guest health care professional discusses with participants health-related risk factors for falls, explains the relationship between leg weakness and balance problems and provides advice on use of assistive devices.	**Program Requirements:** • Two lay MOB coaches trained and certified by two MOB Master Trainers. • One Guest Health Professional (such as physical therapist, occupational therapist, or registered nurse). **Training Requirements:** • Lay MOB coaches participate in a 2-day in-person MOB training. **Materials Needed for Class:** • License is provided at no cost • Participant workbook, printed locally • Flip chart or white board, and • 2 DVDs and TV/DVD player for class viewing: "Fear of Falling" and "Exercise is Never too Late" ***Training and materials are available for purchase. See website for actual cost. Available in English and Spanish.***	https://mainehealth.org/healthy- communities/healthy-aging/matter-of- balance Health outcomes and evidence supporting health outcomes have been published in various peer reviewed journals. For full bibliography, visit the program website.

B.5 TAI CHI FOR ARTHRITIS/FOR FALL PREVENTION				
Program	**Goal**	**Description**	**Requirements**	**Program Website**
Tai Chi for Arthritis/ For Fall Prevention (TCHI)	To improve relaxation and balance, reduce pain and the risk of falls.	TCHI was developed by Dr. Paul Lam, founder of the Tai Chi Health Institute, Sydney, Australia. It utilizes Tai Chi's Sun-style movements. The movements are taught to both left and right sides and with turns to move forward and backward to improve mobility and offer a variety of combinations. Class meets 2 x a week for one hour for 8 weeks by a trained instructor. **Target population:** The program is appropriate for people with mild, moderate and severe joint involvement and back pain. It is also appropriate for adults without arthritis who have a higher risk of falling. **Program components:** • Warm-up and cool-down exercises • One or two Tai Chi movements are taught per session, progressively leading to completing the 6 basic core movements and 6 advanced extension movements (12 movements in total). • Breathing techniques • Tai Chi principles relating to improving physical and mental balance. Movements can be modified to accommodate mobility issues for any participant and can be done seated as a starting exercise.	**Program Requirements:** • One Instructor trained in the Tai Chi for Arthritis program. • No program license is required. **Training Requirements:** There are various levels of training. A certified instructor is trained by TCHI Board certified Master Trainer. List of certified master trainers in the region are available in the TCHI website.Training consists of following: a self-study guide and book; two-days of in-person class and continuous improvement with support from materials provided by the Institute for Health. Training can be done in Spanish by a Spanish-speaking Master Trainer. However, books and DVDs are only available in English. **Materials Needed for Class:** • No materials are needed • Instruction DVD, posters and other educational resources are available to help participants continue to learn movements at home.	https://taichiforhealthinstitute.org/programs/tai-chi-for-fall- prevention/ Health outcomes and evidence supporting health outcomes have been published in various peer-reviewed journals. For full bibliography, visit the program website.

6. PSYCHOLOGICAL CAPACITY

The person's capacity to overcome adversities, setbacks, frustrations and even depressive symptoms is termed 'psychological capacity'.

SELF-EFICACY AND PSYCHOLOGICAL CAPACITY

Self-efficacy is a critical determining factor for healthy aging. It is important for adapting to and adopting new behaviors for successful functioning as we age. A person's capacity to overcome adversities, setbacks, frustrations, and even depressive symptoms is termed 'psychological capacity.'

Self-efficacy refers to an individual's belief in his or her capacity to execute specific behaviors.

GOOD PSYCHOLOGICAL CAPACITY	POOR PSYCHOLOGICAL CAPACITY
• Problem solving ability • Resilience • Rewarding life	• Isolation • Hopelessness • Poor well being

- Depressive symptoms are more common in older adults with long-term and disabling conditions, in social isolation or who are caregivers with demanding care responsibilities.
- Declines in other domains of intrinsic capacity, such as in hearing or mobility, may impair functional abilities, reduce social participation and contribute to depressive symptoms.

ICOPE RECOMMENDS BRIEF STRUCTURED PSYCHOLOGICAL INTERVENTIONS

- **Cognitive behavioural therapy (CBT).** Steps in CBT include (1) identifying problems in one's life, (2) becoming aware of thoughts, emotions and beliefs about these problems, identifying negative or inaccurate thinking, and reshaping this thinking to be more realistic.
- **Problem solving counselling or therapy (PST).** Steps in PST include breaking problems down into specific, manageable tasks by problem-solving and developing coping strategies for specific problems.
- **Behavioural activation (BA).** This approach involves encouraging the person to participate in rewarding activities as a means to reduce depressive symptoms.
- **Multimodal physical exercise.** Exercises tailored to the physical abilities and preferences of the person can reduce depressive symptoms.

MANAGE DEPRESSIVE SYMPTOMS

Mental health counselors or therapists can administer these interventions. However, community health workers, with proper training and supervision can also deliver programs to manage depressive symptoms.

An evidence-based program available in English and Spanish and well tested in the community is the evidence-based Program to Encourage Active, Rewarding Lives (PEARLS).

PEARLS brings high quality mental health care into community-based settings that reach vulnerable older adults. The program was developed at the University of Washington Health Promotion Research Center and Aging and Disability Services and evaluated using a community-based randomized controlled trial between 2000 and 2003. The study showed that over 12 months, individuals who received the PEARLS program were more likely that those who did not receive it to have a reduction in depression symptoms; or achieve complete remission from depression, and have greater health-related quality of life improvements in both functional and emotional well-being.

Program for Encouraging Active Rewarding Lives				
Program	**Goal**	**Description**	**Requirements**	**Program Website**
Program for Encouraging Active Rewarding Lives (PEARLS)	To reduce depression in older adults by using several treatment methods and improve quality of life	PEARLS is a multi-component approach to depression treatment delivered at home or in a center, by a trained social worker or care manager. It was developed by Dr. Mark Snowden, MD, MPH, at the University of Washington's Health Promotion Research Center in collaboration with the City of Seattle's Aging and Disability Services. **Target:** Older adults with minor depression or dysthymia (on-going low-grade depression of two or more years) **Key activities:** • Problem Solving Treatment (PTS) • Social and Physical Activation • Pleasant activity scheduling. • Monthly telephone follow-up for 3-6 months to support participants as they continue to use the tools they were taught. These components of PEARLS are delivered during 6 to 8 50-minute sessions one-to-one over a 19-week period. The delivery is participant focused. The method of delivery is designed to empower participants.	**Training requirements:** • PEARLS counselors are trained by a Master Trainers in a 2-day workshop. **Personnel requirements:** • PEARLS Manager. Supervises, assigns clients to counselors, leads marketing and recruitment. • Clinical Supervisor (psychiatric supervision) provides clinical supervision to the counselors. May be done via telehealth, meets to review cases and provide guidance to the counselors • PEARLS counselors conduct the sessions and follow-up activities and provides service data to the manager. **Materials required:** • PEARLS manual for Counselors and measures and evaluation forms include: PHQ-2; PHQ-9; physical and social activities, pleasant events, client satisfaction.	https://depts.washington.edu/hprc/evidence-based- programs/pearls-program/ Health outcomes and evidence supporting health outcomes have been published in various peer-reviewed journals. For full bibliography visit the program website. The program does not require a license. The tool kit providing guidance for implementation is available in English on the program website. Training is available on demand, in English and Spanish, by the University of Washington.

7. COGNITIVE CAPACITY

Cognitive decline presents as increasing forgetfulness, loss of attention and reduced ability to solve problems.

GOOD COGNITIVE CAPACITY	POOR COGNITIVE CAPACITY
• Ability to clearly think, learn, and remember • Ability in performing everyday activities.	• Problems with memory, language, thinking or judgment • Confusion. • Poor motor coordination / capacity

COGNITIVE CAPACITY

- Cognitive decline can be related to the aging of the brain, to diseases (for example, cardiovascular diseases, such as hypertension and stroke, dementia or Alzheimer's disease) or even environmental factors such as a lack of physical exercise, social isolation and a low level of education.
- Not all cognitive decline means dementia. Dementia interferes with a person's ability to function effectively in their environment. For a person with dementia, specialist care is needed to plan and carry out complex interventions.
- Decline in other domains of intrinsic capacity, such as in hearing or mobility, may impair functional abilities, reduce social participation and contribute to cognitive decline.

MANAGING COGNITIVE DECLINES

Failing in cognitive assessment or reported problems with memory or orientation suggests cognitive impairment. If cognitive declines affect an older person's ability to function effectively within their environment a specialized assessment may be needed to diagnose dementia or Alzheimer's disease.

ICOPE recommends that an important step, before any diagnostic process for cognitive decline, is to assess the presence of any associated conditions and treat these first.

- Severe dehydration
- Delirium
- Polypharmacy
- Major surgery and general anaesthesia
- Cerebrovascular disease
- Cerebrovascular disease

People with cognitive declines can benefit from:

- Cognitive stimulation.
- Multimodal exercise (see locomotor capacity programs)

An evidence-based program being tested to prevent cognitive impairment and disability is the Finnish Geriatric Intervention Study to Prevent Cognitive Impairment and Disability (FINGER). It is the first randomized controlled trial showing that it is possible to prevent cognitive decline using a multidomain lifestyle intervention among older at-risk individuals.

In 2018, WW-FINGERS trials had been planned in several European countries, the United States, China, Singapore and Australia. Currently, discussions are ongoing for similar efforts in Central and South America, Canada, India, Japan, the Republic of Korea and Malaysia.

More information at: https://www.alz.org/wwfingers/overview.asp

The program was developed in Finland (coordinated by the Finnish Institute of Health and Welfare, Helsinki), in collaboration with Karolinska Institute (Sweden), testing the effect of a multidomain intervention in delaying cognitive impairment and disability in older persons at increased risk of dementia. More information about the program's development is set out below.

Finnish Geriatric Intervention Study to Prevent Cognitive Impairment and Disability				
Program	**Goal**	**Description**	**Requirements**	**Program Website**
Finnish Geriatric Intervention Study to Prevent Cognitive Impairment and Disability (FINGER)	Prevent cognitive decline in at-risk older population from the general population using a multidomain approach.	The Finnish Geriatric Intervention Study to Prevent Cognitive Impairment and Disability (FINGER) trial was developed by Professor Miia Kivipelto. It is a "proof-of-concept" double blind, randomized controlled trial, which successfully demonstrated that a 2-year multidomain lifestyle intervention (exercise, dietary counselling, cognitive training, and cardiovascular risk factor control) can improve or maintain cognitive functioning in older persons at risk of cognitive decline. **Target:** Adults aged 60-77. **Key activities from the Research protocol:** • Intervention group comprised of 3 individual sessions and 7-9 group sessions. • Nutrition, physical exercise training, strength training and cognitive training were given to the intervention group. • Physical training was guided by physiotherapists and consisted of programs for progressive muscle strength training and aerobic exercise. • Cognitive training included 10 group sessions led by a psychologist and individual sessions consisted of independent computer-based training. Two 6-month periods included 72 training sessions each (3 times per week). • Social activities were stimulated through the numerous group meetings. • Management of metabolic and vascular risk factors was based on national evidence-based guidelines. • The nutrition component was based on Finnish Nutrition Recommendations and was conducted by study nutritionists (3 individual sessions and 7-9 group sessions). Participants were advised to consume a diet that consisted of 10%-20% daily energy from proteins, 25%-35% energy from fat, 45%-55% of energy from carbohydrates, 25-35g/day of dietary fiber, less than 5g/day of salt, and less than 5% of daily energy from alcohol. Participants were encouraged to eat fruits and vegetables, wholegrain cereal products and low-Fat milk and meat products, limit sucrose intake and eat at least 2 portions of fish per week.	**Participant requirements for the study:** • Age 60-77 years old CAIDE (cardiovascular risk factors, aging and dementia) risk score of 6 or above out of 15 points. Score, based on age, sex, education, blood pressure, BMI, total cholesterol and physical activity • Cognitive screening test conducted by the Consortium to Establish a Registry for Alzheimer's Disease. Criteria selected individuals with cognitive function slightly lower than the Finnish population norms.	https://thl.fi/en/web/thlfi-en/research-and-development/research-and-projects/finger-research-project https://www.alz.org/wwfingers/overview.asp The FINGER model includes identification of those at risk as well as support for healthy lifestyles supporting healthy aging. It is currently available in Finnish and Swedish. The FINGER study is being recreated throughout the United States (U.S. POINTER, in association with the Alzheimer's Association) and Latin America (LatAm FINGER). LatAm FINGER will enroll 1,400 participants from 14 different countries aged 60-77 years who are at high risk of cognitive deterioration. They will evaluate the feasibility of the FINGER program in the Latin American context and evaluate the efficacy of the interventions on episodic memory, executive function and processing speed. The WW-FINGER Network comprises studies at different stages of implementation and with varying graduations of the FINGER trial.

This table describes the FINGER study protocol and methods. Further information is needed regarding the applicability of FINGER as an intervention to be scaled up at community settings. The study has been included in this publication due to its relevance for public health and current context of adaptations being conducted in Latin America. Additionally, due to the lack of available tested evidence-based programs concerning the cognitive domain of the intrinsic capacity, presenting FINGER since now may increase interest and opportunities for its dissemination beyond research.

8. FAMILY CAREGIVERS EDUCATION AND SELF-MANAGEMENT SUPPORT

Caregivers of people with loss of capacity are often isolated and at high risk for psychological distress and depression. A care plan for these people should include caregiver education and self-management support.

Supporting the physical and mental well-being of caregivers and supporting their skills-based care competencies is essential to supporting the care of older people. Caregivers often form a critical component of the unpaid workforce. The mode of training and support for caregivers will differ by setting and should be flexible to suit local needs, capacity and available resources.[12]

CAREGIVERS NEED

Self-Care Behaviors to maintain physical and emotional health	How to skills to increase confidence with caregiving demands	Community Resources to increase use of local services available

12 Integrated care for older people (ICOPE): Guidance for person-centred assessment and pathways in primary care. https://www.who.int/publications/i/item/WHO-FWC-ALC-19.1

POWERFUL TOOLS FOR CAREGIVERS				
Program	**Goal**	**Description**	**Requirements**	**Program Website**
Powerful Tools for Caregivers (PTC)	To reduce depression in caregivers by using several treatment methods and improve quality of life.	Powerful Tools for Caregivers is an evidence-based education program that was developed over three years of pilot testing in Portland, Oregon and has been offered since 1998. **Target:** Caregivers of persons with dependence of care **Key activities:** Six class sessions held once a week are led by trained leaders. The classes gives tools to help: • Reduce Stress • Improve self-confidence • Manage time, set goals, and solve problems • Better communicate their feelings • Locate helpful resources • Make thorough decisions	**Training requirements:** • Training can be done either in 2-full days in person or in an online class leader training. **The training program includes:** • Scripted curriculum • Video and audio resources • The Caregiver Helpbook, companion book to the class. Leader certification fee is included with cost of training. The program is available in English, French, Korean, and Spanish. The program has a modality for contacting caregivers in a virtual setting.	https://www.powerfultoolsforcaregivers.org/ what-we-do/ Outcomes and evidence supporting outcomes have been published in various peer-reviewed journals. For full bibliography, visit the program website.

THE STRESS BUSTING PROGRAM				
Program	**Goal**	**Description**	**Requirements**	**Program Website**
The Stress Busting Program (SBP)	To help family caregivers to manage their stress and cope better with their lives	The Stress-Busting program was developed by Dr. Sharon Lewis and the University of Texas Health branch in San Antonio and has a proven track record of success in helping family caregivers. The program was developed through funding of the National Institutes of Health. **Target:** The program is individualized to meet the need of two specific types of family caregivers: • Caregivers of persons with Alzheimer's Disease; • Caregivers of persons with chronic illness. The programs are available in English and Spanish. **Key activities:** Nine class sessions, in a small group setting, meeting once a week for 90 minutes. Topics include self-management tools to deal with stress, difficult emotions, grief, self-care habits such as nutrition, sleep habits, exercise.	**Training requirements:** The training uses a Master Trainer/ group facilitator model. A license to offer the program is required. Two group facilitators are required to lead a small group class. **Materials needed:** • Facilitators manual • Caregiver handbook • Meditation CD • Relaxation Strategies DVD	Stress-Busting Programs (wellmedcharitablefoundation.org) https://www.wellmedcharitable-foundation.org/caregiver-support/caregiver-stress-busters/ Evidence-Based Program: Stress-Busting Program for Family Caregivers (ncoa.org) https://www.ncoa.org/article/evidence-based-program-stress-busting-program-for-family-caregivers As outcomes, research has shown caregivers had significant decreases in perceived stress, depression, subjective caregiver burden, anxiety, and anger/hostility. Caregivers also had improvements in general health, vitality, social function, and mental health scores. Based on quality of life measures from the beginning to the end of the intervention, improvement was shown by 97.4% of caregivers who participated in the study, with 61% showing improvement on all measures tested.

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APPENDIX
TOOLKIT FOR ORGANIZATION PLANNING TO ADOPT AN EVIDENCE-BASED PROGRAM

Offering evidence-based programs requires a thoughtful, step-by-step approach to assure your success. This toolkit offers information and resources to help with each step of the process, from planning, to evaluation and sustainability.

ToolKit Introduction

Evidence-based healthy aging programs are cost-effective and efficient. However, there is always a cost associated with training human resources, adopting new instructional materials, and reaching out to clients. This initial investment only makes sense if you are also able to plan for a process of implementation that ensures the program is embedded in policies, programs and plans for healthy aging.

Overview of the tools in each of the sections of the Toolkit:

1. **Getting started:** This section provides an overview of the REAIM framework (1.1) to assist you in thinking back, e.g. plan with evaluation in mind. Before getting started review the organization readiness to adopt the evidence based-program of choice: Two tools are provided to assist with readiness assessment: (1.2) a one-page organization screening for readiness; and (1.3) checklist to ensure that you have a realistic view of the cost of start-up and maintenance of the program and that funding is available in your budget, or that you identify a funding source for this purpose.
2. **Building broad based community leadership:** It is well established that programs with broad-based community support are more likely to survive institutional changes and political cycles. If the community has adopted an age-friendly framework, it is important to associate the program with activities supported by the Age-friendly Committee and perhaps develop a taskforce to support healthy aging within the initiative. The first tool in this section (2.1) will help program managers prepare the rationale for the Healthy Aging Task Force or Leadership Council (name to be selected locally) and tips for convening and managing this group. An initial survey (2.2) of

invited members will enable the program manager to have a baseline of the members and ensure that with time the Council (task force) reaches its desired representation and balance.

3. **Strengthen community collaboration for healthy aging:** A logic model is not only a useful tool for evaluation, but also a valuable planning tool that guides actions and partnerships during planning and implementation. The logic model provides a graphic way of showing not only what outcomes are expected with the evidence-based program but also what activities will be needed to achieve these goals and what partnerships will be essential to deliver these activities. (3.1) provides a simple matrix to monitor identified indicators/ measures in the logic model (3.2); and (3.3) is another matrix for developing actions steps needed for each of the goals and strategies identified in the logic model. The matrices provided are only examples. These matrices should be modified or created to meet the specific goals selected in your logic model.

4. **Quality Improvement and Evaluation:** Evidence-based programs have been tested in the community and when followed as prescribed, they guarantee results. Therefore, if the organization is to develop a 'return on investment' or 'cost-effectiveness' argument in support of the selected program. It is of the utmost importance for the program Coordinator to have a quality improvement and evaluation scheme. In (4.1), there is a list of areas that can generate indicators for developing a continuing quality improvement plan is provided.

1.1 RE-AIM for Program Planning and Evaluation:

The overall goal of the RE-AIM framework is to pay more attention to essential program elements that can improve the sustainable adoption and implementation of effective, evidence-based health promotion programs: https://www.re-aim.org/about/what-is-reaim/reach/improving-reach/

The five components of the RE-AIM framework are: Reach, Effectiveness, Adoption, Implementation and Maintenance.

Definitions:

Reach: This is the absolute number, proportion, and representativeness of individuals who are willing to participate in a given evidence-based program, and reasons why or why not. Paying attention to the reach of the program is an important component of quality improvement. Is the program attracting the target population? If not, what can be done to improve the reach of the program?

Effectiveness: This refers to program outcomes. Evidence-based programs have been proven to deliver outcomes. However, local support of the program can be enhanced by showing that the population locally served is reporting program outcomes similar to those reported in research publications.

Adoption: This indicator is similar to Reach but is assessed at the level of the settings (such as community-based organizations, clinics, or worksites) involved in a program. It consists of the participation rate among potential settings and the representativeness of these settings. A key concern is whether a program can be adopted by most settings, especially those having few resources, rather than by only those funded by studies or academic institutions. The key to both Reach and Adoption is to identify a "denominator" of eligible persons or settings for use in calculating participation rate. This can be challenging, but there are multiple approaches and tools available to help decision-makers estimate such denominators.

Implementation: This indicator is sometimes referred to as intervention fidelity. It includes the extent to which different components of an intervention are delivered as intended by the program developers. Local modifications that significantly alter essential components of the program can adversely affect outcomes. Implementation is also concerned with the consistency of intervention delivery across different staff, and with the extent to which programs are adapted or modified over time. It is important to use whenever possible, both qualitative and quantitative approaches to monitoring implementation.

Maintenance: Just as with Reach and Adoption, this indicator applies to both the individual participant and the setting or organization levels. At the individual level, maintenance addresses the long-term effects of the intervention on both targeted outcomes and quality of life indicators. Some of the evidence-based

programs have published research showing how long the effect of the intervention was found to last. This is an important mea-sure because it helps demonstrate the 'cost-effectiveness of the intervention'. At the setting level, maintenance refers to the pro-gram's institutionalization, or the extent to which a program is sustained (or modified or discontinued) over time. Are those who adopt the program able to maintain it for the long run? When maintenance is found to be lacking, a quality improvement task can find out what factors are causing this to happen.

Why Use RE-AIM for Planning and Evaluation?

All evidence-based programs have a cost. Therefore, in an environment of limited resources dedicated to health promotion and prevention in the community it is essential to plan a cost-effective implementation and have a system of continuous quality improvement to ensure that the program is reaching the right target population with fidelity and that it has partners in the community committed to adopt and maintain the program.

How do we use RE-AIM for Planning?

If the program is going to be implemented in a geographical area with a network of collaborating partners, then the first step is to carefully select the partners. These are useful questions in building a network of collaborators:

- Who is most likely to adopt this program? Senior centers, clinics, retiree clubs, hospitals, etc.
- Do they have the required space and personnel to do the program?
- How formal is the network of collaborators? Are we entering into a collaborative agreement, with specific roles assigned to all members of the collaborative? Do members of the collaborative expect to be reimbursed for the work they do? Or, Are they embedding the program intervention in the organization's portfolio of programs?
- How many partners do we need in order to reach the desired number of persons?

Example: Paradise Town has a total of 1100 older persons with multiple chronic conditions and poor health out-comes. In order to reach this population, the Chief Medical Of-

ficer decides to form a "Healthy Aging Collaborative" for Paradise Town. A pre-requisite for any community partner to become part of the Collaborative is to commit to offering three to four self-management workshops a year for the target population.

Goal of the Collaborative: Every year, 270 older persons in Paradise Town will participate in a self-management workshop. In four years, Paradise Town Healthy Aging Collaborative will have reached a total of 1,100 older persons with an evidence-based program. To meet this goal, the Healthy Aging Collaborative will have to enroll a minimum of six members, each committed to deliver three workshops a year and reach 45 older persons with chronic conditions. [45 x 6 = 270].

In order to provide the complete program to the target population, how will the implementation be structured? What kind of centralized support will the collaborative need?

Ultimately, the goal of a successful program is to demonstrate that it can be maintained over time. Planning for maintenance is an essential part of the RE-AIM framework.

Building the right infrastructure to deliver a program in a geographical area is key to maintenance. This includes among other things making it easy to train instructors, organize bulk buying of materials for the program, developing avenues and products for marketing the work of the Healthy Aging Collaborative. The cost of a successful program will be minimized to a large extent when the program becomes embedded and therefore maintained in a community.

How do we use RE-AIM for Evaluation?

Evidence-based programs have proven outcomes and each of the programs listed in the portfolio has extensive publications with detailed research outcomes resulting from community-based implementation. However, it is important to understand how well the program is being implemented locally and how effective the program is for the target population.

Resources for evaluation are often very limited and in direct competition with resources needed for implementation. Therefore, it is advisable to have a university public health program as a partner, or if not possible, to build a simple process of collecting strategic data to be used for quality improvement and data to

be able to provide a return-on-investment case for the program. Advocates for any evidence-based program need to be able to illustrate the cost-effectiveness of the program.

Lists questions to ask about RE-AIM dimensions when evaluating health promotion/prevention programs

Reach: What percent of potentially eligible participants a) were excluded, b) took part and c) how representative were they? How many of those who started the program completed it? What was the attrition rate?

Effectiveness: What impact did the intervention have on all those who completed the program? What pre/post self-reported or objective data were collected? Were questions consistent with research questions used to prove program outcomes? Did attrition impact conclusions about effectiveness?

Adoption: What percent of settings and instructors participated? How representative were they of the target?

Implementation: To what extent was the intervention delivered as intended (in the manual/protocol)?

Maintenance: What were the long-term effects (minimum of 6-12 months following intervention)? To what extent was the program continued or institutionalized after a year, after two years, etc.? Was the original program modified in any way?

For more information visit RE-AIM: http://www.re-aim.org

1.2 IS THE ORGANIZATION READY TO ADOPT AN EVIDENCE-BASED PROGRAM?

☐ **1. Is the organization willing to:**

- Work closely with a regional coordinator for training and technical support?
- Support the adoption of a structured program with fidelity (i.e. without changing the program content or structure unless authorized)?
- Invest institutional resources in the training and on-going staffing of the program?
- Designate a local coordinator for managing the program, for collecting data on program reach and monitor fidelity of implementation?
- Develop and implement a plan for embedding the program into the organization's offerings to the community?

☐ **2. Do you know why you are adopting this program?**

- Do you know whether this program addresses an important issue in your community?
- Is there anything being done in your community to address this issue?

☐ **3. Do you know who your target audience will be and how to reach them?**

- Do you know what percentage of your target population will participate in the program in the first year?
- Do you know how will you reach the target audience?
- Do you have a marketing plan for the program?
- Do you have accessible locations to offer the program?

☐ **4. How would you know if your program is effective?**

- Do you plan to collaborate with a university or local researchers to help you evaluate the effectiveness of the program in your community?
- Will you be able to participate in the Regional database to collect simple pre/post data to measure reach and effectiveness?

1.3 KEY QUESTIONS RELATED TO PROGRAM COST

1. Staffing

- How many staff hours are required to implement and maintain this program (e.g. length and frequency of classes, or number of one-on-one contact hours)? Do the staff that deliver this program need to have any special certifications, medical training, etc.?

2. Training

- What are the training requirements for this program? How far will our staff need to travel to receive training? What is the training cost per attendee?

3. Space and Materials

- What type of space is required to run this program (e.g. size)?
- Will we need to buy any equipment for our program space (e.g. exercise equipment)? Will we need to buy any educational materials (e.g. books)?
- Are there any other supplies that we will need to provide on an ongoing basis for this program?

4. Monitoring

- Is there an existing database that we can use to submit this information, or will we be responsible for developing our own data tracking and reporting system?
- How often, if at all, are program classes monitored by staff?

5. Fidelity

- Are there any requirements for program fidelity?

2.1 CREATING BROAD-BASED COMMUNITY SUPPORT HEALTHY AGING LEADERSHIP COUNCIL

Multi-sectorial Leadership Council in support of evidence-based programs promoting healthy aging:

Rational:	Purpose for the Council (be specific and clear) Examples:

(Provide a brief epidemiological basis for the program selected and describe the need)
 	
Example: __% of persons with chronic conditions evidence inadequate self-management and/ or adherence to treatment.
 	
In order for the community to improve in this area, community based opportunities for chronic disease self-management education and support are needed.
 	
The great news is that effective programs addressing this has been developed and proven effective and can be implemented.
 	
WHO reports that a healthy lifestyle is more influential than genetic factors in helping older adults maintain intrinsic capacity and therefore as a greater number of people reach old age, reducing loss of intrinsic capacity, not just treatment of disease, must play an important role in improving quality of life and promoting healthy aging.
	• To raise (regional) or (local) awareness of the importance of healthy aging;
	  • To facilitate the creation and sustainability of an infrastructure (among health service providers, older adults, social service providers, faith based organizations, national, regional or local governments) for the adoption and continued implementation of cost-effective, evidence-based programs specifically designed to support and reduce loss of intrinsic capacity.
	  • To provide advice and counsel to program managers in marketing plan.
	
	<u>Establish a clear and actionable scope of work for members of the Council.</u> For example: Assist in a) media and marketing plan; b) advocate for healthy aging among key stakeholders at the country, municipal or system levels; c) open doors of opportunity for expanded reach of evidence-based programs.
	
	<u>Establish reasonable level of involvement</u>. For example: two meetings per year, or four conference calls per year; etc.

Grid for Planning Invitations to Healthy Aging Leadership Council

Name	Professional/ Organizational Affiliation	Potential Contribution	Comments

List of professional/organizational affiliations desired: (this list should be prepared by each program to fit their needs and goals)

1. Hospital affiliation
2. Geriatric academic community - physicians/nurses/social workers
3. Primary care physicians
4. Leaders in local community health centers
5. National Social Security Agency, or any other Health Insurance (if applicable)
6. Home health care providers
7. Faith-based organizations
8. Communications/media/marketing
9. Public health
10. Advocates, disease-specific foundations/patient associations (diabetes/heart/arthritis)
11. Potential funders: charitable foundations, family foundations, etc.
12. Local and municipal leaders

2.2 SURVEY OF INVITED MEMBERS TO ENSURE A REPRESENTATIVE COUNCIL (TASK FORCE)

Name:_____

Name of your Organization:_____

Your Personal Opinion:_____

(Please circle the number that best represents your response.)

Statements	Strongly Agree	Agree	Disagree	Strongly Disagree
a. Healthy aging is an important issue in (name of city/area)	**1**	**2**	**3**	**4**
b. There are adequate services for older adults in _____.	**1**	**2**	**3**	**4**
c. Community agencies are adequately meeting the health needs of older adults.	**1**	**2**	**3**	**4**
d. There are adequate health promotion activities for older adults in _____.	**1**	**2**	**3**	**4**
e. My organization will benefit from being involved in this collaboration.	**1**	**2**	**3**	**4**
f. I believe health programs for older adults are very important.	**1**	**2**	**3**	**4**

GENERAL INFORMATION:

Which of the following sectors best describes the organization you represent?

□ **Public** □ **Private** □ **Not-for-profit** □ **Other:**

Which of the following areas best represents your employment?

□ Communication	□ Economic	□ Health	□ Education
□ Political	□ Religious	□ Social Service	□ Voluntary Groups
□ Technology	□ Patient Network	□ Social Security	□ Other:_____

Which of the following categories represent your age?

□ **Under 40 years old** □ **Under 60 years** □ **Under 70 years**
□ **Over 70 years old**

What is your gender?

□ **Male** □ **Female** □ **Other**

3.1 HEALTHY AGING MEASURES

Strategies Assessment

Strategy	Progress	Target
Community Assessment		
Identify target older persons' needs/geographical areas		
Identify community partners in selected geographical areas		
Identify evidence-based program that best meets target population's needs.		
Capacity Building		
Training of program coordinator(s), community health workers, and healthy aging leaders in selected programs		
System Infrastructure or partnership with university to coordinate and evaluate program		
Referral and Network System		
Promote the adoption of selected program in selected geographical area		
Network of providers is accessible to targeted population		
Advocate for Public Policy/ Systems Change		
Appropriate funding for programs		
Appropriate recognition for the Decade of Healthy Aging		
Recognition of healthy aging targets in primary health care		

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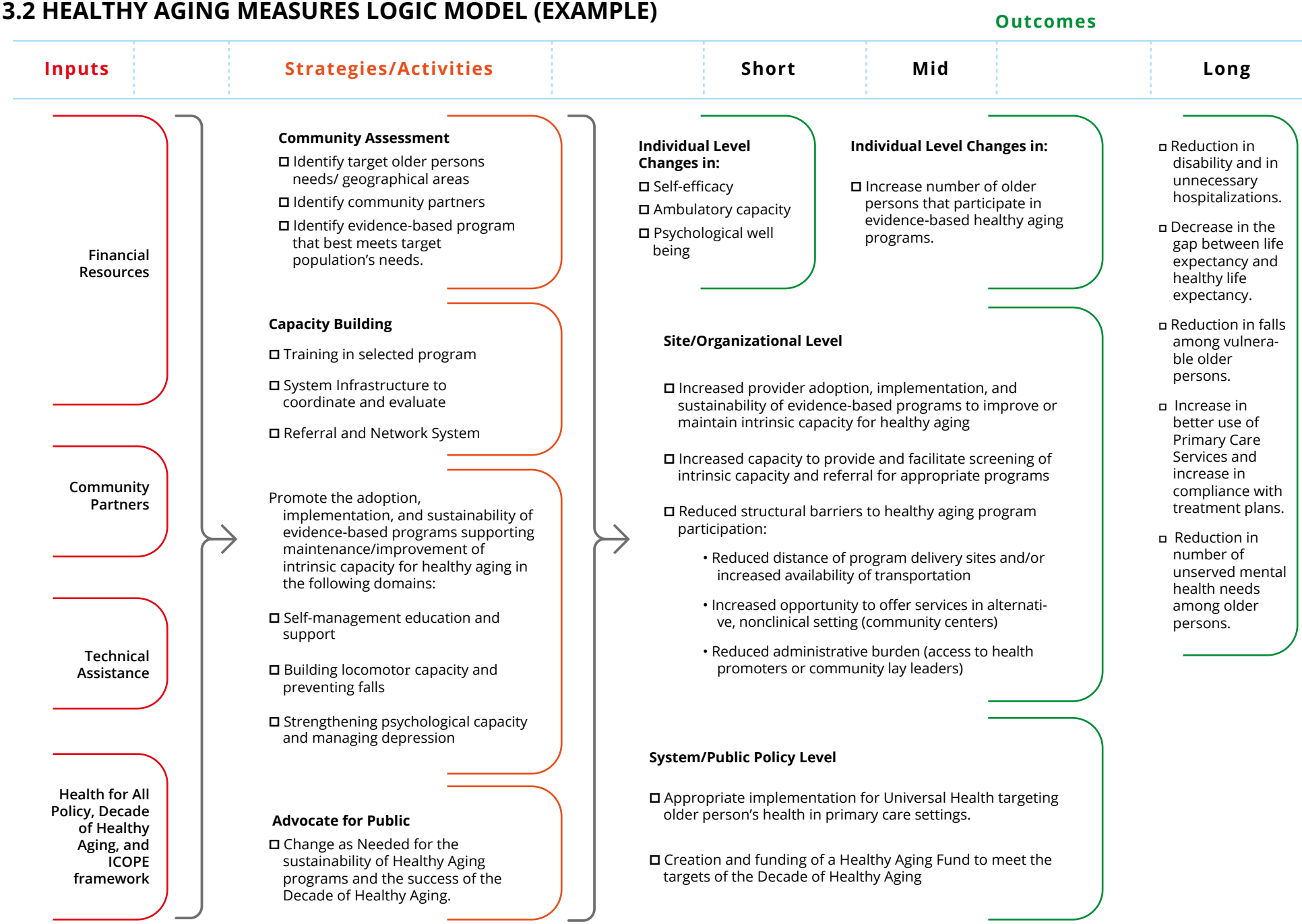
3.2 HEALTHY AGING MEASURES LOGIC MODEL (EXAMPLE)



3.3 PLAN TO STRENGTHEN COMMUNITY COLLABORATION FOR HEALTHY AGING (EXAMPLE)

GOAL 1: Be a catalyst, convener and clearinghouse for evidence-based programs designed to improve or maintain intrinsic capacity for healthy aging and develop collaborative efforts.		
STRATEGY 1: Engage key community partners in the planning, implementation, and evaluation of selected evidence-based program.		
Action Steps	**Timeframe**	**Status**
Action Step 1: Identify providers of aging services in the selected geographical area to establish the "universe" of settings and partners as well as sources of referrals.		
Action Step 2: Conduct a high-level 'healthy aging' planning meeting and invite identified partners. Survey interest in collaboration and develop an initial plan to gather information on resources from each provider: how many staff, volunteers, would be able to contribute to the healthy aging initiative? Is the appropriate space available? How would each contribute?		
Action Step 3: Develop letter of agreement among organizations and create an identity for the group. For example: Neighborhood Hub for Healthy Aging.		
STRATEGY 2: Seek collaborative opportunities across sectors to leverage resources, increase system efficiency, and reduce duplication of services.		
Action Step 1: Form a Healthy Aging Collaborative including Ministry of Health, Social Security, social services, universities, foundations, etc. [This could become the Leadership Council of the initiative].		

Action Step 2: Identify a minimum of x number of partners to work with to accomplish the overall goal of increasing intrinsic capacity for healthy aging among older people in the selected geographical area resulting in enhanced coordination, collaboration and leveraging of resources.		
Action Step 3: Identify at least two funding sources that support would support healthy aging education and intervention programs to leverage financial resources.		
GOAL 2: Increase access and availability of evidence-based programs and number of older persons reached with these programs.		
STRATEGY 1: Assess current state of affairs.		
Action Step 1: Compile baseline data of health and chronic conditions in persons 60 and over in selected geographic area, and other available data for benchmarking.		
Action Step 2: Make baseline data available for community providers to inform program development and targeted outreach.		
STRATEGY 2: Select, promote the adoption, implementation, and sustainability of evidence-based programs needed to meet the goals of improving or maintaining intrinsic capacity for healthy aging.		
Action Step 1: Select an evidence-based program that best meets community needs and appears to be most sustainable with existing resources.		
Action Step 2: Coordinate with PAHO and local authorities for technical assistance and training in selected evidence-based programs.		

Action Step 3: Assess infrastructure for coordination and build a network of referrals.		
STRATEGY 3: Add to the evidence of Healthy Aging as part of the Decade of Healthy Aging		
Action Step 1: Develop an evaluation scheme for the initiative and partner with a local public health program of the local University to assist with database, analyzing and evaluation reports to be shared with others in the country, regionally and even globally.		
Action Step 2: Continue to research the Portfolio for other evidence-based programs in the area of interest.		

GOAL 3: Advocating for public policy and system changes needed for the sustainability of Healthy Aging programs and the success of the Decade of Healthy Aging.		
STRATEGY 1: Identify top public policy priorities at the State and local levels that advance healthy aging (look for policies across sectors).		
Action Step 1: Explore policy priorities among health and social service providers that are supportive of healthy aging.		
Action Step 2: Raise awareness among legislators and other decision-makers of the need to have support for healthy aging issues and strategies on their agenda.		
Action Step 3: Advocate for the inclusion of evidence-based programs supportive of healthy aging in the programming budget of aging service providers.		

4.1 QUALITY IMPROVEMENT FOR EVIDENCE-BASED PROGRAMS

The following is a list of areas that can generate indicators in developing a continuing quality improvement plan.

1. Training:

- Training is based on network needs and program requirements
- Training is conducted with fidelity by certified trainers in the program, utilizing all prescribed materials
- Trained personnel (community health workers, peer leaders, and trainers) are able to maintain 'active' status as defined by the program
- Trained personnel evidence satisfaction with training and with support provided after training
- Program coordinator is trained in the program.

2. Reach:

- Number and demographic profile of older persons reached by the program, and completion rate of these participants, are tracked in a database
- Database is monitored on a quarterly basis
- Reach goals are met
- Participants reached by the program meet the inclusion criteria intended for the program. For example, sedentary older persons, people with chronic conditions, or persons with depression symptoms, etc.

3. Effectiveness:

- Monitoring of program fidelity is done by trained personnel
- Program schedule and structure maintain fidelity to program protocol
- A minimum of 84% of participants complete the minimum set requirements of the program

4. Adoption:

- The program is offered in locations accessible to the target population
- Settings offering evidence-based programs embed the program in its regular offerings
- The program has a broad-based partnership contributing leadership, advocacy, and/or resources to ensure its delivery in multiple settings

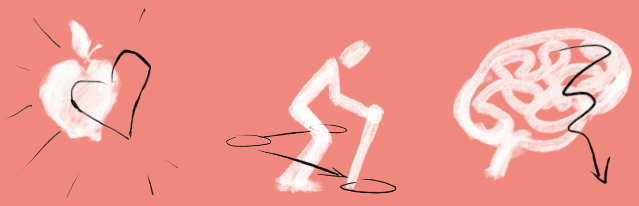
5. Implementation:

- Program meets the number of days and hours required
- Program facilitators (community health workers, peer leaders, and trainers) have the required instructional materials and follow the structured program
- Participants have access to books, pamphlets, handouts, and any other materials required by the program
- Number and profile of participants meet the program criteria

6. Maintenance:

- Evaluation protocol to demonstrate lasting value of program six months and a year after implementation to ensure continued support of the program
- Database to document retention of facilitators who are active in the program
- Program budget and resources are monitored on a regular basis and are used to demonstrate cost-effectiveness of the program (return on investment)
- Plan of action with strategies to ensure sustainability of program is reviewed periodically. Healthy Aging Measures Logic Model (Example)

A great challenge for public policies is to transform the current demographic transition into opportunity. Longer lives call for new paradigms and concepts in the field of healthcare. This publication, ***Portfolio: Evidence-based programs for a person-centered, integrated care for older people at the primary health-care level***, presents several interventions/programs that are evidence-based and enable healthy aging. To improve older person's health is crucial to access older adult's needs as well as provide timely identification and action on losses in their physical and mental capacities, that is the intrinsic capacity. The selected programs presented in this document have the objective to improve or maintain older adults' intrinsic capacity at the community level, focusing on one or more of its main domains. The portfolio focuses mainly on locomotor, psychological and cognitive capacity, as well as self-care and caregiver support. Through the identification of declines in the intrinsic capacity it is possible to create a personal care plan, which will help to prevent or ameliorate declines, support disease management, as well as promote active participation in their own care, as supported by the WHO Integrated Care for Older People (ICOPE). With the ICOPE model, older adults not only have knowledge of what to do to improve their own health, but they also feel empowered to achieve specific goals. The portfolio programs have been proven to deliver positive outcomes in improving older adults' capacities, as well as their adherence to self-care; therefore, it should become part of any primary care toolkit designed to promote and improve healthy aging in the community, accompanying the ICOPE model. Older adults require an integrated approach and a continuum of care with adequate support and transitions from one level to another, depending on their specific needs. Strengthening primary care is one strategy to prepare and align health systems to an aging society.



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https://www.paho.org/en/topics/healthy-aging

Healthy Life Course Unit, Department of Family, Health Promotion and Life Course

Pan American Health Organization

525 23rd Street NW: Washington: District of Columbia: 20037

PAHO Pan American Health Organization World Health Organization Regional Office for the Americas