Age-friendly Primary Health Care Centres Toolkit

World Health Organization

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- International Federation on Ageing (IFA)
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SECTION I

I.1 Background of the Age-friendly PHC Centres Toolkit

The toolkit builds upon the concepts and principles of the WHO's Active Ageing Policy Framework, published in 2002 on the occasion of the Second World Assembly on Ageing in Madrid (1). The Active Ageing Policy Framework calls on policy-makers, governments, and the non-governmental sector to ***optimize opportunities for health, participation and security in order to enhance the quality of life of people as they age***.

The framework recognizes that active and healthy ageing depends on a variety of determinants that surround individuals throughout the life course:

- Cross-cutting determinants: culture and gender
- Determinants related to health and social service systems e.g. health promotion and disease prevention.
- Behavioural determinants e.g. tobacco use and physical activity.
- Determinants related to personal factors e.g. biological and psychological factors.
- Determinants related to the physical environment e.g. safe housing and falls.
- Economic determinants e.g. income and social protection

These determinants and the interplay between them are good predictors of how well individuals age; they cope with illness and disability; or remain active contributors of their community.

The World Health Organization (WHO) has recognized the critical role that primary health centres play in the health of older persons in all countries and the need for these centres to be accessible and adapted to the needs of older populations.

Consequently, all primary health care workers should be well versed in the diagnosis and management of the chronic diseases and the so-called four giants of geriatrics: memory loss, urinary incontinence, depression and falls/immobility that often impact people as they age.

Stages of the toolkit development

The first stage of the project consisted of a background research in primary health care models. Strengths and weaknesses in staff skills and knowledge; organizational structure of primary health care centres; and common practices were underlined.

Focus groups were then conducted in six countries – Australia, Canada, Costa Rica, Jamaica, Malaysia and the Philippines. These focus groups included older people and their health care providers to explore:

- barriers to care;
- current patterns and insights into what older people want from primary health care providers and centres;
- what practitioners think are the issues and problems of primary health care for older people.

The results of the focus groups, backed up by background research and a consensus meeting of experts, led to the development of a set of Age-friendly Principles (2). The principles were designed to guide primary health care centres in modifying their structure to better fit the needs of their older patients. The Age-friendly Principles address three areas:

- **Information, education, communication and training**,
- **Health care management systems**, and
- **The physical environment** of the primary health care centre.

The second and last stage consisted of developing the toolkit through identifying scientifically sound tools that help primary health centres and therefore health workers implement the Age-friendly principles.

Objectives

The toolkit aims at:

- Improving the primary health care response for older persons.
- Sensitizing and educating primary health care workers about the specific needs of their older clients.
- Assisting primary health workers in how to operate the geriatric care instruments/tools contained in the toolkit.
- Raising awareness of the accumulation of disabilities – both minor and major – experienced by older people to primary health workers.
- Providing guidance on how to make primary health care management procedures more responsive to the needs of older people.
- Providing guidance on how to do environmental audits to test primary health care centres for their age-friendliness.

Methods

The toolkit comprises a number of tools (evaluation forms, slides, figures, graphs, diagrams, scale tables, country guidelines, exam sheets, screening tools, cards, checklists, etc) that can be used by primary health care workers to assess older persons' health. The four geriatric giants were the focus of the toolkit development. A literature research for instruments on these four subjects was done and studies on reliability and validity of questions common to all instruments were consulted.

The tools were then tested by the five countries that participated in the project: Brazil, Costa Rica, Jamaica, Singapore and Turkey. Their recommendations were used to modify the tools. Several rounds of testing and modifications were implemented.

The toolkit includes flowcharts describing steps to follow for each tool; they will allow countries to include specific actions particular to their situation.

Throughout the toolkit, countries are encouraged to use the guidelines of their own national protocols. As an example, two Jamaican guidelines are included:

1. the management guidelines of hypertension, and
2. the management guidelines of diabetes

The first of these guidelines was adapted from the WHO/ISH Hypertension guidelines (WHO 1999, 2003).
http://www.who.int/cardiovascular_diseases/guidelines/hypertension/en/

The guidelines for diabetes were written by the Caribbean Health Research Council (CHRC) with the Pan American Health Organization (PAHO) collaboration. They are aimed at producing an unified, evidence-based approach to the management of diabetes in the Caribbean. Both are included as examples of adopting WHO guidelines.

The draft tools were circulated among participants of the project in 2005 and discussed at two meetings. Further recommendations from these meetings lead to revisions. The tools were then pre-tested in primary health care centres in the five participating countries. The findings were discussed at a third meeting and again tested in the clinics and further amended. During the testing period, Brazil and Costa Rica translated the tools of the toolkit into Portuguese and Spanish respectively and adapted the material according to their country specific situation.

The toolkit is the result of five years of collaborative work (meetings, discussions and fieldwork) between ALC, primary health care technical experts, and countries.

Review-by date

It is anticipated that the recommendations in this toolkit will remain valid until June 2011. The Ageing and Life Course Programme at WHO headquarters in Geneva will be responsible for initiating a review of this guideline at that time.

Enjoy – together we can work towards the Age-friendly PHC centre that older people need and deserve!

SECTION II

General Objectives

This section includes information, training modules and necessary tools to orient the PHC team to manage older persons' health problems in order to shift their focus from a disease-oriented approach to a preventive one.

Contents:

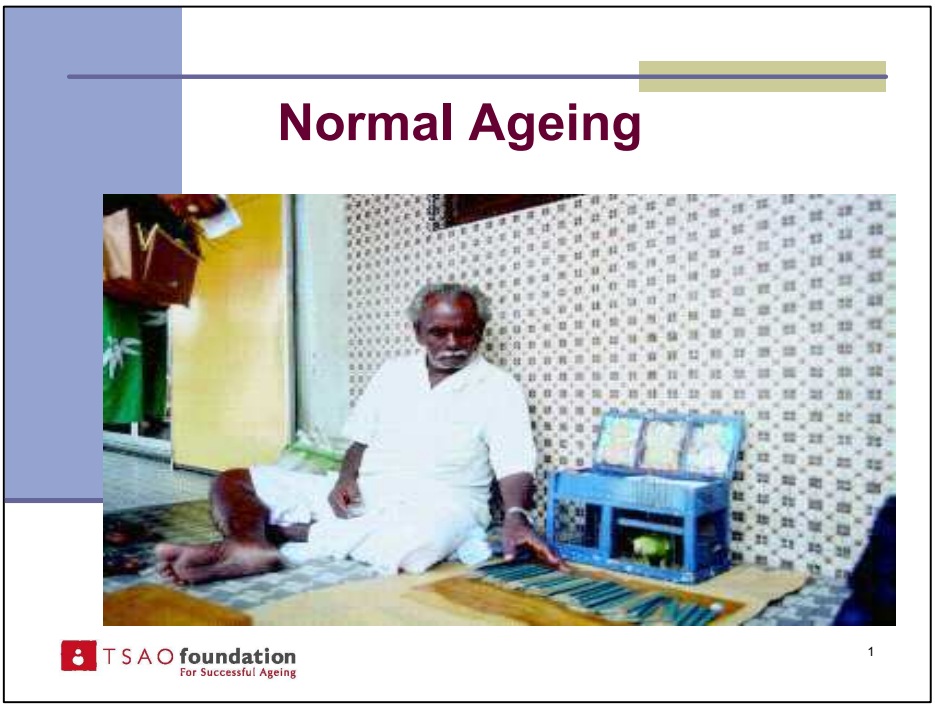
Note: See Annex 1 at the end: Trainer guide for normal ageing and communication

II.1 Normal ageing

What for?	To sensitize all PHC staff to older persons and introduce normal ageing
By whom?	Trainer (can be a nurse or a trained health care centre worker)
How long?	1- 1.5 hours

Note: See **Trainer Guide in annex 1**

Example of a *normal ageing* slide with trainer notes:



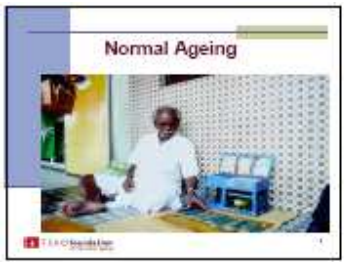
Slide 1

Begin with a joke / ice breaker:

- People across all ages have certain beliefs about ageing. Did you hear the story about the 85 year old woman who went to the doctor because of pain in her right knee? The doctor told her, “What do you expect, you’re 85 years old. Of course it hurts!” The lady looked at him and said, “But doctor, my other knee is 85 years old too but it doesn’t hurt!”

- In the next 1.5 hours, we are going to understand what the normal ageing process is about and how it can affect us.
    - During the course of this session, we will look at the normal changes that occur as we age. We will take a fairly holistic or total approach in understanding this process.
    - In addition, we will also talk about how we can adapt to some of these changes as a person ages.

Overview of slides on *normal ageing* that you can find in annex 1:



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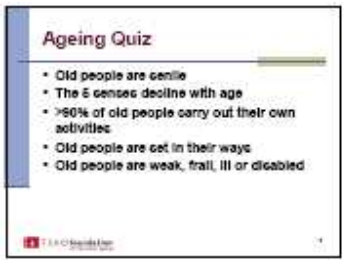

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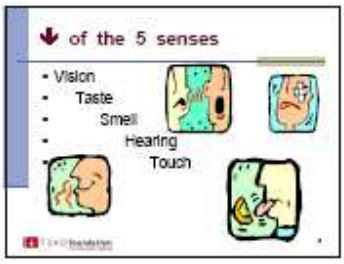

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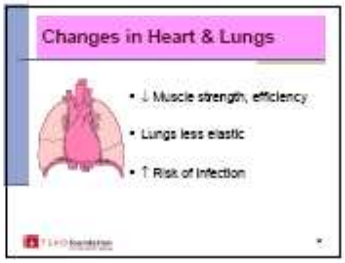

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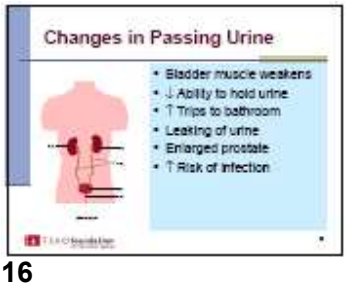

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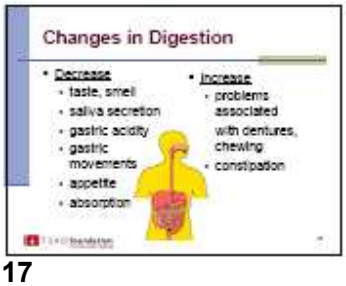

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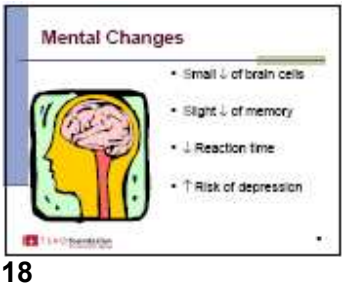

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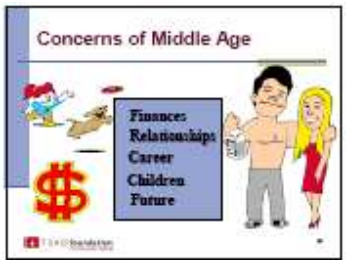

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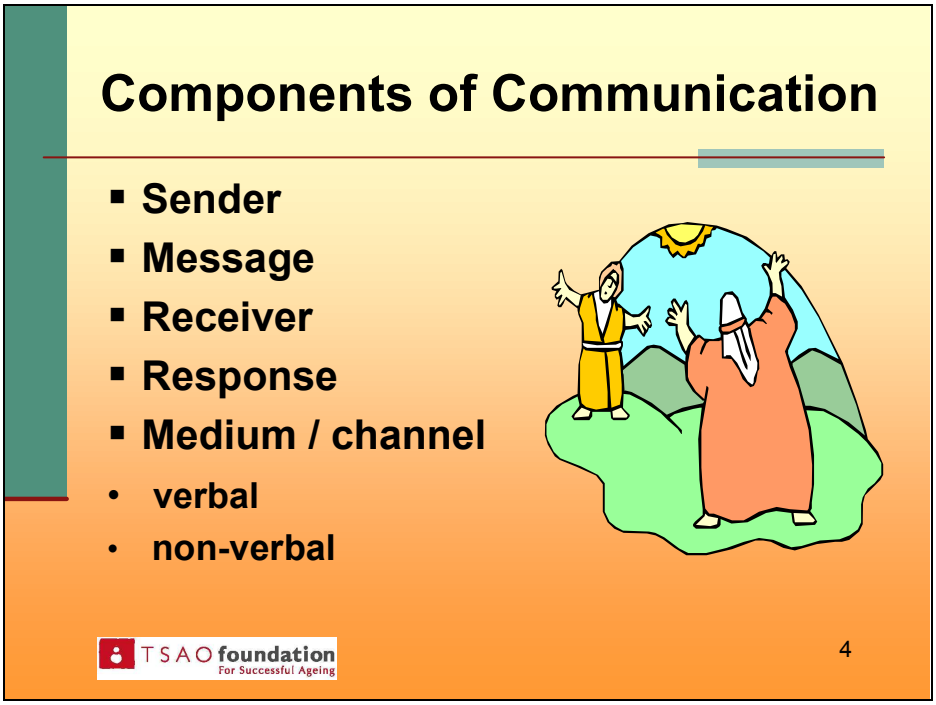
II.2 Communication with older persons

What for?	To improve all staff's awareness, knowledge and skills concerning communication with an older person
By whom?	Trainer (can be a nurse or trained health care centre worker)
How long?	1- 1.5 hours

Note: See **Trainer Guide in annex 1**

Example of a *communication* slide with trainer notes:



Slide 4

- A message is not just information, advice or instructions but also feelings, encouragement, understanding, praise…
- There is a sender, message and receiver – we often forget the RESPONSE.
- There are two major components of communication:
  1. Verbal communication is the actual words that are said or the content (accounts for 7% of communication).

2. Non-verbal communication is basically everything else (accounts for 93%) and includes our tone of voice and facial expression.

- Example: Frown, furrow your eyebrows and speak in a sharp tone of voice as if you were scolding someone. Do it in such a way that participants know how you feel when they look at you. Ask for the participants' responses.
- Hand gestures and posture, for example, if I were standing here slumped over, looking at the floor with a frown (do this posture) it would communicate one message in contrast to if I stand up straight, look you in the eye and smile (do this posture)!
- Non-verbal communication also has to do with the general tone or presence of the person – the feeling you get when you talk to him.

Overview of slides on communication that you can find in annex 1:

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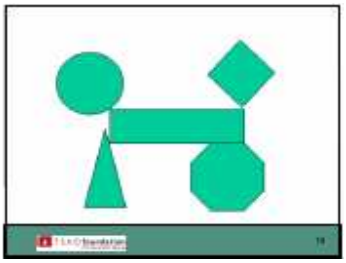

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II.3 Age-friendly health promotion

General Objectives

This section aims to train PHC workers in the approaches and tools necessary to provide preventive services, especially the brief behavioural counselling to target the three common risk factors: smoking, physical inactivity and unhealthy diet.

Contents:

II.3.1 Recommendations on preventive services for older adults

Health promotion interventions in later life require a different focus than those at younger ages, with an emphasis on reducing age-associated morbidity and disability and the effects of cumulative disease co-morbidities as illustrated in **Figure 1 (page 18)**.

PHC practitioners should have the opportunities to alter risky behaviours. Lack of time and skills are key barriers. Since the common risk factors, smoking, physical inactivity and unhealthy diet are risk factors that contribute to most of the health conditions among older adults, modifying these and keeping healthy lifestyles are key components of good health practice in older age. This section focuses on providing guidelines, recommendations and tools of behavioural counselling to target these three common risk factors.

Figure 1

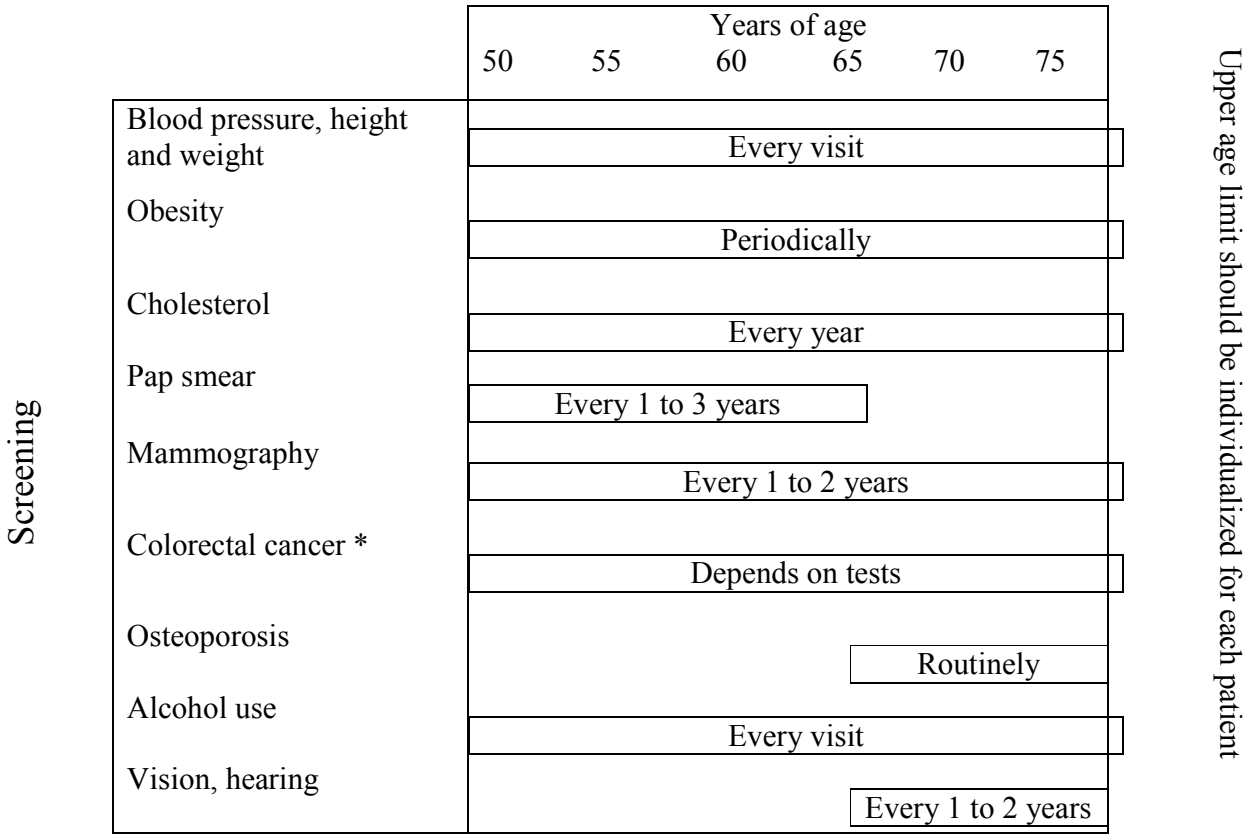
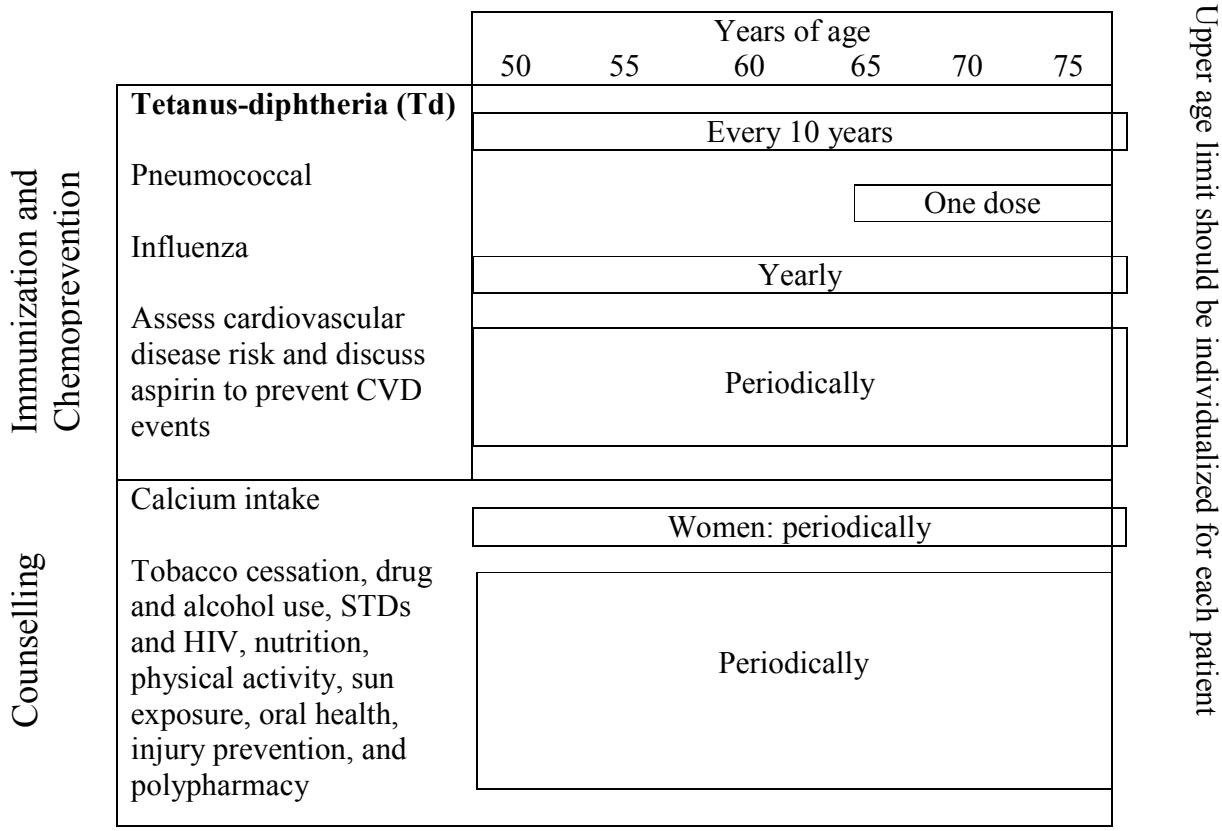

Screening
Years of age
50
55
60
65
70
75
Blood pressure, height and weight
Every visit
Obesity
Periodically
Cholesterol
Every year
Pap smear
Every 1 to 3 years
Mammography
Every 1 to 2 years
Colorectal cancer *
Depends on tests
Osteoporosis
Routinely
Alcohol use
Every visit
Vision, hearing
Every 1 to 2 years
Upper age limit should be individualized for each patient

Figure 1 (continuation)



* See www.preventiveservices.ahrq.gov for U.S. preventive Task Force recommendations on colorectal screening and other clinical preventive services.

Source: *The pocket guide to staying healthy at 50 +*. US Department of Health and Human Services. (http://www.ahrq.gov/ppip/50plus/ accessed on 22 October 2007)

II.3.2 General guidelines to consider when providing clinical counselling

It has been suggested that clinician counselling focused on improved personal health practices may be more valuable to patients than conventional clinical activities such as diagnostic testing (3). The following are general guidelines to consider when providing clinical counselling:

1. Counselling should be culturally appropriate. Present information and services in a style and format that is sensitive to the culture, values, and traditions of the patient.
2. Several measures may be taken to improve delivery of counselling:
    a. Use a variety of resources to reinforce healthy behaviors:
        i. Display pamphlets, posters and other materials in a range of common languages conspicuously so that they are readily available.
    b. Short questionnaires to quickly assess patient's needs for counselling (can be done by non-clinical staff or volunteers).
    c. A team approach to provide counseling is preferable.
    d. Provide repeated messages to patients.
3. Counselling is a goal-oriented process: apply your expertise to benefit each recipient, directing them to use information in a way that serves best in everyday life.
4. Here are 11strategies for patient education and counselling with which PHC providers should be familiar:
    a. Frame the teaching to match the patient's perceptions.
    b. Fully inform patients of the purposes and expected effects of interventions and when to expect these effects.
    c. Suggest small changes rather than large ones.
    d. Be specific.
    e. It is sometimes easier to add new behaviours than to eliminate established behaviours.
    f. Link new behaviours to old behaviours.
    g. Use the authority of the profession in a sensitive way.
    h. Get explicit commitments from the patient.

i. Use a combination of strategies.
j. Involve office staff.
k. Monitor progress through follow-up contact.

II.3.3 5 steps organizational construct for clinical counselling on cessation of tobacco

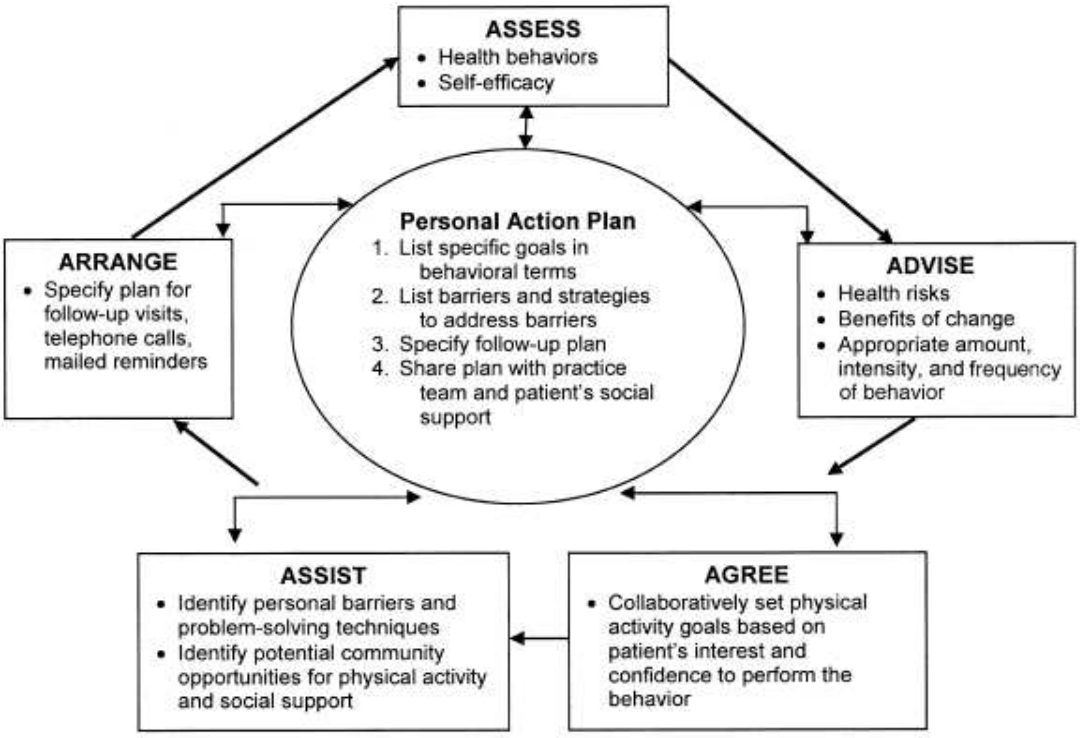
The Canadian Task Force on Preventive Health Care (CTFPHC) proposed that clinicians use the following construct to organize their general approach to assist patients with behavioural counselling issues (4). This construct can be applied to brief PHC interventions for a variety of risk behaviors.

It describes five minimal contact interventions that are provided by a variety of clinical staff in PHC settings: Assess, Advise, Agree, Assist, and Arrange.

Assess:	Ask about/assess behavioural health risk(s) and factors affecting choice of behaviour change goals/methods.
Advise:	Give clear, specific and personalized behaviour change advice, including information about personal health harms/benefits.
Agree:	Collaboratively select appropriate treatment goals and methods based on the patient's interest in and willingness to change the behaviour.
Assist:	Using behaviour change techniques (self help and/or counseling) aid the patient in achieving agreed-upon goals by acquiring the skills, confidence, and social/environmental supports for behaviour change, supplemented with adjunctive medical treatments when appropriate (e.g. pharmacotherapy for tobacco dependence, contraceptive drugs/devices).
Arrange:	Schedule follow-up contacts (in person or by telephone) to provide ongoing assistance/support and to adjust the treatment plan as needed, including referral to more intensive or specialized treatment.

While this is a unifying construct to describe counselling interventions across behaviours, the content of each step necessarily varies from behaviour to behaviour. To implement these points, you can start and stop at any step as indicated in the following diagram. You do not need to start from "Assess" and end with "Arrange" every time with every patient. This is because people's behaviour may stay at a different stage of change. If you are familiar with them, you can start at an appropriate step.

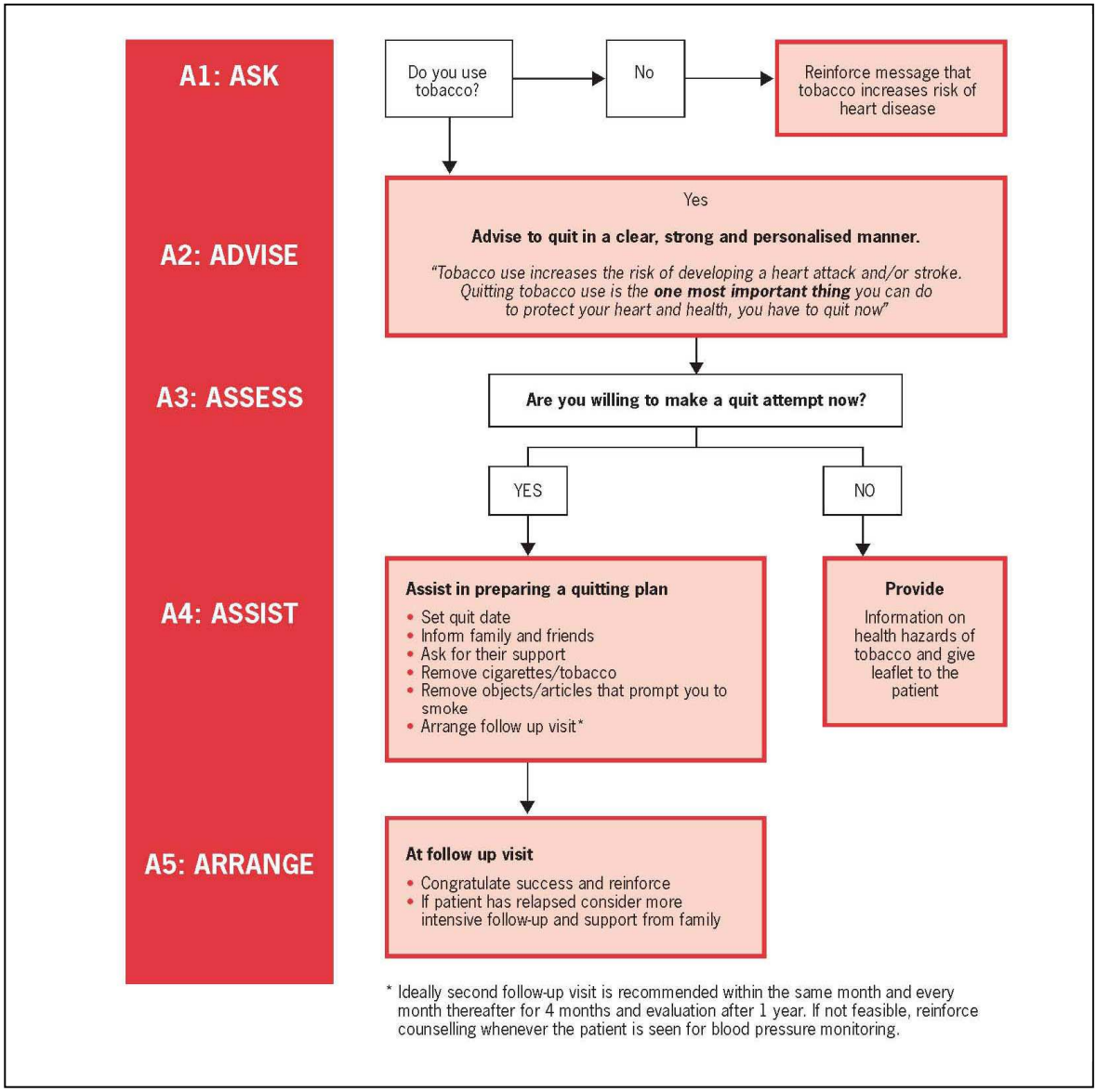
A schematic to direct effective multiple behaviour change counselling in a PHC setting



Source: Russell E. Glasgow. Translating What We Have Learned into Practice Principles and Hypotheses for Interventions Addressing Multiple Behaviors in Primary Care. Am J Prev Med 2004; 27(2S):88–101.

As an example of the adoption of this strategy, see the following diagram that applies to smoking cessation.

The 5 steps organizational construct for clinical counselling on cessation of tobacco



Source: WHO CVD-risk management package for low- and medium-resource settings, World Health Organization, 2002.

At each time of the clinical counselling, PHC providers should aim to help patients set a goal and make a short-term action plan to achieve it.

Example of an action plan form (contract form)

In your action plan, be sure to include:

1. **What?** *(for example, walking or avoiding snacks)*
2. **How much?** *(for example, walking 4 blocks)*
3. **When?** *(for example, after dinner on Monday, Wednesday, Friday)*
4. **How often?** *(for example, 4 times; try to avoid "every day")*

For example: this week, I am planning to walk (what?) 500 meters (How much?) after dinner (When?) 3 times (How often?).

This week I am planning to *walking* （What）
500 meters （How much）
After dinner （When）
3 times (Monday, Wednesday, Friday) （how often）

Confidence: level 7 or more *(0=no confidence to 10=total confidence; that you will complete the ENTIRE action plan)*

When	Check	Comments
Monday		
Tuesday		
Wednesday		
Thursday		
Friday		
Saturday		
Sunday		

Source: Lorig K, Holman H, Sobel D, Laurent D, Gonzalez V, Minor M, et al. Living a healthy life with chronic conditions: self-management of heart disease, arthritis, stroke, diabetes, asthma, bronchitis, emphysema & others. Palo Alto (CA): Bull Publishing Company; 1994.

II.3.4 Basics of smoking cessation counselling

1. Designation of an office smoking cessation coordinator, responsible for the administration of the smoking cessation programme.

2. Systematically **identify smokers**:

- Treat smoking status as a vital sign.
- Place a sticker or other visual cues on the charts of patients who smoke as a reminder of the need to address the issue of smoking at every visit.
- Use a flow chart in patient records to keep track of smoking cessation interventions.
- Use of a brief, self-administered questionnaire, as illustrated in the following, that may facilitate assessment of smoking status.

Smoking assessment form

Name: _____Date: _____
1. Do you now smoke cigarettes? ____Yes
____No
2. Does the person closest to you smoke cigarettes? ____Yes
____No
3. How many cigarettes do you smoke a day? _____Cigarettes
4. How soon after you wake up do you smoke your first cigarette?
____Within 30 minutes____More than 30 minutes
5. How interested are you in stopping smoking?
____Not at all____A little____Some____A lot____Very
6. If you decided to quite smoking completely during the next 2 weeks, how confident are you that you would succeed?
____Not at all____A little____Some____A lot____Very

Source: Glynn TJ, Manley MW. How To Help Your Patients Stop Smoking: A National Cancer Institute Manual for Physicians. Bethesda, Md: National Institutes of Health; 1995. NIH publication NIH 95-3064.

3. **Advise** all smokers to stop smoking:

- **Clearly**: "I think it is important for you to quit smoking now and I will help you. Cutting down when you are ill is not enough."
- **Strongly**: "As your clinician I need you to know that quitting smoking is the most important thing you can do to protect your health."
- **In a personalized way**: Tie smoking to current health or illness; the social and economic costs of tobacco use; motivation level/readiness to quit; and/or the impact of smoking on children and others in the household.

4. Ask every smoker "**Are you ready to make a quit attempt?**
5. Assist patients who are ready to quit:

- Set a quit date: ideally, within two weeks
- Counsel patients who are preparing to quit to:
    - Inform their families, friends, and co-workers of their intention to quit smoking and request their understanding and support.
    - Remove cigarettes from their environment. Should consider avoiding smoking in places where they spend a lot of time e.g. home.
    - Review previous quit attempts. What helped? What led to relapse?
    - Anticipate challenges to the planned quit attempt, particularly during the critical first few weeks. These challenges include nicotine withdrawal symptoms.
- Encourage Nicotine Replacement Therapy (NRT) if available.
- Provide key advice on successful quitting:
    - **Abstinence**: Total abstinence is essential. "Not even a single puff after the quit date."

- **Alcohol:** Drinking alcohol is highly associated with relapse. Persons who stop smoking should review their alcohol use and consider limiting/abstaining from alcohol during the quit process.

- **Other smokers in the household**: Patients should consider quitting with others and/or staying abstinent in a household where others still smoke.
  - Referral: Consider referring patients to a group clinic or intensive smoking cessation programme.
  - Provide self-help materials.

6. **Schedule follow-up** contact:

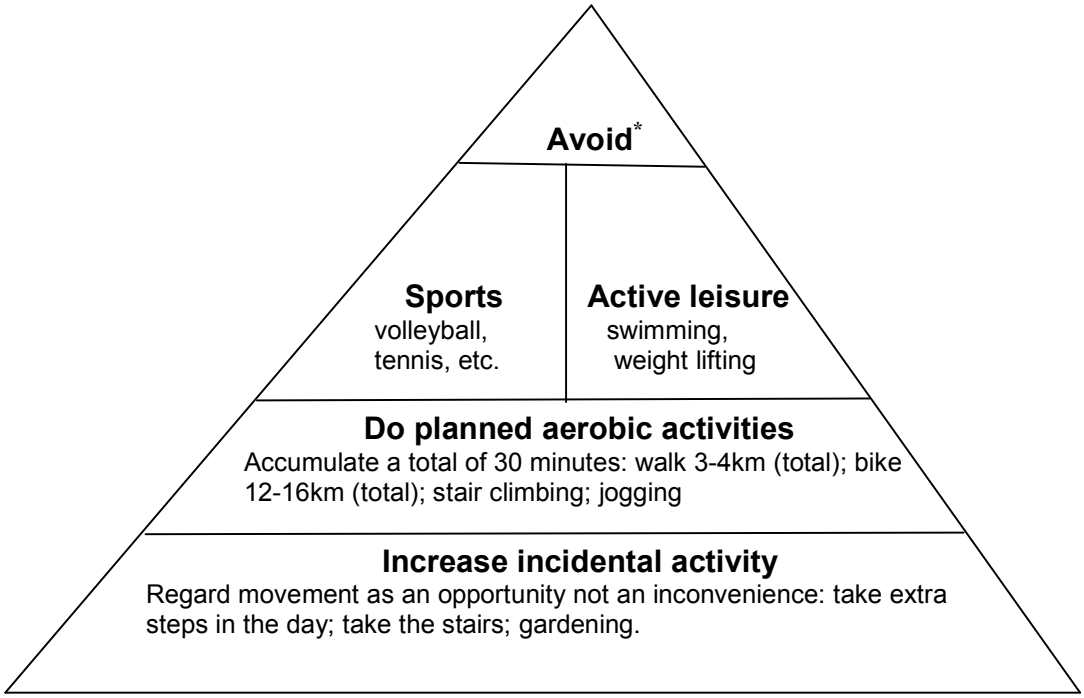
- Call or write patients within seven days after the quit date. A second follow-up contact is recommended within the first month. Schedule further follow-up contacts as indicated.
- Actions during follow-up:
  - Congratulate success
  - If smoking occurred, review circumstances and elicit recommitment of total abstinence. Remind patient that a lapse can be a learning experience.
  - Identify problem areas already encountered and anticipate challenges in the immediate future.

II.3.5 Basics of physical activity counselling

1. Evaluation of patients' usual physical activity
    - Ask all patients about their physical activity habits. Include organized activities, general activities and occupational activities.
    - Determine if the patient's level of activity is sufficient using the following physical activity pyramid. Experts agree that **physical activity that is at least of moderate intensity, for 30 minutes or longer, and performed on most days of the week** is sufficient to confer health benefits.

Tell patients, as doing the moderate-intensity physical activity, they will feel faster heart rate, faster breathing and slightly warmer.

Physical activity pyramid



* Avoid sedentary lifestyle such as watching TV or sitting in front of a computer for many hours a day.

Source: Rauramaa, R. & Leon, A.S. Physical Activity and risk of cardiovascular disease in middle aged individuals. *Sports Medicine*. 1996, 22(2):65-69.

2. Assist patients who lack sufficient physical activity for health benefits and/or wish to improve physical activity habits in planning a programme that should be:

- **Medically Safe***:* Existing heart disease presents the biggest risk.
    - Medical Evaluation: recommended prior to embarking on a vigorous exercise programme for the following individuals:
        - persons with cardiovascular disease (CVD);
        - men over 40 years and women over 50 years of age with multiple CVD risk factors – hypertension, diabetes, elevated cholesterol, current smoker, or obesity.
    - Additional advice to promote medically safe physical activity includes:
        - increase the level of exercise gradually rather than abruptly,
        - decrease the risk of musculoskeletal injuries by performing alternate-day exercises and using stretching exercises in the warm-up and cool-down phases of exercise sessions. This is particularly important for older adults and those who have not been physically active recently.
- **Enjoyable**: Patients will not continue activities that they do not enjoy.
    - They should:
        - choose activities they find inherently pleasurable,
        - vary activities,
        - share activities with friends or family.
    - Encourage patients to identify barriers to enjoyment and to find ways to overcome these barriers. Examples of methods for overcoming barriers are listed in the next table:

Overcoming barriers to exercise

Barrier	Suggested Response
Exercise is hard work.	Start with ordinary walking, or an exercise that is not work for most people. See where it might lead.
I do not have the time.	That may be true, but you will never know for sure unless you try to make it.
I am usually too tired for exercise.	Tell yourself, "This activity will give me more energy." See if it doesn't happen.
I hate to fail, so I will not start.	Physical activity is not a test. You will not fail if you choose an activity you like and start off slowly. Setting reasonable, realistic goals reduces the chances for failure.
I do not have anyone to work out with.	Maybe you have not asked. A neighbor or a coworker may be a willing partner. Or you can choose an activity that you enjoy doing by yourself.
There is not a convenient place.	Pick an activity you can do at a convenient place. Walk around your neighborhood or a nearby mall, or do exercises with a TV show or a videotape at home.
I am afraid of being injured.	Walking is very safe and is excellent exercise. Choose a safe, well-lighted area.
The weather is too bad.	There are many activities that you can do in your own home or at a shopping mall in any weather.
Exercise is boring.	Some ways to make exercise more fun are: listening to music, exercising with a companion, varying the exercise with the season, setting a non-exercise related goal such as getting an errand or two done in the course of it, or giving yourself a reward periodically.
I am too overweight.	You can benefit regardless of your weight. Pick an activity that you are comfortable with, like walking.
I am too old.	It is never too late to start. People of any age, including older people, can benefit from physical exercise.

Source: Jonas S. The Exercise Recommendations in Clinical Practice. Presented at the 16th Annual Medical Seminar, ISC Division of Wellness Role of Exercise and Nutrition in Preventive Medicine, 1997. Originally adapted from: Project PACE. Physician-based Assessment and Counselling for Exercise. San Diego, Calif: San Diego State University, 1991.

- **Convenient**: Encourage participation in activities that can be enjoyed with a minimum of special preparation, ideally those that fit into daily activities.

- **Realistic**: A too difficult programme in terms of goals and integration with other daily activities will lead to disappointment. Gradual change leads to permanent change; therefore, stress the importance of gradually increasing the intensity, frequency and duration of exercise.
- **Structured**: Having defined activities, goals for performance and a set schedule and location may help improve some patients' compliance. Signing a physical activity "contract"/"action plan" may be helpful.

3. Encourage **patients who are unwilling or unable to participate in a regular exercise** programme to increase the amount of physical activity in their daily lives:
    - taking the stairs rather than the elevator when possible,
    - leaving the subway or bus one or two stops early and walking the rest of the way,
    - doing household chores and yard work on a regular basis.
4. **Involve nursing and office staff** in monitoring patient progress and providing information and support to patients. Some form of routine follow-up with patients about their progress is very helpful.
5. Convey **positive messages about exercise and physical activity** using posters, displays, videotapes, and other resources in offices or clinics.
6. Providers should try to engage in adequate physical activity themselves. Studies show that providers who exercise regularly are significantly better at providing exercise counselling to their patients than those who do not.

II.3.6 Basics of nutrition counselling

1. Regularly **weight and measure** every patient. Advise them on their healthy weight range based on age, gender and distribution of body fat.

2. Talk with all patients about their **dietary habits**, including use of dietary supplements. Use a brief nutritional screening questionnaire accepted in your country if available to identify nutritional vulnerability, or consider an evidence-based tool. **(Green, S.M. and**

Watson, R. (2006) Nutritional screening and assessment tools for older adults: Literature review. *Journal of Advanced Nursing*, 54, (4), 47-490

While nutritional vulnerability is often associated with under nutrition, the prevalence of obesity is increasing among older persons, with potential health risks.

3. Provide basic information about managing a **healthy diet**. Use dietary guidelines of your country if available.

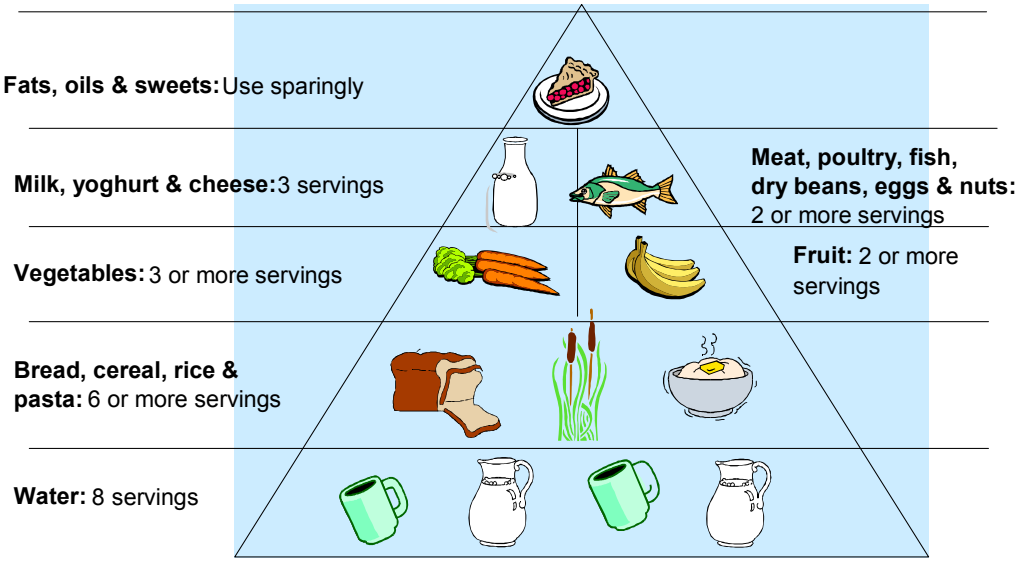
USA dietary guidelines

Eat a variety of foods.
Balance the food you eat with physical activity; maintain or improve your weight.
Choose a diet with plenty of grain products, vegetables, and fruits.
Choose a diet low in fat (less than 30% of calories), saturated fat (less than 10% of calories), and cholesterol (300 mg or less per day).
Choose a diet moderate in sugars.
Choose a diet moderate in salt and sodium (less than 2400 mg per day).
If you drink alcoholic beverages, do so only in moderation (no more than one drink daily for women or 2 drinks daily for men). One drink is 12 oz of regular beer, 5 oz of wine, or 1.5 oz of 80-proof distilled spirits.

4. Use the following **Food Guide Pyramid** as an educational tool for planning healthful diet.

Food Guide Pyramid

Eating right from bottom to top in people aged 70 and older



Source: A food guide for older adults, Human Nutrition Research Center on Aging, Tufts University, USA, 2000

5. For women, recommend special dietarian particularly for calcium. Counsel older women to consume adequate calcium, which helps in:

- building optimal bone after menopause,
- controlling bone loss and delay development of osteoporosis.

Dairy products are major sources of calcium. Other sources of calcium are canned fish with soft bones, vegetables such as broccoli and spinach, and fortified cereals and grains.

Optimal calcium requirements recommended

Group	Optimal daily intake of calcium (mg)
Men aged 25 to 65 years	1000
Men over age 65 years	1500
Postmenopausal women (aged 50 to 65 years)	1500 (1000 if receiving estrogen)
Women over age 65 years	1500

Source: *Optimal Calcium Intake: National Institute of Health Consensus Statement.* National Institutes of Health. Bethesda MD, 1994.

6. For overweight patients, recommend:

- a diet with fewer total calories from fat,
- a modest increase in physical activity. See information on physical activity counselling.

In general, the goal should be a weight loss of 1 / 2 to 1 pound per week. Behaviour therapy and physical activity have been shown to help maintain weight loss.

7. Ongoing support and reinforcement to patients undertaking significant dietary changes. This support can take several forms, including

- follow-up visits,
- telephone calls and postcards.

Recommend making changes gradually, in small, achievable steps over time. Encourage patients through the plateaus and regressions that occur as a normal part of efforts at long-term change.

8. Refer if necessary: patients with multiple or severe nutritional problems should benefit from a nutrition professional counselling as possible.

II.4 Core competencies of geriatric clinical assessment and key clinical management approaches

Clinical background

Older people often have multiple complex health and social conditions and may also present with vague complaints such as dizziness. These intertwining symptoms are difficult to diagnose and treat in the limited time available at most primary care settings. Many of these conditions are chronic and must be screened, early detected and managed to prevent avoidable complications and disability such as amputation from diabetes.

It is not possible to include all geriatric assessment and treatment approaches in this toolkit. The focus therefore, is on assessment and key management strategies for the four **geriatric giants**: memory loss, urinary incontinence, depression and falls/immobility. In addition, the diagnosis and key management of hypertension and diabetes – the two major chronic diseases which account for a high portion of illness and disability – are also included.

General Objectives

This part aims to sensitize and train PHC workers to the approach and use of the necessary tools to deal with the above-mentioned four geriatric giants and two major chronic diseases.

Who should use the tools?

Some PHC settings are staffed with doctors and nurses, while some only have nurses or community health workers. Each tool is marked with a recommendation for the lowest level staff to use the tool. A characteristics table is provided for each tool, that specifies the more adapted staff to use the tool ("by whom?"). Some staff will require training before being competent in use of the tools.

Contents:

Below are the critical core competencies for PHC providers working with older people. This list can be used as a guide or checklist for identifying staff training needs.

Communication – refer to tool on communication with older people

1. Demonstrate knowledge skills and behaviour necessary to communicate effectively with older persons.
2. Encourage participation in decisions.
3. Assess barriers to seniors' understanding of information.
4. Provide health protection, health promotion and disease prevention information.
5. Include family member and/or caregivers in teaching/learning activities.

Knowledge

1. Demonstrate a knowledge and understanding of age and gender related changes and how they impact care.
2. Demonstrate an awareness of the sensory changes associated with ageing.
3. Demonstrate the knowledge of atypical presentations common in old age.

Assessment of health status

1. Be able to assess the relationship between acute illness and known chronic illness in older persons.
2. Assess health/illness by conducting a complete history.
3. Perform a comprehensive physical exam considering the changes associated with ageing.
4. Perform a comprehensive functional assessment including mental status, social support and nutrition.
5. Assess the task and stressors of the care giving system of the older person.

Diagnosis and treatment

1. Recognize the commonly occurring conditions associated with ageing.
2. Implement screening using age-appropriate instruments.
3. Plan appropriate interventions based on the assessments.
4. Demonstrate an understanding of age appropriate drug use for seniors including knowledge of compliance issues.
5. Plan therapeutic intervention to restore and or maintain optimal level of function.
6. Coordinate care with other available health and social services.

II.4.1 Overall examination

Overall exam sheet

Note: If there are national forms, please use.

PART 1 – CAN BE DONE BY NURSE OR TRAINED HEALTH CARE WORKER

Date:_____ Name:_____ Age:_____
Sex: ☐Male ☐Female
Vital Sign:
BP:_____ Pulse:_____ Temperature:_____ Weight:_____ Height:_____

Social History:
Martial Status:_____ Who are you living with ? _____
Native language:_____

Do you have any children ? Y / N How often do you see them ?_____
Who assists you ? _____ Is it sufficient ? Y / N

In which type of housing do you live ?_____
Are there stairs ? Y / N

Family History
☐Hypertension ☐Diabetes ☐Dementia
☐Heart disease ☐Others_____

Past Medical History (check positives)

☐hypertension	☐cardiovascular disease		☐thyroid
☐cholesterol	☐stroke	☐neuropathy	☐peripheral vascular
☐diabetes	☐hepatitis	☐head injury	☐Parkinson's
☐alcohol	☐depression	☐seizures	☐cancer
☐hear, vision			

ROS (do appropriate to complaint include psychiatric history)

Level of Function (ADL-Tool 7):
☐Independent ☐Need assistance ☐Dependent

PART 2 – TO BE DONE BY DOCTOR (do sections appropriate to exam)
Eyes ☐ normal conjunctiva & lids
Pupils ☐ pupils symmetrical, reactive

ENT-External ☐☐no scars, lesions, masses
Otoscopic ☐☐normal canals & timpanic membranes

Ant. Oral □□ normal lips, teeth, gums
Oropharynx □□ normal tongue, palate

Neck palp. □ symmetrical without masses
Thyroid □□no enlargement or tenderness

Resp.
Respiratory rate :_____per min
Chest percuss. □ no dullness or hyper resonance
Auscultation □□ normal bilateral breath sounds without rales

Heart palp. □ normal location, size
Cardiac ausc. □no murmur
Carotids □ normal intensity without bruit
Pedal pulses □ normal posterior tibial & dorsalis pedis

Breasts □□normal l inspection & palpation
Abdomen □□no masses or tenderness
L/S □□no liver/spleen
Hernia □□no hernia identified

Genitourinary male □□external genitalia normal without lesions
Prostate □□ normal size without nodularity

Genitourinary female
Int. inspection □□ normal bladder, urethra, & vagina
Cervix □□ normal appearance without discharge
Uterus □□ normal size, position, without tenderness
Adnexa □□no masses or tenderness

Additional description of positive findings (including behavioural changes):

Preliminary diagnostic assessment (impairment level, co morbid health conditions, potential treatable elements):

Recommendations/plan:

□Diagnosis

□ investigations

□Lab:

□Electrolytes □Ca □TSH □B_{12} □others

□ Imaging (type, history)_____

□□Last EKG: date_____ Description_____

□Management

-Treatment:

-Referrals:

-Follow-up:

II.4.2 Clinical assessment and key management approaches for the four geriatric giants

- The organized clinical approach is an efficient way to identify, assess and manage patient care. The clinical approach as illustrated in the flowchart on the back **on page 42** is a stepwise flow from the 10-minute comprehensive screening through identification of health problems; assessment; management and follow-up.
- Patients who come to the PHC centre for health care will be screened by a trained community health aid in the waiting room (Step 1).
- If the screening is positive for any of the four geriatric giants, steps 2,3 and 4 as specified below will be followed.
- If a nutritional problem is identified, the patient should be referred to the doctor (See section II.3).
- If a hearing or vision problem is identified, the patient should be referred to the doctor for an appropriate action.

The organized clinical process consists of the following four steps:

Step 1: 10-minute comprehensive screening (Tool 1)
- Should be done by a member of the PHC centre while the patient is waiting to see the doctor and included in the medical record.
- Try to provide privacy for the patient as much as possible.

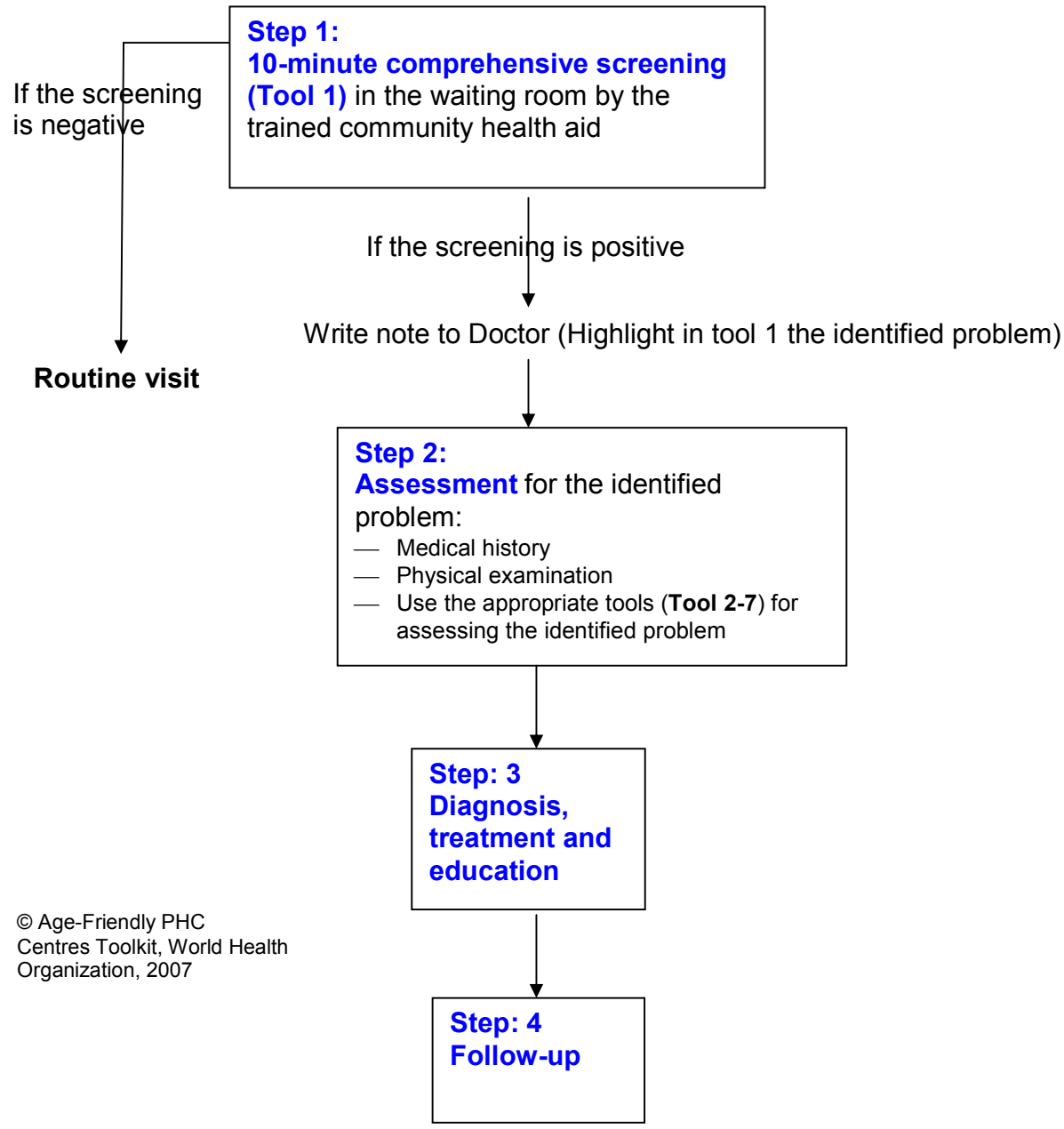
Step 2: Geriatric giants assessment (Tool 2 to 7)
- Assessment by doctors using questionnaire and physical examination.
- Where there are multiple conditions, the doctor needs to prioritize assessment and decide which condition to work up in the first visit and schedule subsequent visits for other conditions. The following order is suggested:
    1. **Memory loss**
    2. **Depression**
    3. **Urinary Incontinence**
    4. **Falls/immobility**

Step 3: Diagnosis, treatment and education
- Establish diagnosis.
- Plan pharmacological and non pharmacological management strategies.
- Counsel patients and family/caregivers on appropriate targets for reducing risk, including education. This can be done by nurse or a community health worker.
- Refer to appropriate services when needed.

Step 4: Follow-up
- Assess response and effectiveness of treatment.
- Change clinical management as necessary.
- If needed, discuss referral for specialty evaluation and management.

Stepwise flow from screening through identification of health problems to management and follow-up

Apply annually to all patients of 60 years old and over
(or as appropriate)



Tool 1: 10-minute comprehensive screening

What for ?	Screening of the main geriatric clinical issues
By whom ?	All members of the health care team
How long ?	10 minutes

Tool 1: a 10-minute comprehensive screening (step 1)

Name_____Date___/____/____ M/F_____

A. Memory

1. Instruct : "I am going to name 3 objects: pencil, truck, book. I will ask you to repeat their names now and then again a minute from now. Please try to remember them."

Record this after asking question on physical functional Capacity (Item D)

All 3 objects named? Yes_____ No_____ *If no, refer to "clinical process of managing memory loss"*

B.Urinary Incontinence

1. Ask "In the last year have you ever lost your urine and gotten wet?
   Yes___ No_____
   If yes, then ask the following:
2. "Have you lost urine over the past week?

If yes to both questions, refer to "clinical process of managing urinary incontinence"

C.Depression

1. Ask " Do you often feel sad or depressed?" Yes____ No____ *If yes, refer to "clinical process of managing depression"*

D.Physical Functional Capacity (immobility)

Ask "Are you able to… "

1. Run/fast walk to catch the bus? Yes_____No___
2. Do heavy work around the house, like washing windows, walls or floors? Yes___ _No___
3. Go shopping for groceries or clothes? Yes_____No___
4. Get to places out of walking distance? (drive, take a bus) Yes_____No___
5. Bath, either a tub bath or shower? Yes_____No___
6. Dress, like putting on a shirt, buttoning and zipping, or putting on shoes? Yes_____No___

Positive screen (for each): *Unable to do or able to do with help or supervision from another person.*

If positive, refer to doctor

Have patient complete 3 item recall above

1. Ask for three items recall 1) _____ 2)_____ 3)_____

E.Falls

1. Have you fallen 2 or more times in the past 12 months? Yes_____ No_____

If no, then do the following:

2. Instruct: " Rise from the chair, walk around it without holding on"
   Unable to do: Yes_____ No____ Unsteady: Yes____ No___ *If yes to at least one question, refer to "clinical process of managing falls"*

Additional common problems

Nutrition

1. Have you noticed a change in your weight over the past 6 months? Yes___ No___
   Increase_____Kg decrease_____Kg (If weight was recorded last visit)
   Record: Date___/____/____, Today's weight_____Kg. *If problem identified, refer to "age-friendly health promotion"* (*Alternative question allowed if culturally acceptable*)

Hearing

1. Stand behind person and ask the person to repeat after you - 6, 1, 9; (softly then in normal voice)
   Soft: Right Ear____ Left Ear____
   Normal Right Ear____ Left Ear____

Positive screen: *patient unable to hear in both ears or in one ear(or any combination of two negative response)*

- *If problem detected, inform doctor for referral if available/appropriate*

Vision

1. Ask:"Do you have difficulty reading or doing any of your daily activities because of your eyesight?"(even with wearing glasses)

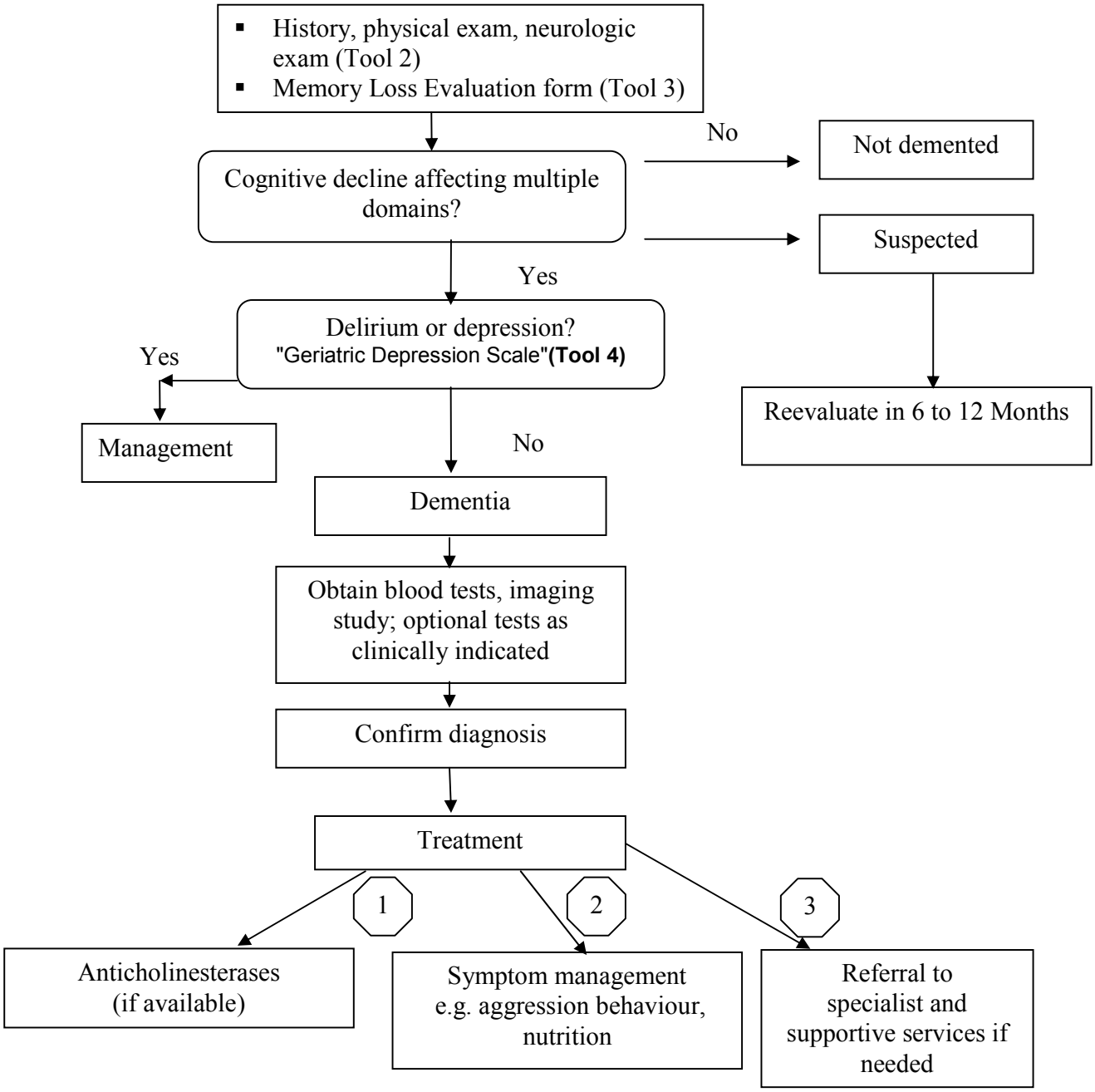
Positive screen: *Yes.*

2. If positive screen, if available, ask to complete SNELLEN eye chart (without glasses & then with glasses)
   Right Eye_____ Left Eye_____

1. MEMORY LOSS

Managing memory loss – If positive on screening tool

Note: If there are national guidelines, please follow.



Tool 2-: Mini-mental state examination (MMSE)

What for ?	Screening of cognitive impairments
By whom ?	Medical doctor
How long ?	15 minutes

MiniMentaL

NAME OF SUBJECT _____ Age_____

Years of School Completed ____

Approach the patient with respect and encouragement. Date of Examination_____
Ask: Do you have any trouble with your memory? Yes [ ] No [ ]
May I ask you some questions about your memory? Yes [ ] No [ ]

SCORE ITEM

5 ( ) TIME ORIENTATION
Ask:
What is the year _____ (1), season_____(1),
month of the year_____ _ _ (1), date_____(1),
day of the week_____ (1)?

5 ( ) PLACE ORIENTATION
Ask:
Where are we now? What is the state_____(1), city _____(1),
part of the city_____(1), building_____(1),
floor of the building_____ _____(1)?

3 ( ) REGISTRATION OF THREE WORDS
Say: Listen carefully. I am going to say three words. You say them back after I stop. Ready? Here they are... PONY (wait 1 second). QUARTER (wait 1 second), ORANGE (wait one second). What were those words?
_____(1)
_____(1)
_____(1)
Give 1 point for each correct answer, then repeat them until the patient learns all three.

5 ( ) SERIAL 7 s AS A TEST OF ATI'ENION AND CALCULATION
Ask: Subtract 7 from 100 and continue to subtract 7 from each subsequent remainder until I tell you to stop. What Is 100 take away 7 ?_____ (1)
Say:
Keep Going_____ (1), _____(1),
_____(1), _____(1).

3 ( ) RECALL OF THREE WORDS
Ask:
What were those three words I asked you to remember?
Give one point for each correct answer._____(1),
_____(1), _____(1).

2 ( ) NAMING
Ask:
What is this? (show pencil)_____(1), What is this? (show watch)_____(1).

MiniMentaL

1 ( ) **REPETITION**
Say:
Now I am going to ask you to repeat what I say. Ready? No ifs, ands, or buts.
Now you say that._____(1).

3 ( ) **COMPREHENSION**
Say:
Listen carefully because I am going to ask you to do something:
Take this paper in your left hand (1), fold it in half (1), and put it on the floor. (1)

1 ( ) **READING**
Say:
Please read the following and do what it says, but do not say it aloud. (1)

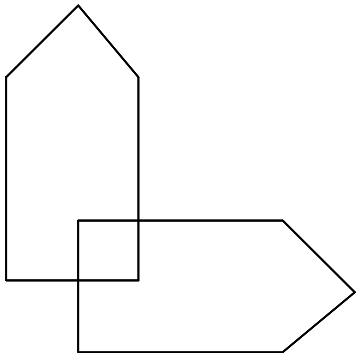
Close your eyes

1 ( ) **WRITING**
Say:
Please write a sentence. If patient does not respond, say: Write about the weather. (1)

_____

_____

1 ( ) **DRAWING**
Say: Please copy this design.



TOTAL SCORE _____ (*)

*: **Score**:

27-30	Normal
20-26	Mild impairment
10-19	Moderate impairment
Below 10	Severe impairment
For scores below 27	Complete the memory loss evaluation form(**Tool 3**) and follow the flowchart for managing memory loss

Source: Folstein, M. F., Folstein, S. E., McHugh, P. R. " Mini-Mental Test ": A practical method for grading the cognitive state of patients for the clinician. *J. Psychiatry Res.*, 1975; 12: 189-198.

Tool 3: Memory loss evaluation form

What for ?	Memory loss clinical questioning
By whom ?	Medical doctor
How long ?	5-15 minutes

Name:_____ Age:_____ Date:_____

History of the Memory Problem

Psychiatric history

Family History

□hypertension □dementia □Parkinson's disease □depression
□stroke □cardiovascular disease □down's syndrome
□diabetes

Medications currently taking

Symptoms (circle positives)

□speech difficulty □confusion □aggressive □delusions
□hallucinations □emotional change □fall, injury
□balance problems □eating problems □behaviour changes

Main problem identified by family/caregiver

1.
2.
3.

Tool 4: Geriatric Depression Scale (GDS)

What for ?	Assessing state of depression
By whom ?	Patient, nurse or trained health worker
How long ?	5 minutes

Instructions:	Circle the answer that best describes how you felt over the <u>past week</u>.		
	1. Are you basically satisfied with your life?	yes	**no**
	2. Have you dropped many of your activities and interests?	**yes**	no
	3. Do you feel that your life is empty?	**yes**	no
	4. Do you often get bored?	**yes**	no
	5. Are you in good spirits most of the time?	yes	**no**
	6. Are you afraid that something bad is going to happen to you?	**yes**	no
	7. Do you feel happy most of the time?	yes	**no**
	8. Do you often feel helpless?	**yes**	no
	9. Do you prefer to stay at home, rather than going out and doing things?	**yes**	no
	10. Do you feel that you have more problems with memory than most?	**yes**	no
	11. Do you think it is wonderful to be alive now?	yes	**no**
	12. Do you feel worthless the way you are now?	**yes**	no
	13. Do you feel full of energy?	yes	**no**
	14. Do you feel that your situation is hopeless?	**yes**	no
	15. Do you think that most people are better off than you are?	**yes**	no
	Total Score		

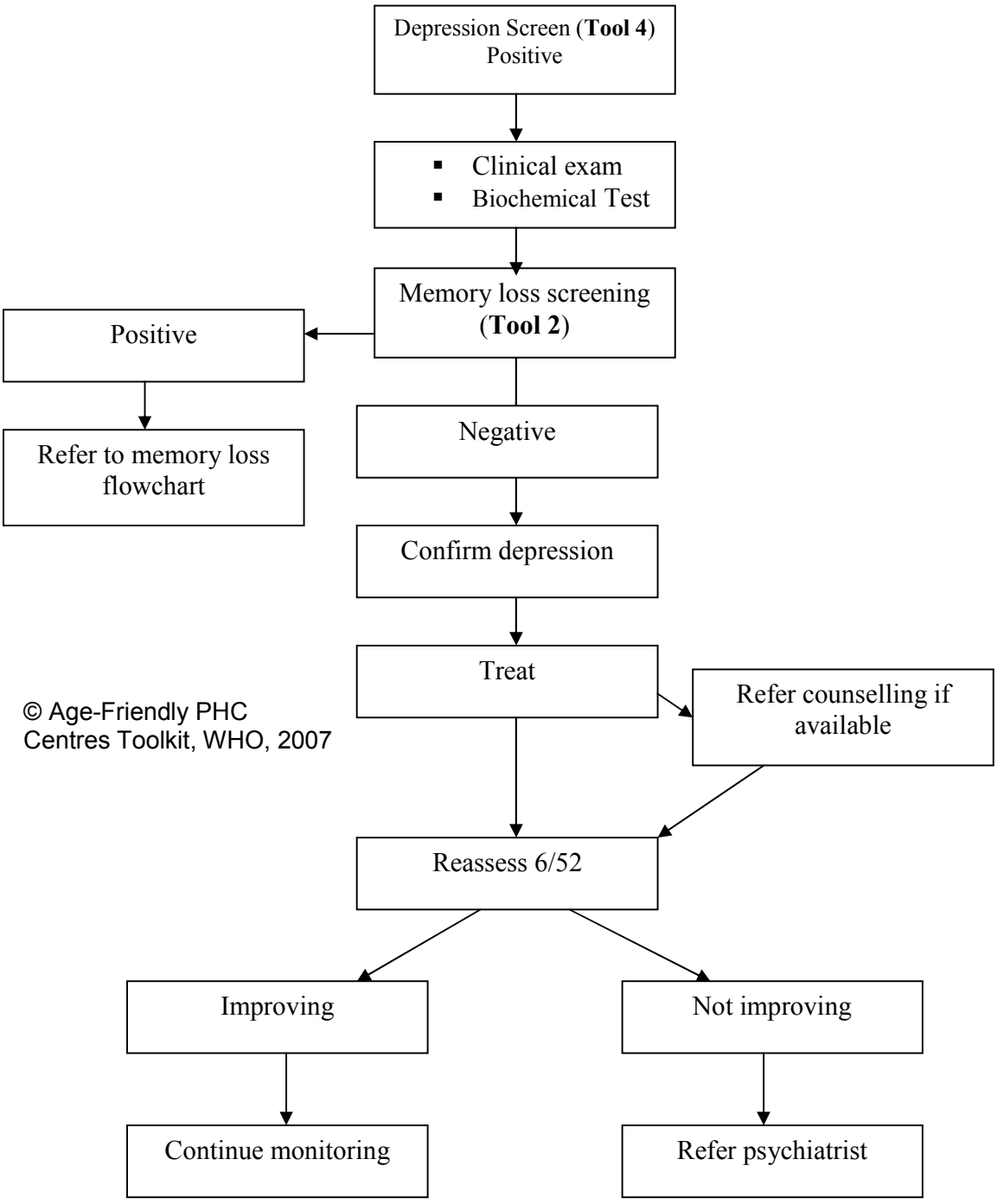
Scoring Instructions:	***Score one point for each bolded answer.*** A score of 5 or more suggests depression.	
	Total Score:	

If positive, follow the depression management flowchart.

Source: Yesavage JA, Brink TL, Rose TL, Lum O, Huang V, Adey MB, Leirer VO. Development and validation of a geriatric depression screening scale: A preliminary report. *Journal of Psychiatric Research 17:* 37-49, 1983.

2. DEPRESSION

For persons without mental impairment:
Managing depression if screening tool indicates positive for depression (nurse does screening tool)
Note: If there are national guidelines, please follow.



Tool 4: GDS

What for ?	Assessing state of depression
By whom ?	Patient, nurse or trained health worker
How long ?	5 minutes

Instructions:	Circle the answer that best describes how you felt over the past week.		
	1. Are you basically satisfied with your life?	yes	**no**
	2. Have you dropped many of your activities and interests?	**yes**	no
	3. Do you feel that your life is empty?	**yes**	no
	4. Do you often get bored?	**yes**	no
	5. Are you in good spirits most of the time?	yes	**no**
	6. Are you afraid that something bad is going to happen to you?	**yes**	no
	7. Do you feel happy most of the time?	yes	**no**
	8. Do you often feel helpless?	**yes**	no
	9. Do you prefer to stay at home, rather than going out and doing things?	**yes**	no
	10. Do you feel that you have more problems with memory than most?	**yes**	no
	11. Do you think it is wonderful to be alive now?	yes	**no**
	12. Do you feel worthless the way you are now?	**yes**	no
	13. Do you feel full of energy?	yes	**no**
	14. Do you feel that your situation is hopeless?	**yes**	no
	15. Do you think that most people are better off than you are?	**yes**	no
	Total Score		

Scoring Instructions:	***Score one point for each bolded answer.*** A score of 5 or more suggests depression.	
	Total Score:	

If positive, follow the depression management flowchart.

Source: Yesavage JA, Brink TL, Rose TL, Lum O, Huang V, Adey MB, Leirer VO. Development and validation of a geriatric depression screening scale: A preliminary report. *Journal of Psychiatric Research 17:* 37-49, 1983.

Tool 2: MMSE

What for ?	Screening of cognitive impairments
By whom ?	Medical doctor
How long ?	15 minutes

MiniMentaL

NAME OF SUBJECT _____ Age_____

Years of School Completed ____

Approach the patient with respect and encouragement. Date of Examination_____
Ask: Do you have any trouble with your memory? Yes [ ] No [ ]
May I ask you some questions about your memory? Yes [ ] No [ ]

SCORE ITEM

5 ( ) TIME ORIENTATION
Ask:
What is the year _____ (1), season_____(1),
month of the year_____ _ _ (1), date_____(1),
day of the week_____ (1)?

5 ( ) PLACE ORIENTATION
Ask:
Where are we now? What is the state_____(1),
city _____(1), part of the city_____(1),
building_____(1), floor of the building_____ _____(1)?

3 ( ) REGISTRATION OF THREE WORDS
Say: Listen carefully. I am going to say three words. You say them back after I stop. Ready? Here they are... PONY (wait 1 second). QUARTER (wait 1 second), ORANGE (wait one second). What were those words?
_____(1)
_____(1)
_____(1)
Give 1 point for each correct answer, then repeat them until the patient learns all three.

5 ( ) SERIAL 7s AS A TEST OF ATI'ENION AND CALCULATION
Ask: Subtract 7 from 100 and continue to subtract 7 from each subsequent remainder until I tell you to stop. What Is 100 take away 7 ?_____ (1)
Say:
Keep Going_____ (1), _____(1),
_____(1), _____(1).

3 ( ) RECALL OF THREE WORDS
Ask:
What were those three words I asked you to remember?
Give 1 point for each correct answer._____(1),
_____(1), _____(1).

2 ( ) NAMING
Ask:
What is this? (show pencil)_____(1), What is this? (show watch)_____(1).

1 ( ) **REPETITION**

Say:

Now I am going to ask you to repeat what I say. Ready? No ifs, ands, or buts.

Now you say that._____(1).

3 ( ) **COMPREHENSION**

Say:

Listen carefully because I am going to ask you to do something:

Take this paper in your left hand (1), fold it in half (1), and put it on the floor. (1)

1 ( ) **READING**

Say:

Please read the following and do what It says, but do not say it aloud. (1)

Close your eyes

1 ( ) **WRITING**

Say:

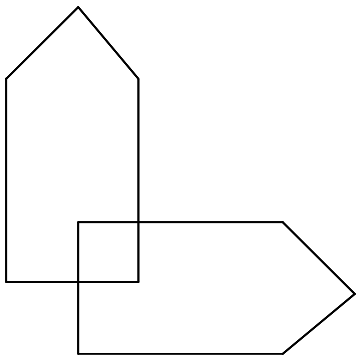
Please write a sentence. If patient does not respond, say: Write about the weather. (1)

_____

_____

1 ( ) **DRAWING**

Say: Please copy this design.



TOTAL SCORE _____ (*)

*: **Score**:

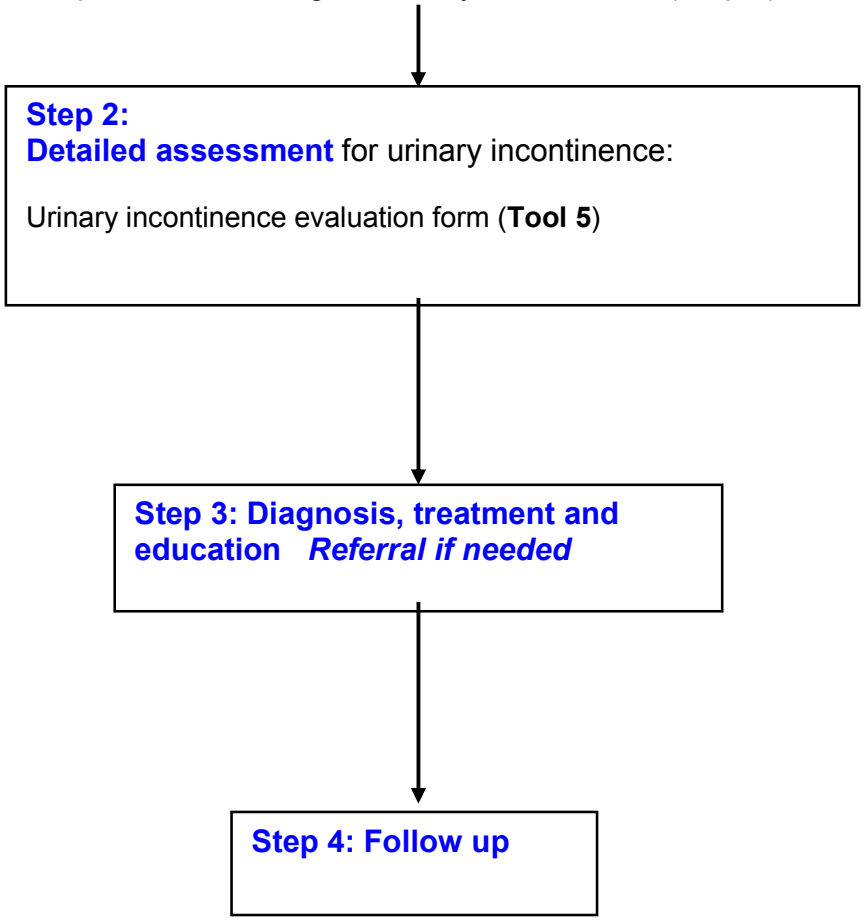
27-30	Normal
20-26	Mild impairment
10-19	Moderate impairment
Below 10	Severe impairment
For scores below 27	Complete the memory loss evaluation form (**Tool 3**) and follow the flowchart for managing memory loss

Source: Folstein, MF Folstein, SE, McHugh, PR "Mini-Mental Test ": A practical method for grading the cognitive state of patients for the clinician. *J. Psychiatry Res.*, 1975; 12: 189-198.

3. URINARY INCONTINENCE

Clinical process of managing urinary incontinence
– When risk of urinary incontinence is found

If positive screening for urinary incontinence (Step 1)



Tool 5: Urinary incontinence evaluation form

What for ?	Urinary incontinence evaluation
By whom ?	**Part 1**: Nurse or trained health care worker **Part 2**: Medical doctor
How long ?	15 minutes

PART 1

Name:_____ Age:_____ Date:_____

Genitourinary history.

□Bladder tumor □Recurrent UTI □Kidney stones □Prostate problem

Women only

N° of Pregnancies ____

Menopause? Y/N How long?_____

Estrogens Y/N

□Family history cancer breast □Hysterectomy □Ovaries removed

Summary of incontinence

When did the problem begin?

Does it influence with your activities of daily living?

If yes, how?

What makes the problem worse?

□Running □Sneeze, cough □Laugh □Lift □Bending down

□Running water

What problems do you have with passing your urine? (adapt culturally)

- Starting
- Slow stream
- Discomfort

- Hematuria
- Inc. emptying

Voiding problems (circle all that apply)

Damp without recognition

Can hold:

□Indefinitely □Few minutes □Minute or two □Nocturia

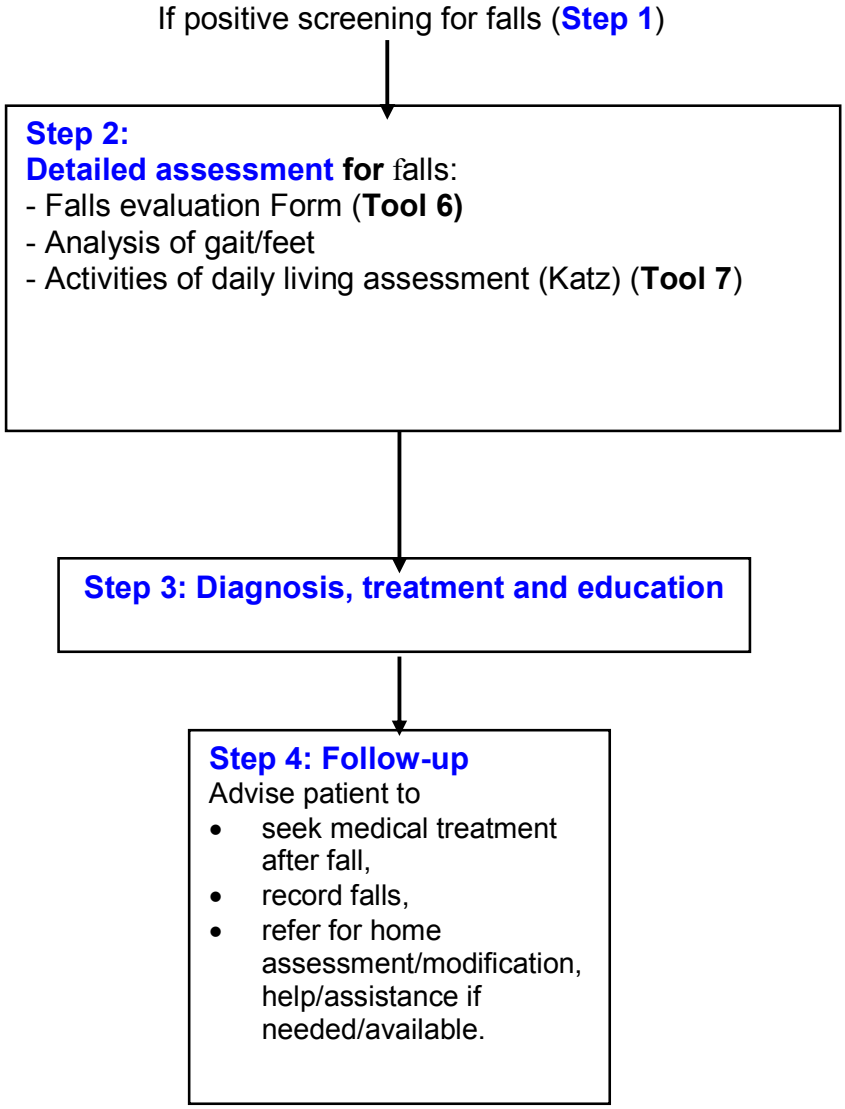
PART 2

Medication review – What medication are you currently taking?
(note beta blocker, sedative, narcotic, diuretic, anticholinergic, calcium channel blockers, non-prescription drugs, cold remedy, herbals)

Treatment (as indicated)

4. FALLS

The clinical process of managing falls
(When risk of falls is found)



Tool 6: Falls evaluation form

What for ?	Investigation of the origin of falls
By whom ?	**Part 1**: Nurse or trained health care worker **Part 2**: Medical doctor
How long ?	20 minutes

PART 1
Name:_____ **Age:**_____ **Date:**_____

History of Your Falls
Description of the fall
We need to hear the details of your falls so we can understand what is causing them. Answer the following questions about your last fall.

When was this fall? _____

Date (approximate) _____ Time of Day _____

- What were you doing before you fell?
- Do you remember your fall, or did someone tell you about it?
- How did you feel just before?
- How did you feel going down?
- What part of your body hit?
- What did it strike?
- What was injured?
- Anything else you recall?
- Do you think you passed out?
- Do you have joint pain?
- Do you have joint instability?
- Do you have foot problems?
- Do you use a cane/walker?

How often have you fallen in the past six months?

What medication are you currently taking?

☐Psychotropic medications ☐Diuretics ☐Antiarrhythmics

☐Noticed any vision changes Yes/Non

☐Eye exam past year Yes/Non

PART 2

Feet – any abnormalities

Gait analysis

Gait: ☐normal ☐abnormal

Up-and-Go test:____sec

(patient who takes more than 30 seconds is at risk)

Abnormal if: Hesitant start

☐Broad-based gait

☐Extended arms

☐Heels do not clear toes of other foot

☐Heels do not clear floor

☐Path deviates

Up-and-Go test:
-Stand from chair,
-Walk 10 feet (3 meters),
-Turn around,
-Walk back,
-Sit down

Balance test:	YES	NO
(1) Side-by-side, stable 10 sec	☐	☐
(2) Semi-tandem, stable 10 sec	☐	☐
(3) Full tandem, stable 10 sec	☐	☐

Balance test:
(1) **side-by-side**: feet side by side, touching;
(2) **semi-tandem**: side of the heel of one foot touching the big toe of the other;
(3) **tandem**: heel of one foot directly in front of and touching the toes of the other foot.
Each stance is progressively more difficult to hold. People unable to hold a position for 10 seconds are not asked to attempt further stands.

Tick if abnormal

	STRENGTH		TONE	
	Left	Right	Left	Right
ARM	☐	☐	☐	☐
LEG	☐	☐	☐	☐

Quad strength: can rise from chair without using arms Y / N

Treatment (to be completed by the doctor):

1.

2.

Tool 7: Activities of Daily Living Assessment (ADL)

Index of independence in ADL

What for ?	Assessing autonomy in daily activities
By whom ?	Nurse or medical doctor
How long ?	10 minutes

ACTIVITIES Points (0-6)	**INDEPENDENCE** (1 Point) **NO** supervision, direction or personal assistance	**DEPENDENCE** (0 Points) **WITH** supervision, direction, personal assistance or total care
BATHING Points----------	(1 POINT) Bathes self completely or needs help in bathing only a single part of the body such as the back, genital area or disabled extremity.	(0 POINTS) needs help with bathing more than one part of the body, getting in or out of the tub or shower. Requires total bathing.
DRESSING Points----------	(1 POINT) Gets clothes from closet and drawers and puts on clothes and outer garments complete with fasteners. May have help tying shoes.	(0 POINTS) Needs help with dressing self or needs to be completely dressed.
TOILETING Points----------	(1 POINT) Goes to toilet, gets on and off, arranges clothes, cleans genital area without help.	(0 POINTS) Needs help transferring to the toilet, cleaning self or uses bedpan or commode.
TRANSFERRING Points----------	(1 POINT) Moves in and out or chair unassisted. Mechanical transferring aides are acceptable.	(0 POINTS) Needs help in moving from bed to chair or requires a complete transfer.
CONTINENCE Points----------	(1 POINT) Exercises complete self control over urination and defecation.	(0 POINTS) Is partially or totally incontinent of bowel or bladder.
FEEDING Points----------	(1 POINT) Gets food from plate into mouth without help. Preparation of food may be done by another person.	(0 POINTS) Needs partial or total help with feeding or requires parenteral feeding.

TOTAL POINTS = _____ 6 = High (patient independent) 0 = Low (patient very dependent)

Source: Katz S, Down TD, Cash HR, Grotz RC. Progress in the development of the index of ADL. *The gerontologist* 1970 10(1), 20-30.

HYPERTENSION AND DIABETES

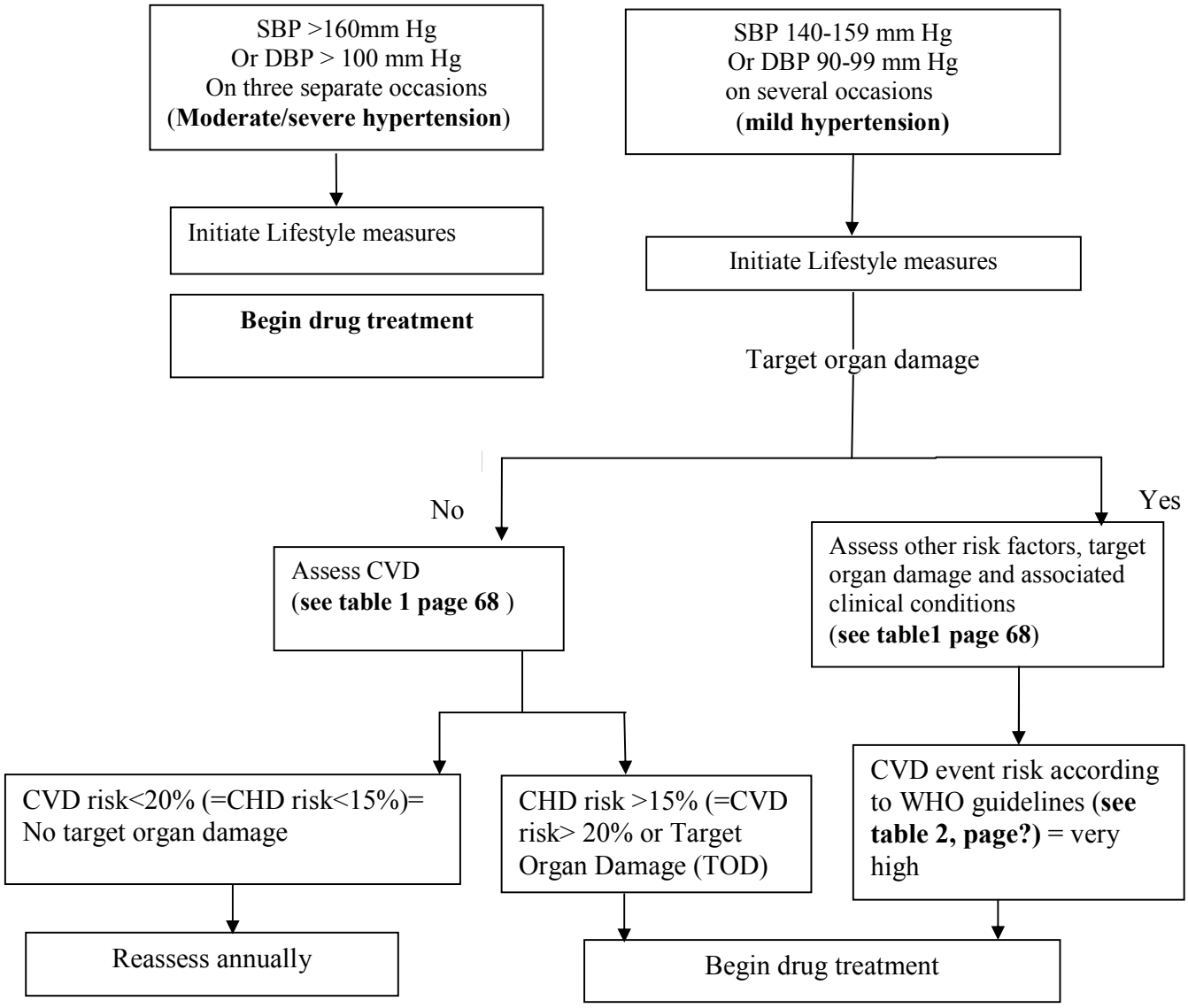
- **These are two of the most common illnesses in older persons.**
- **If there are national guidelines, please follow them. The example given here is from Jamaica.**
- **Please refer to health promotion materials on physical activity and nutritional counselling.**

II.4.2 Clinical assessment and key management approaches for two major chronic diseases

Management of hypertension

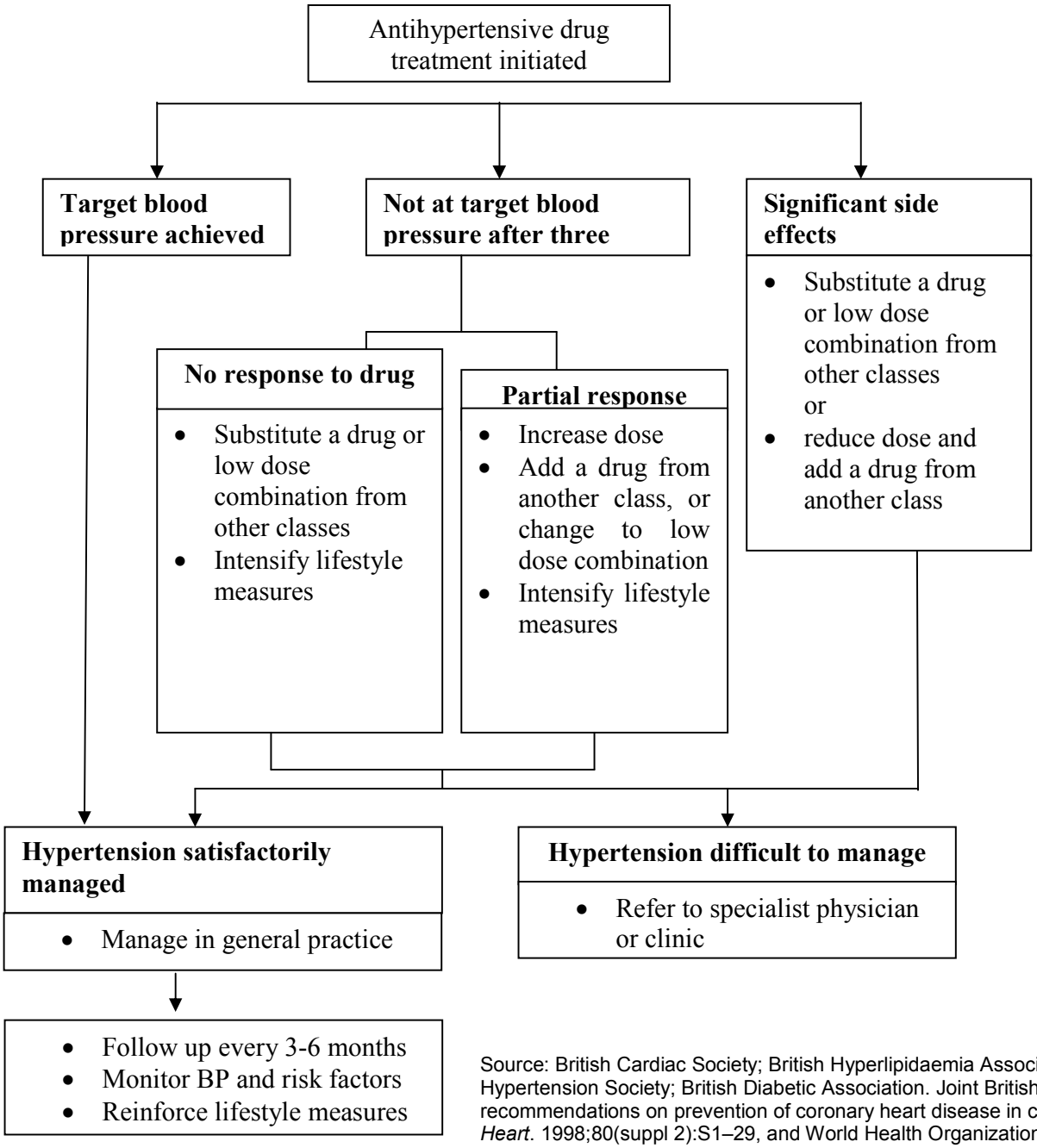
Most countries have national guidelines for classification of hypertension which should be followed. If local guidelines are not available, please refer to the following guideline:

INTIATION OF TREATMENT FOR HYPERTENSION IN OLDER PEOPLE



Source: British Cardiac Society; British Hyperlipidaemia Association; British Hypertension Society; British Diabetic Association. Joint British recommendations on prevention of coronary heart disease in clinical practice. *Heart*. 1998;80(suppl 2):S1–29, and World Health Organization, International Society of Hypertension Writing Group. 2003 World Health Organization (WHO)/International Society of Hypertension (ISH). Statement on management of hypertension. J Hypertens.2003;21:1983-1992

STABILISATION, MAINTENANCE AND FOLLOW-UP AFTER INITIATION OF ANTIHYPERTENSIVE DRUG THERAPY



Source: British Cardiac Society; British Hyperlipidaemia Association; British Hypertension Society; British Diabetic Association. Joint British recommendations on prevention of coronary heart disease in clinical practice. *Heart*. 1998;80(suppl 2):S1–29, and World Health Organization, International Society of Hypertension Writing Group. 2003 World Health Organization (WHO)/International Society of Hypertension (ISH). Statement on management of hypertension. J Hypertens.2003;21:1983-1992

Table 1 – Important factors influencing prognosis and assessment of CVD risks

Risk factors for cardiovascular disease (CVD)	Target Organ Damage (TOD)	Associated Clinical Conditions (ACC)
I Used for risk stratification ▪ Systolic and diastolic blood pressure (mild, moderate or severe) ▪ Age>55 (men) >65 (women) ▪ Smoking ▪ Total cholesterol>6.5mmol/l or TC/HDL ratio>5.0 ▪ Diabetes ▪ Family history of CVD	▪ Left ventricular hypertrophy (ECG or echo) ▪ Proteinuria and/or creatinine>150 µmol/l ▪ Atherosclerotic plaque (X-ray or ultrasound evidence in carotid, iliac, or femoral arteries or aorta)	▪ Cerebrovascular disease ▪ Ischaemic stroke ▪ Haemorrhagic stroke ▪ Transient ischaemic attack ▪ Vascular dementia ▪ Cardiovascular disease ▪ Myocardial infarction ▪ Congestive cardiac failure ▪ Renal disease ▪ Peripheral vascular disease ▪ Aortic aneurysm ▪ Retinopathy
II Other Factors adversely influencing prognosis - Reduced HDL cholesterol - Raised LDL cholesterol - Microalbuminuria in diabetics - Impaired glucose tolerance - Obesity		

Source: British Cardiac Society; British Hyperlipidaemia Association; British Hypertension Society; British Diabetic Association. Joint British recommendations on prevention of coronary heart disease in clinical practice. *Heart*. 1998;80 (suppl 2):S1–29.

Table 2 – Stratification of CVD risk to quantify prognosis

	Blood pressure (mm Hg)		
Other risk factors and disease history	**Mild hypertension** SBP 140-159 or DBP 90-99	**Moderate hypertension** SBP 160-179 or DBP 100-109	**Severe hypertension** SBP ≥180 or DBP ≥110
No other risk factors	LOW RISK*	MEDIUM RISK	HIGH RISK
1-2 risk factors	MEDIUM RISK	MEDIUM RISK	VERY HIGH RISK
3 or more risk factors Or TOD or	HIGH RISK	HIGH RISK	VERY HIGH RISK

diabetes			
Presence of associated clinical conditions	VERY HIGH RISK	VERY HIGH RISK	VERY HIGH RISK

**Risk category refers to the risk of a cardiovascular event within 10 years: low risk: <15 %, medium: 15-20%, high: 20-30%, very high: >30%*

Source: British Cardiac Society; British Hyperlipidaemia Association; British Hypertension Society; British Diabetic Association. Joint British recommendations on prevention of coronary heart disease in clinical practice. *Heart*. 1998;80(suppl 2):S1–29, and World Health Organization, International Society of Hypertension Writing Group. 2003 World Health Organization (WHO)/International Society of Hypertension (ISH). Statement on management of hypertension. J Hypertens.2003;21:1983-1992

Guidelines for management of hypertension

Assessment

- A full assessment of cardiovascular risks should be carried out for all hypertensive patients
- Blood pressure measurement is critical to the management of hypertension. Validated equipment should be used and national guidelines or the guidelines above should be followed.
- The normal range for home blood pressure measurements and ambulatory blood pressure monitoring is lower than “normal” surgery or clinic values.
- Accelerated phase (malignant) hypertension requires urgent hospital admission for investigation and treatment.

Thresholds and targets for treating hypertension in older people

- Both systolic and diastolic hypertension require treatment.
- Thresholds for antihypertensive therapy and targets for treatment should be set and should take into account both the level of blood pressure and other risk factors.
- The decision to start treatment should be based on a structured assessment of cardiovascular risk.
- A target blood pressure of <140/90 mmHg is recommended for older hypertensive patients.
- Even a small reduction in blood pressure is worthwhile if absolute targets prove difficult to achieve.
- Hypertensive patients with diabetes or with renal disease should be considered for specialist referral. Some patients may require further investigation and lower target blood pressures may be desirable.
- Accelerated phase (malignant) hypertension requires urgent hospital admission for investigation and treatment.

Lifestyle modification

- Lifestyle measures aimed at controlling hypertension should be recommended in all cases.
- Overweight and obese hypertensive patients (BMI≥25.0) should be encouraged to lose weight.
- Alcohol intake should be reduced when it exceeds 21 units per week for men and 14 units per week for women.
- Sodium intake should be reduced towards a target of <5g/day.
- Fruit and vegetable consumption should be increased to a total of five portions/day, and saturated fat consumption reduced.
- Increase physical activity by taking regular exercise.
- All patients should be actively discouraged from smoking.

Drug treatment/optional

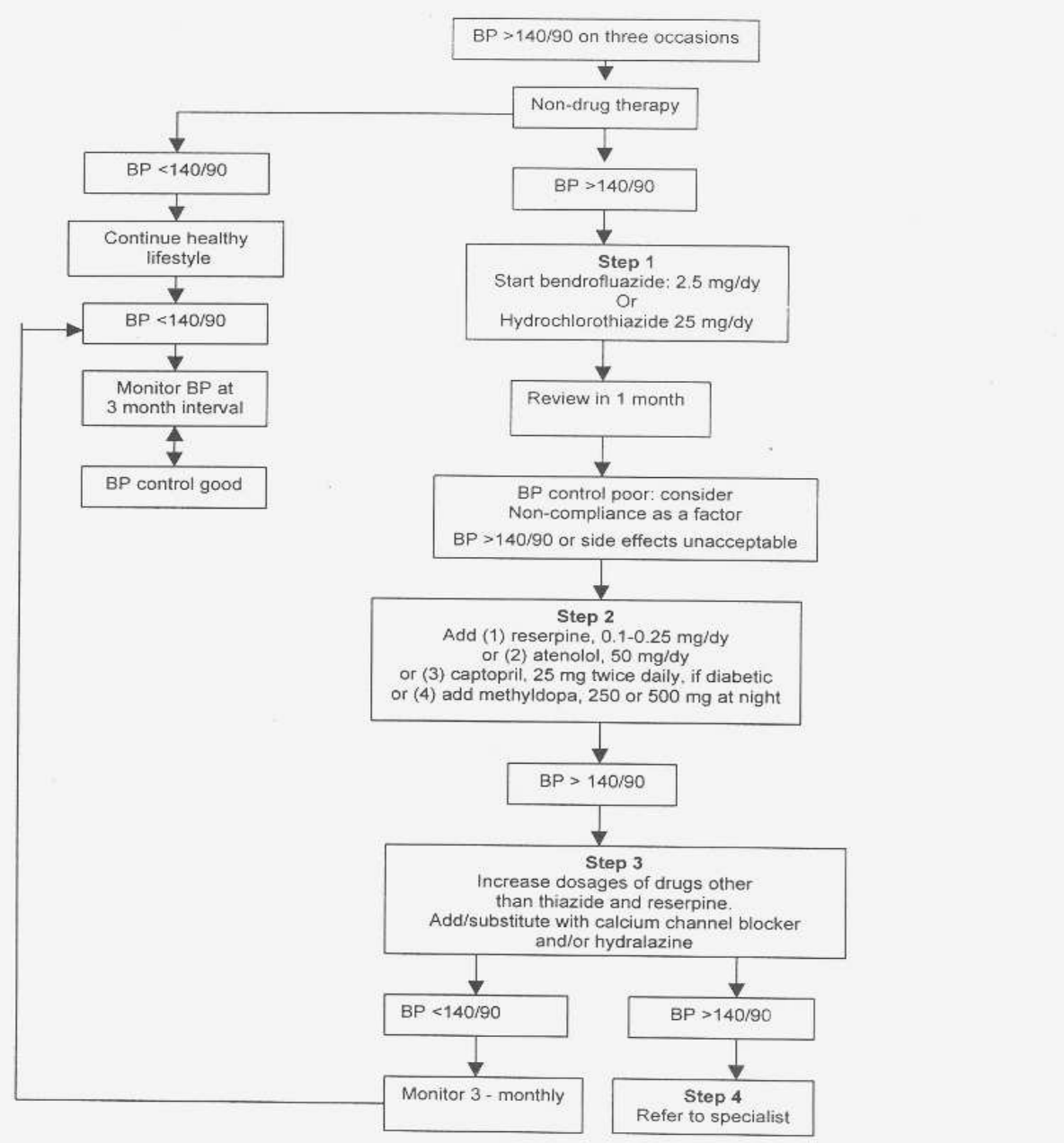
- **Thiazide diuretics** are recommended as first line therapy for drug of hypertension in older patients.
- Low doses of thiazide should be used as there is clear evidence that this minimizes potential adverse biochemical and metabolic disturbance.
- **β-blockers** can be used as alternative or supplementary therapy to thiazide diuretics in older patients.
- **Long-acting dihydropyridine calcium antagonists** can be used as alternative therapy to thiazide diuretics or supplementary to other therapy, particularly in patients with isolated systolic hypertension.
- **Short-acting dihydropyridine** calcium antagonists should be avoided.
- **ACE inhibitors** are specifically indicated as first line therapy for hypertension in patients with type 1 diabetics, proteinuria, or left ventricular dysfunction.
- In most other hypertensive patients, ACE inhibitors are recommended as alternative or supplementary therapy in the absence of renal artery stenosis. α-blockers may be used as supplementary therapy.
- **Intake of aspirin** 75mg a day is recommended for older hypertensive patients who have:
    - no contraindication to aspirin,
    - blood pressure controlled to < 150/90mm Hg. and any of the following:
        - cardiovascular complications
        - TOD
        - cardiovascular event risk ≥2% per year (20% over 10 years)
        - coronary event risk ≥1.5% per year (15% over 10 years).
- Single daily dosing of drugs (or, when this is not available, twice daily) should be encouraged.

Guidelines for annual blood pressure (BP) review for all patients

MONITOR	INTERVENTION
General ▪ Smoking and alcohol ▪ Diet review ▪ BP ▪ Treatment check	▪ Advise against smoking and alcohol ▪ Advise against salt and fats ▪ Maintain regular blood pressure checks ▪ Adjust where relevant
Feet ▪ Peripheral sensation ▪ Foot pulses ▪ Oedema (swelling)	▪ Readjust medication as appropriate
Eyes ▪ Visual acuity ▪ Fundoscopy ▪ Pallor or mucous membrane	▪ Refer patients with deteriorating vision or serious retinal lesions ▪ Anaemia may indicate chronic renal disease, therefore renal check is needing
Kidneys ▪ Urine protein and electrolytes ▪ Serum creatinine	▪ Improve BP control and avoid long-acting sulfonylurea drugs in patients with renal involvement
Heart ▪ BP ▪ ECG ▪ Glycaemia control ▪ Body weight ▪ Diet ▪ Exercise ▪ Alcohol ▪ Smoking ▪ Symptoms	▪ Improve control, regular BP checks ▪ Refer to the cardiologist if not available at PHC centre ▪ Improve control of blood glucose ▪ Maintain average weight ▪ Low salt and low fat intake ▪ Regular exercise ▪ Moderate alcohol intake ▪ Stop smoking ▪ Refer where appropriate

Protocol for the Management of Hypertension, Jamaica: Annual review for All Patients. Health Services Planning and Integration Division, Ministry of Health, Jamaica, 2005.

Example of treatment scheme algorithm
(For Persons <60 years of age)
Note: Refer to national guidelines if available



Protocol for the Management of Hypertension, Jamaica: Annual review for All Patients. Health Services Planning and Integration Division, Ministry of Health, Jamaica, 2005.

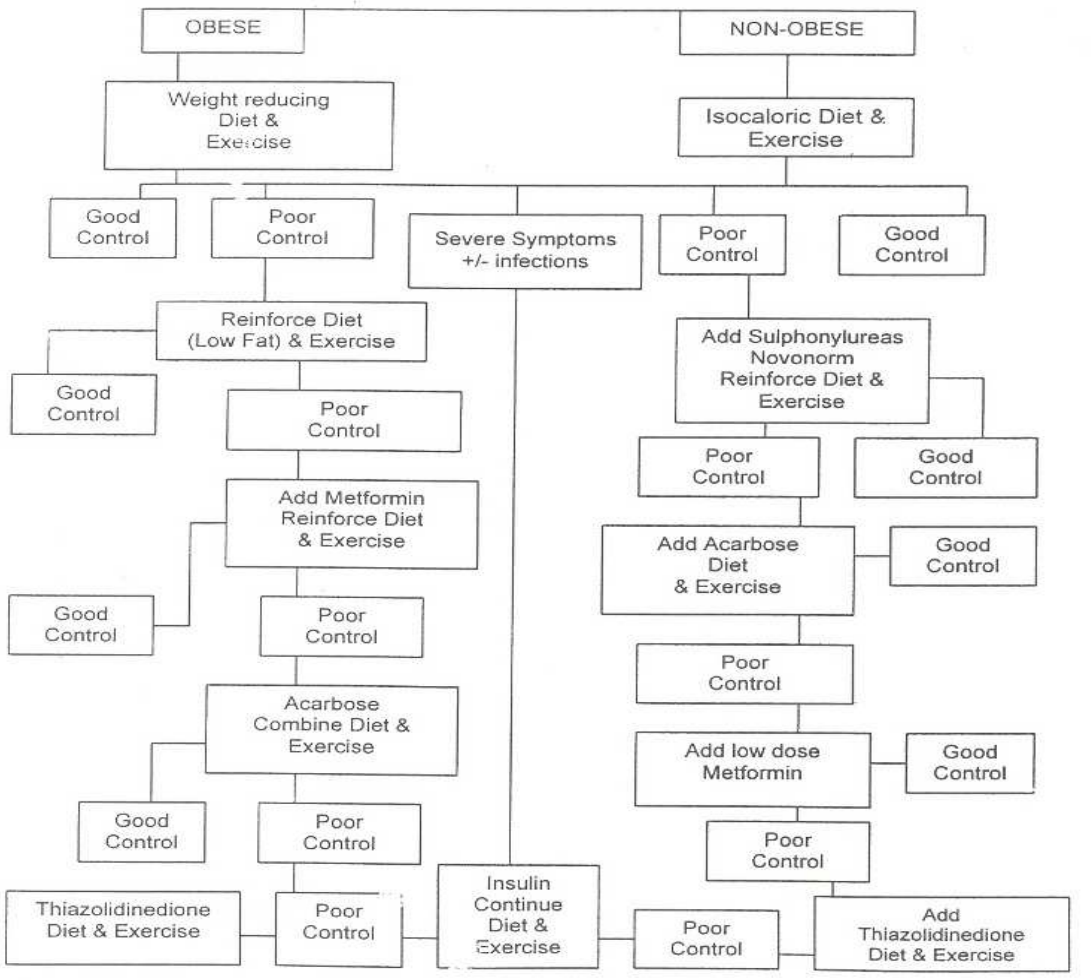
Management of diabetes

Refer to national guidelines for management of diabetes if available. If there are no national guidelines, please refer to the guidelines below.

Guidelines for annual diabetes review for all patients

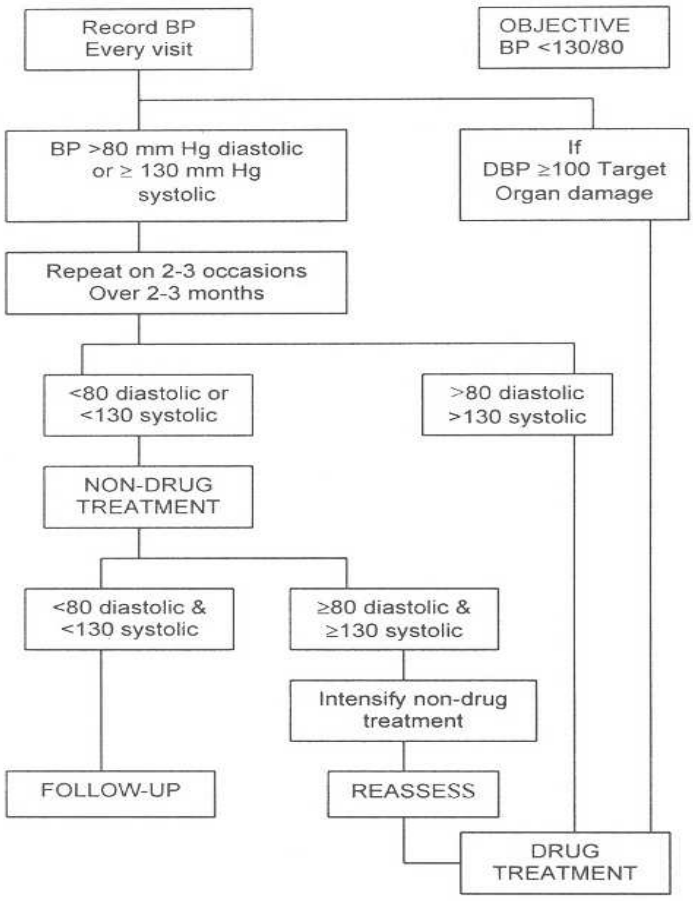
MONITOR	INTERVENTION
General ▪ Smoking and alcohol ▪ Diet review ▪ Blood sugar and glycosylated haemoglobin (Hb $A1_c$) ▪ Treatment check	▪ Advise against smoking and alcohol, restrictions ▪ Refer to diabetes educator/nutritionist/dietitian ▪ Manage according to national protocol guidelines ▪ Adjust where appropriate
Feet ▪ Foot inspection ▪ Peripheral sensation ▪ Foot pulses	▪ Advise on care of feet/refer to chiropodist if available
Eyes ▪ Visual acuity and fundoscopy	▪ Refer patients with deteriorating vision or serious retinal lesions
Kidneys ▪ Urine protein ▪ Serum creatinine	▪ Improve BP and BG control and avoid long-acting sulfonylurea drugs in patients with renal involvement
Heart ▪ Glycaemia control ▪ BP ▪ Body weight ▪ Diet and exercise ▪ Smoking ▪ Alcohol ▪ Symptoms	▪ Improve control of BG ▪ Regular BP checks ▪ Maintain average weight ▪ Consult diabetes educator/nutritionist/dietitian ▪ Stop smoking ▪ Moderate alcohol intake ▪ Refer where appropriate

Stepwise therapeutic management of Type 2 diabetes common to all approaches: diabetes mellitus education, diet and exercise



Source: Protocol for the Management of Diabetes, Jamaica. Stepwise Therapeutic Management of NIDDM Common to all Approaches: Diabetes Mellitus Education, Diet and Exercise. Health Services Planning and Integration Division, Ministry of Health, Jamaica, 2005.

BP management in persons with diabetes



Source: Protocol for the Management of Diabetes, Jamaica. Blood pressure Management in Persons with Diabetes. Health Services Planning and Integration Division, Ministry of Health, Jamaica, 2005.

Complications of diabetes

Blindness, limb amputations and stroke are leading causes of adult disability. Prevent complications, detect them early and treat before major problems develop

MONITOR	INTERVENTION
▪ Fasting BG ▪ Urine glucose every visit	▪ Diet and physical exercise readjustment
▪ Home testing and recording	▪ Assess
▪ Drug compliance	▪ Oral hypoglycemic drugs ▪ Readjustment of insulin
▪ BP every visit	▪ Aim at ≤130/80
▪ Visual symptoms ▪ Fundoscopy	▪ Refer to ophthalmologist
▪ Foot examination ▪ Loss of sensation ▪ Signs of injury ▪ Deformity	▪ Advise on foot care or refer to chiropodist
▪ Test for proteinuria at each visit	▪ Treat hypertension >130/80 ▪ Control BG
▪ Blood urea and creatinine yearly	▪ If elevated assess kidney function
▪ Blood glucose ▪ BP ▪ Body weight ▪ Diet and exercise ▪ Smoking and alcohol	▪ Control BP and BG, reduce weight, increase fitness, stop smoking and allow moderate alcohol consumption only
▪ Glycosylated haemoglobin	▪ Do at least once in 6 months
▪ Weight every visit ▪ Adherence to diet	▪ Prescribed individual diet ▪ Prescribe exercise ▪ Counselling ▪ Refer to diabetes educator/nutritionist/dietician
▪ Activity patterns	
▪ Smoking habits ▪ Drinking habits	

Protocol for the Management of Diabetes, Jamaica. Blindness, limb amputations and stroke are leading causes of adult disability in the Caribbean. prevent complications, detect them early and treat before major problems arise. Health Services Planning and Integration Division, Ministry of Health, Jamaica, 2005.

SECTION III

General Objectives

This section aims to help the PHC centre adapt their administrative procedures to the special needs of older persons and support continuity of care.

Contents:

III.1 Organizing services for an age-friendly PHC centre

This section is primarily applicable to the health centre manager and local policy-makers.

What are the key managerial elements for the success of an age-friendly PHC centre?

The effective implementation of an age-friendly PHC centre system will require political commitment at the national and local levels, including adequate funding to meet the needs of the older population and adequate number of trained staff.
System reorientation of health systems towards continuing comprehensive care and an emphasis on a primary rather than a tertiary approach to care of older persons is needed.
Below, there is a checklist of common operational and managerial barriers that may impact the effective implementation of the Age-friendly Principles in a PHC centre.
Please make an action plan to address any barriers that are relevant to your PHC centre and include all stakeholders. Remember, the entire set of Age-friendly Principles does not need to be implemented at once – choose the principles you can implement and work from there.

Operational and managerial barriers

1. Insufficient operationalization of Age-friendly Principles. Are there measurements or indicators that provide evidence of implementation of the Age-friendly Principles?
2. Lack of, or incomplete information on health needed by the older population. Does the information system include appropriate health indicators for planning and evaluating the health needs of the older population?
3. Absence of explicit responsibility for older people's health services negotiated with the health system as part of the centre's management agreement. Does the management agreement include a budget for specific services to be provided for older adults?
4. Lack of clinical guides and protocols in geriatric preventive medicine including the protocol for the periodic health exam of older adults. Is a periodic health exam with required lab and screening tests guaranteed to older adults?
5. Lack of clinical guidelines, protocols and instrument to detect and address the health needs of older adults. Are clinical guides and protocols developed with the guidance of professionals trained in geriatric care?
6. Excessive focus on vertical problems based on disease rather than on an integrated approach to improve the health in older age. Is quality of care estimated by measuring disease, or health and function?
7. Lack of sustainable finance mechanisms to address the basic needs for essential medicine and nutrition of poor and extreme poor older adults. Are older adults that are unable to purchase their medication or buy a balance meal able to receive appropriate and timely assistance? How is their situation measured in comparison with the situation of other population groups?

8. Lack of effective community networks and health promoters trained to identify and negotiate community resources for older adults. Does the contract with health promoters include the task of watching and promoting for the health of older adults?
9. Ineffective referral systems. Is the PHC centre able to track the effectiveness of their referral system?
10. Inadequate incentives for the primary level to address the health needs of older adults. Are health centres monitored and rewarded for improving the health and function indicators of the older population in their community?
11. Geriatric competences are not developed as part of continuing education of health personnel. Does the centre have explicitly stated the competencies that every health professional working with older adults, need to know? Are there training plans that address those competencies?
12. Lack of monitoring and quality improvement systems focused on outcomes for older adults' health. Does the information system at the Health Centre include monitoring appropriate indicators for quality improvement of care for older adults?

III.2 Patient care coordinators

Introduction

A PHC centre can be very confusing to the older person who may have difficulty navigating the various services, appointments, providers and lines. Not all PHC centres will have a designated care coordinator; however, these functions can be done, in some cases, by trained volunteers. Where a volunteer or care coordinator is not available, the list of key functions should be reviewed and critical functions should be assigned to each staff member.

Functions of patient care coordinator

- Coordinating services within the PHC centre
- Coordinating of internal and external referrals.
- Working in coordination with clinical team.

Key functions:

1. Monitor that patients keep appointments
   a. Create follow-up system for “no shows” – patients who do not keep appointment.
   b. When contacting patient home, do not disclose patient information other than appointment information
2. Ensure correct patient flow within the clinic e.g. between registration, consultation, procedure room, pharmacy, cashier etc.
   a. Arrange wheelchair or other mobility aids and/or escort when available as needed.
3. Ensure next appointment is at a medically appropriate date and time and when patient’s transport and/or caregiver are available.
   a. Advocate for patient when there are clinic schedule constraints
4. For patients who use transport, coordinate with transport service.
5. Ensure that medical/social referrals that are affordable to patient are made and followed up.
   a. Advocate for referral subsidized rate for patients e.g. subsidized rate at specialist clinic.
   b. Explain purpose, charge and what to expect from referral to patient e.g. eye clinic will make recommendation on need for cataract surgery.
6. Obtain and communicate patient feedback on clinic services in coordination with patient ombudsman where available e.g. create channel of communication for patient to express concerns not expressed during consultation e.g. insufficient time for patient to ask questions about medication.

III.3 Age-friendly appointments
This section is primarily applicable to clerical and nursing staff. Is this format followed in all the tools e.g. introduction, target staff, etc.

1. Rationale
Key features of an appointment system that meets older people's needs:
a. shorter waiting times,
b. simple management systems,
c. continuity of PHC provider,
d. appointment times of appropriate length.
Investing in a well-designed appointment system is beneficial to both patients and PHC providers for the following reasons.

For patients:
- Higher attendance rates: patients are less likely to forget appointments or refuse to attend as condition improves.
- Increase of patient's satisfaction: increased trust in the system.
- Positive attitudes towards staff: enhances relationships and trust towards staff.
- Work for better clinical outcomes: increased compliance with appointments is an indicator of compliance in other health care aspects: patients can be seen before their conditions deteriorate.

For PHC providers:
- Better management of resources: improved compliance is more financially efficient; better time management possible: increase staff satisfaction; decreased pressure on practitioners; better delivery of health care services.
- Allows PHC centres to adapt to demand: make changes to adapt to demand e.g. hiring temporary staff; attempt to match capacity to demand and make contingency plans for unwanted situations e.g. local epidemics, sick leave.

2. Content of section
PHC centres are variable and dynamic entities. There are variations among countries, urban and rural, public or private, large or small – some are even mobile. It is unrealistic to expect all PHC centres to apply a single age-friendly template for appointment systems which will suit the older population worldwide. The key lies within individual practitioners who know best the needs of their patients.
This section proposes an age-friendly appointment system that PHC centres can consider implementing in order to improve their own systems, which include:

- A suggested flowchart (**III.3.2**)
- Special considerations for making an appointment (**III.3.3**)
- Checklist of task and skills for age-friendly appointments (**III.3.4**)
- Reminders and reinforcements (**III.3.5**)

- Before and after the appointment (**III.3.6**)
- Specific consulting times (**III.3.7**)
- Age-friendly follow-up system (**III.3.8**)

III.3.1 Suggested flowchart summarizing the proposed age-friendly appointment system

The age-friendly appointment system requires a streamlined approach to appointment making:

- Patient initiation by making the appointment.
- Recording the appointment (on the healthcare centre's system and on the patient's appointment card, table 1 shows an example of an appointment card.
- Reminders.
- Following on from the initial appointment with discharge, further appointment or follow-up for patients who did not attend.

Table 1: Sample of an appointment card as a memory aid

APPOINTMENT CARD OF:

Patient name:
Identification number:
Date of birth: Address:
Contact details:
Next-of-kin/ Carer's name:

Name of healthcare centre

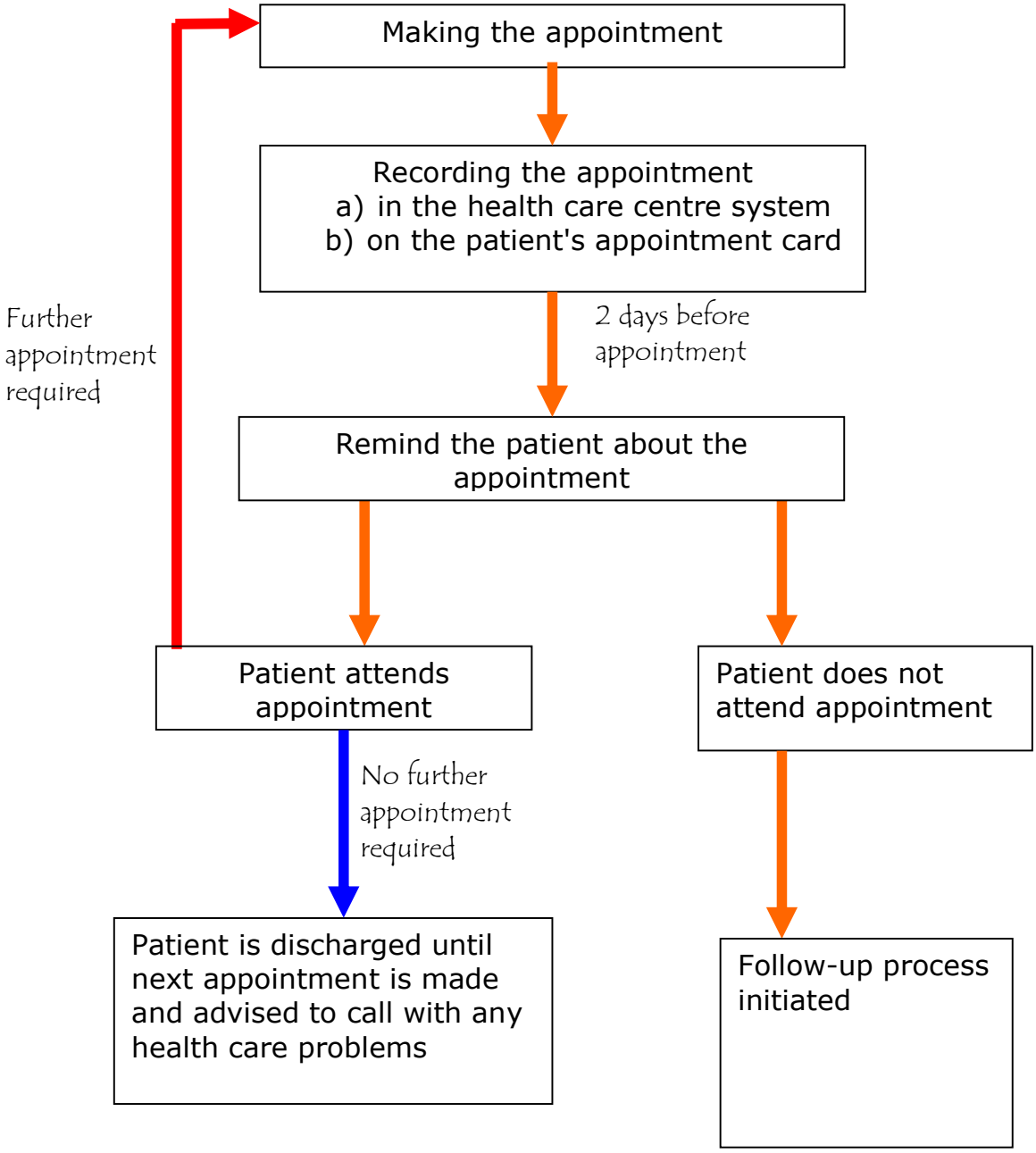
Address of healthcare centre
Contact details

My next appointment is:

Date	Time	Practitioner

**Please be at the clinic on time for your appointment!*
Thank you for your cooperation.
**Please bring this card with you when you come for your appointment.*

Suggested flowchart summarizing the appointment system



III.3.2 Special considerations for making an appointment

There are specific barriers that older people face in making an appointment at the PHC centre. A friendly reception and good contact with staff should be emphasized.

1. Potential physical barriers to communication
   - Hearing impairments
     - ensure that patients have appropriate aids with them
     - speak clearly face-to-face with the patient
   - Visual impairments
     - ensure that the patient has appropriate aids with them
     - use direct lighting
     - verbalise instructions and appointment times in addition to writing them down
2. Staff attitude
   - Smile.
   - The greeting should be professional and welcoming.
   - Listen to patient's requests.
   - Patients may prefer not to be asked what is wrong in public, or over the phone or within earshot of other people – always protect patient's confidentiality.
3. Gender issues
   - Ask if the patient would prefer to see a male or female practitioner – if this is an option.
4. Language barriers
   - Arrange for a provider who speaks same language if possible. If not, arrange for translation.
   - Use appropriate words.
   - Do not use incomprehensible terms and medical jargon.
5. Waiting time
   - Try to give an estimate of the waiting time.
6. Length of appointment times
   - Develop a range of types of appointment times tied to visit type e.g. geriatric assessment, new patient, follow-up visit, procedure, etc.
   - For follow-up patients, the health provider designates the type of follow-up appointment needed.
   - For new patients ask: how soon the patient needs to see the doctor and for how long e.g. "Will 15 minutes be enough?"
   - If unsure about how long such consultations normally take, consult the practitioner who will be attending them.
7. Continuity of provider
   - Try to make appointment with same doctor.
   - Provider continuity is related to higher levels of patient trust, satisfaction and enablement.

8. Documentation
    - Inform patients of what they should be bringing with them on next visit e.g. documentation, previous results, ALL current medications, hospital discharge summary, appointment cards for other clinics, specialist appointments, etc.
9. Problems with memory
    - Repeat appointments to patients after making them: day, date, time and name of practitioner they will be seeing.
    - Offer an appointment card.
    - Obtain details of an alternative person to contact e.g. family member to remind them of their appointment or of any other information.

III.3.3 Checklist of tasks and skills for age-friendly appointments

Task	Skills
1.Greet the patient	✓ Establishing a relationship ✓ Speaking the patient's language
2.Ask for patient details : • Name • Identification number • Date of birth • Address	✓ Clarifying information
3.Ascertain patient request	✓ Listening
4. When would the patient like to be seen? • Date • Time	✓ Listening ✓ Probing
5. How long does the patient feel they need with the doctor?	✓ Ensuring appointment time is not too short
6. Would the patient prefer to see: • A particular doctor • A male/ female doctor	✓ Ensuring continuity of care ✓ Considering gender sensitivity
7.Summarize: • Time and date of appointment • Name of practitioner they will be seeing • The length of the appointment • What they should bring with them • Importance of punctuality • Estimated wait time (if any)	✓ Providing information
8.Provide appointment card	✓ Supporting memory

III.3.4 Reminders and reinforcements

Reminders from PHC staff have been shown to be an effective way of increasing the number of patients keeping their appointments. An effective system can ensure that older patients are contacted 1- 2 days ahead of their scheduled appointments.
Details of an alternative person to contact should be obtained when the patient first makes an appointment – refer to section III.3.3. Patients should be asked whether they prefer the PHC centre to get in touch with this alternative contact or not, for the purposes of appointment reminders.

Reminder System

1. Check the records for the appointments a few days ahead, allowing 2 to 3 days extra if reminders are being posted. All older persons can be identified from the list.
2. Compile a list of all the patients identified, along with their contact details.
3. Communications to patients can be performed at the end of each working day by the preferred method e.g. post, telephone or e-mail.

III.3.5 Before and after the appointment

When the patient arrives for their appointment:

- Direct the patient to the reception desk.
- Greet the patient.
- Maintain a friendly approach and eye contact – this is associated with positive patient experiences in health care.
- Ask for the appointment card.
- Confirm it is the correct patient (check address).
- Make an acknowledgement of the patient's arrival in the PHC centre's system records and on the patient's appointment card.
- Give an estimate of the waiting time.
- Ask the patient to take a seat in the waiting area.
- Prepare the patient's notes for their consultation with the practitioner.

When the patient finishes the consultation:

- Thank them for attending.
- The patient should be handed a slip by the practitioner with information on whether they should book a further appointment or if they have been discharged until further notice.
- Refer the patient back to the reception desk.
- The slip should be handed in there.
- If a further appointment is required, start a new appointment and fill appointment card.
- The slip should be kept in the patient's notes as a reference.

III.3.6 Specific consulting times

Age-friendly consultation hours

Age-friendly consultation hours relate to specific consulting times in a day or week dedicated to the older persons' needs. They will be the main users of these sessions.
In some cultures and circumstances, older persons deem dedicated consulting hours set aside for them as preferable to consulting hours that go together with other age groups. Special consultation hours may be perceived by older persons as being safer and more comfortable. These hours enable the practitioners to focus more on their needs as a group and other services such as transport or allied health facilities to be better coordinate around it, if older patients come on the same day.
The age-friendly consulting hours need not be standard to every PHC centre. They may vary to suit to the workload of the practitioner; therefore, assuming that there is more than one practitioner at the centre, other groups of patients can still be seen at the same time. This way, the continuity of practitioner is also maintained.

Age-friendly consultation hours: where to start?

1. Estimate weekly demand: record the daily demand for one week for each practitioner.
2. Analyse demand: analyse the records.
3. Choose a day/session for the age-friendly consulting hours – if deemed appropriate.
There may be clear trends in the attendance of older persons that can be the basis for picking a day. Otherwise, clinics can be run in the hours when the healthcare centre is less busy.
4. Inform patients: Once a date has been selected to start, keep patients informed by displaying notices about the new system, handing out brochures and constant reminders from staff.
**Please refer to section III? on age-friendly signage for guidelines on how to display information in an age-friendly way.*

III.3.7 Follow-up system

Following up patients who do not attend their appointments can be done in a simple, systematic manner. All communications, including sending out patient reminders to attend (refer to section III?) can be assigned to the end of the day.

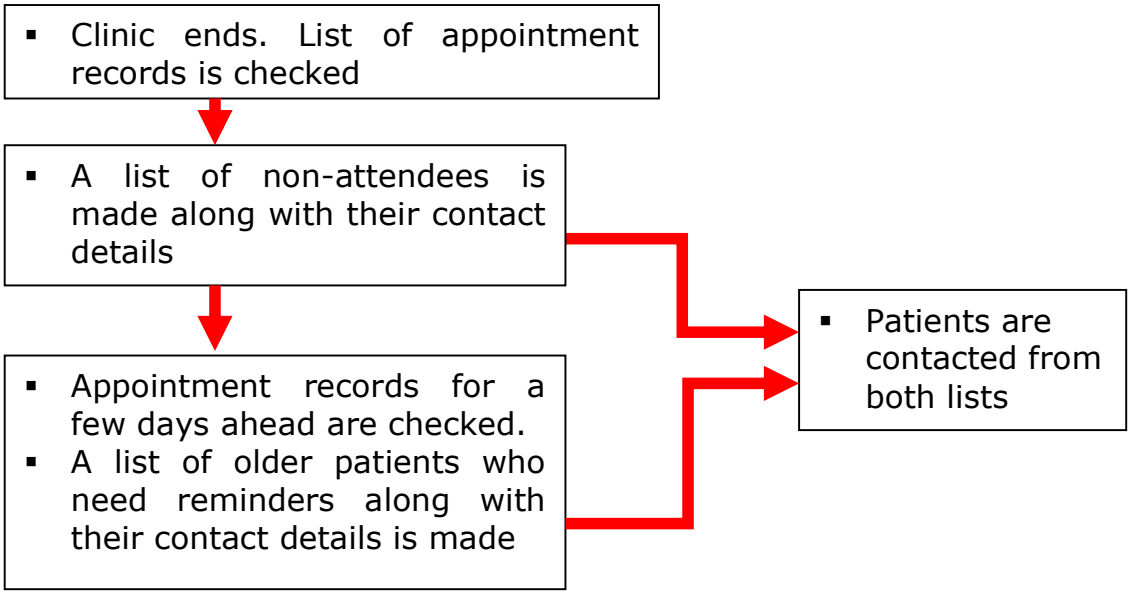
Analysis of “no-shows”

1. Analyse patterns of patients who do not keep appointments
    a. Is it a certain day, time of day?
    b. Is it a certain provider?
    c. Are there common patient characteristics?
        i. Difficulty with transport.
        ii. Difficulty with paying for consultations, medications, diagnostic procedures, etc.
        iii. Language, ethnicity, gender, with or without caregiver.
        iv. Diagnoses.
2. Identify patterns, take corrective actions and monitor results.

Follow-up system

1. At the end of each day, refer to the day's appointment records. Identify from the records all the patients who have failed to attend their appointments that day.
2. Make a list of those patients and their contact details. These patients can then be contacted via the preferred method (telephone, post or alternative methods) along with the patients who need to be reminded of their appointments.

Suggested flowchart summarizing the communication for follow up system



III.4 Directory for community-based services for older people

Older people have multiple medical and social needs that may be identified during consultations with PHC staff. It is, however, often difficult for older people to know where to go either for help or to know the range of services provided, criteria and charges. The PHC centre plays an important role in educating older people and their caregivers on available services and making referrals.

Check if your PHC centre has a complete and updated list of community services for older adults. If not, we suggest you contact your local agencies for such a directory or, if none is available, develop a directory of local community-based services for older people. Remember that services change so the directory needs to be kept up-to-date. It is useful to create a data base sorted by type of service provided e.g. day care, financial assistance. Print the directory in a form in which pages can be added and removed as services change.

The following is an example of key information that the directory should contain:

Name of organization	
Address	
Telephone	
Fax	
E-mail	
Website	
Contact person with phone number and e-mail	
Range of services provided	
Criteria	
Charges	
Notes/Comments	
Date updated	

III.5 Referral system between the PHC centre and the hospital

The following information should be included in all referrals to other hospitals, specialists or other health care providers

- From: Referring doctor name_____
- To:_____
- Date:_____
- Re:_____
- Medical diagnoses: _____
- Present Medications: _____
- Reason for referral:
- Signature: _____.

The following form is an example of the reply from the provider to whom you refer

- Clinic name
- Clinic address
- Clinic phone and email contact

To: Doctor concerned Date:

Patient's label

The above-mentioned is under the care of XXX clinic that provides community-based primary geriatric care, in collaboration with aged-care agencies in the community.

Your update on the outcome of today's visit is invaluable to us in the care of this older person.

Please feel free to speak to me if you need any information on this patient for your clinical management.

Yours sincerely

SPECIALIST'S REPLY (PLEASE COMPLETE AND RETURN TO THE PATIENT ON THE SAME DAY AS THE VISIT)

Name: Identification number:

_____ _____ _____

Signature of Doctor Name of Doctor Clinic's Stamp

Source: Form provided by the TSAO Foundation, Singapore

III.6 Privacy guidelines for confidential examinations and consultations

When the examination and consultation are conducted in a private environment with the assurance of confidentiality, patients and caregivers are more comfortable and tend to be more forthcoming with medical and social information. Some older people are especially uncomfortable discussing bodily functions, family or social problems, or disrobing. They must be assured that their health and social information is shared only with their consent even to family members. This is of special concern when elder abuse is suspected.
General practice on privacy and usual and locally legislated guidelines for maintenance of confidentiality of patient information should be followed with particular attention to the following:

1. **Physical privacy**
   - Shield patient from public view during exam.
     - If the exam room has a door, keep it closed during consult and exam.
     - If not, provide curtain or screen whenever possible.
   - Uncover only part of body being examined.
   - Provide sheet or other covering.
   - Conduct consult out of hearing of others – especially if provider or patient needs to speak loudly due to hearing deficit.
   - If caregiver or translator is present, ask them to stand outside of patient screen/curtain.

2. **Confidentiality during consultation**
   - Ask patient consent for family/accompanying person (friend or paid assistant) to be present during interview/exam.
   - Create opportunity for patient to see practitioner alone as desired – be attuned to discomfort in answering certain questions and offer to see them alone.
   - Request patient permission for translator to be in room during exam/interview.
   - Disclose only information to which patient has given consent even to family members/caregivers.
   - If needed to obtain comprehensive picture, interview patients and caregivers separately with patient's consent.
   - For patients with cognitive impairment and inability to provide history or give consent for sharing of information, disclose only necessary information on a need to know basis in a respectful manner to patient.
   - Refrain from discussing patient specific information in the halls or lifts.

SECTION IV

General Objectives

Global ageing has resulted in older people living longer with higher risk for chronic conditions that often lead to disabilities. The commonest disabilities are: reduced vision, hearing and mobility. Many older persons require a wheelchair for mobility, either temporarily or permanently. Older people, whether disabled or non-disabled need PHC facilities for their health care especially in developing countries. These PHC centres should facilitate an environment where older people can move around independently, actively, safely and securely.

The following services are also essential for PHC centres for older people:

- accessible transport
- assistive devices – mostly wheelchairs
- personal assistance

This section includes resources on how to make the physical environment of a PHC centre more age-friendly.

Contents:

IV.1 Universal design – design for an user-friendly PHC centre

IV.1.1 The Principles of Universal Design

The principles of universal design are presented in the following format:

- name of the principle,
- definition of the principle,
- brief description of the principle's primary directive for design,
- Guidelines – a list of the key elements that should be present in an age-friendly design.

Note: all guidelines may not be relevant to all designs.

PRINCIPLE 1: Equitable use

The design is useful and marketable to people with diverse abilities.

Guidelines:

a. Provide the same means of use for all users; identical whenever possible, equivalent when not.
b. Avoid segregating or stigmatizing any users.
c. Provisions for privacy, security, and safety should be equally available to all users.
d. Make the design appealing to all users.

PRINCIPLE 2: Flexibility in use

The design accommodates a wide range of individual preferences and abilities.

Guidelines:

a. Provide a choice in methods of use.
b. Accommodate right- or left-handed access and use.
c. Facilitate the user's accuracy and precision.
d. Provide adaptability to the user's pace.

PRINCIPLE 3: Simple and intuitive use

Use of the design is easy to understand, regardless of the user's experience, knowledge, language skills, or current concentration level.

Guidelines:

a. Eliminate unnecessary complexity.
b. Be consistent with user expectations and intuition.
c. Accommodate a wide range of literacy and language skills.
d. Arrange information consistent with its importance.
e. Provide effective prompting and feedback during and after task completion.

PRINCIPLE 4: Perceptible information

The design communicates necessary information effectively to the user, regardless of ambient conditions or the user's sensory abilities.

Guidelines:

a. Use different modes (pictorial, verbal, tactile) for redundant presentation of essential information.

b. Provide adequate contrast between essential information and its surroundings.
c. Maximize "legibility" of essential information.
d. Differentiate elements in ways that can be described e.g. make it easy to give instructions or directions.
e. Provide compatibility with a variety of techniques or devices used by people with sensory limitations.

PRINCIPLE 5: Tolerance for error
The design minimizes hazards and the adverse consequences of accidental or unintended actions.
Guidelines:

a. Arrange elements to minimize hazards and errors.
b. Provide warnings of hazards and errors.
c. Provide fail safe features.
d. Discourage unconscious action in tasks that require vigilance.

PRINCIPLE 6: Low physical effort
The design can be used efficiently and comfortably and with a minimum of fatigue.
Guidelines:

a. **Allow** user to maintain a neutral body position.
b. Use reasonable operating forces.
c. Minimize repetitive actions.
d. Minimize sustained physical effort.

PRINCIPLE 7: Size and space for approach and use
Appropriate size and space is provided for approach, reach, manipulation, and use regardless of user's body size, posture, or mobility.
Guidelines:

a. Provide a clear line of sight to important elements for any seated or standing user.
b. Make reach to all components comfortable for any seated or standing user.
c. Accommodate variations in hand and grip size.
d. Provide adequate space for the use of assistive devices or personal assistance.

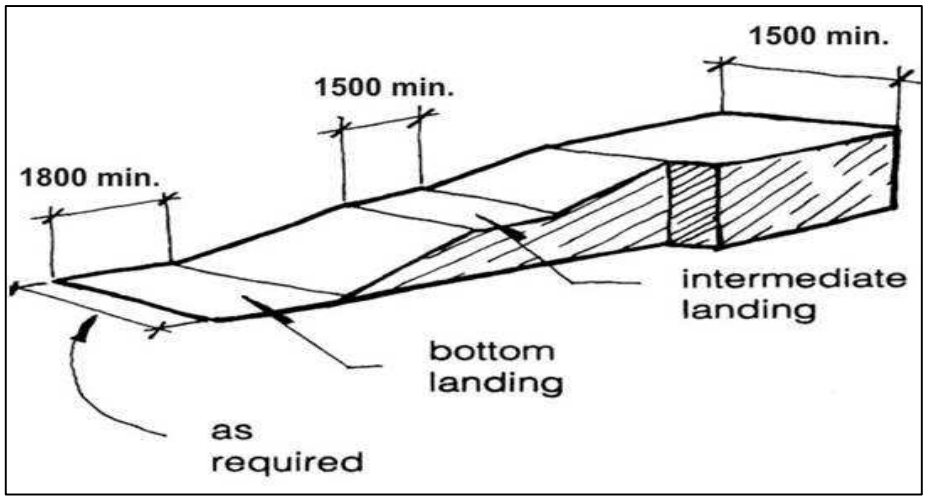
Please note that the Principles of Universal Design address only universally usable design, while the practice of design involves more than consideration for usability. Designers must also incorporate other considerations such as economic, engineering, cultural, gender, and environmental concerns in their design processes. These principles offer designers guidance to better integrate features that meet the needs of as many users as possible.

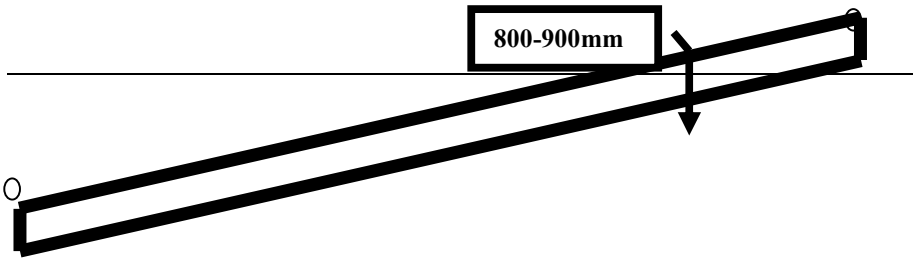
IV.1.2 Design considerations (14-16)

Ramps

If the entrance has steps it also needs to have a ramp. The ramp needs the following features:

- Gentle slope (1:12 minimum - 1:14 or 1:16 are much better) which means for 10 mm height to cover, one needs to have 120 mm long slope.
- Landings (every 750 mm of vertical rise).
- Width (1200 mm or more).
- Surfaces (ramp + landing) should be slip resistant
- Hand rails (preferably at two layers) on the side at the height of 800-900 mm above the floor level at top and 300-400 mm at bottom

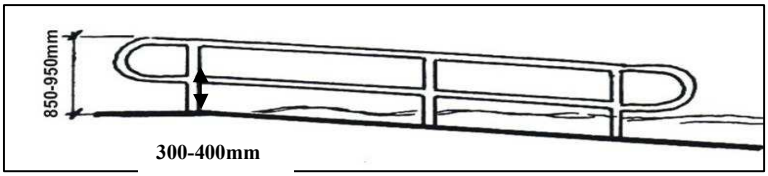




Handrails or grab bars

It helps person to walk/move around safely and independently. Ideally, it should be of two layers. Spin offs – it protects the wall especially the painting part. Common features are as follows:

- Preferably of steel pipe (GI) circular in section with a diameter of 45-50mm; at least 45mm clear of the surface to which they are attached.
- Upper one – both sides at a height of 850mm-900mm.
- Lower one – both sides at a height of 300mm-400mm.
- Both ends to be rounded and grouted.
- Extend 300mm beyond top and bottom of ramp and stairs.
- Color of the handrail needs to be contrast to the wall.



Floor plans

The most important areas to make an optimum use of PHC facilities. Rooms should be organized in such a manner that it requires an older person to access the service without much stress and moving around. Some common features are:

- Reception counter near the entrance and easily identifiable.
- Sitting arrangements needs to be comfortable enough.
- Floor needs to be non-slippery and well maintained.
- Level differences should be beveled.
- Furniture and fittings needs to be well organized to reduce possible fall or injuries.
- Corridors should have an unobstructed width of 1200-1500mm.
- Eating place is accessible and easy to reach.
- Rooms and corridors have enough light and ventilation.

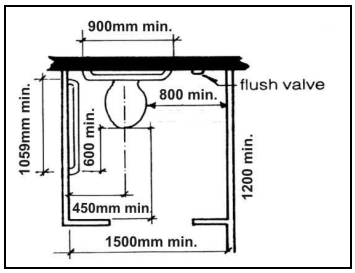
Doors

The doors need to be wide enough without any threshold to ensure easy movement of everyone. Some common features are:

- Doors to be with a clear opening of 900mm.
- Preferably with D-handles of circular section.
- Door color needs to be contrast with the surrounding wall.
- Preferably sliding should not be too heavy – easy to operate.

Toilets

One of the most important areas of any PHC centre but often neglected. Pay special attention to ensure that it is roomy and toilet doors are nearly as big as other doors. Some common features:



- Door preferably sliding with a clear opening of 900mm.
- Slip resistant flooring.
- With a horizontal pull bar.
- Have a back support.
- Grab bars at the rear and the adjacent wall – preferably folding.
- On the transfer side better to have swing up grab bars.
- Easy to use fittings and wash facilities.

Steps, stairs and lift

Usually most of the PHC facilities have one ground floor, but in case there is two or more, then stairs with handrails, steps and lift have to be provided. Some common features are:

- Uniform risers: 150 mm and tread: 300 mm.
- The maximum height of a flight between landings will be1200mm.
- Landing should be 1200mm deep, clear of any door swing.
- The steps should have an unobstructed width of at least 1200mm.
- Stair edges need to have bright contrasting colors.
- Accessible path leading to the lift/elevator.
- Clear door opening width more than 900 mm.
- Needs to be easily identifiable – contrast colour to the surrounding wall.
- Friendly to disabled persons.

Access audit

Before occupying the building, do a simple evaluation of the facilities with a checklist which is commonly known as "access audit" (please see page ?). It allows you to check how well a PHC centre performs in terms of access and ease of use by potential users including older people. The evaluation gives a snapshot of a building and can be used to highlight areas for improvements. Access audits can guide you to check the age friendliness in a systematic way and can also help in prioritizing either renovation or alteration of existing infrastructure.

Conclusion

The demographic structure is rapidly changing because the older population is increasing all over the world. Changes in family lifestyles show that more older people live on their own. They will need health-care support and assistance from PHC centres and other health facilities. Many of them will use these facilities more frequently than now. It is important to think about the future and start to plan for the changing of the demographic situation. The care of older people will be tomorrow’s challenge. A barrier-free PHC will be a milestone in that direction.

IV.1.3 PHC access audit checklist

This audit may be conducted annually by a trained nurse or PHC worker in order to plan improving actions for the coming year.

Name of the PHC: Date of audit: ___/___/_____

Name of the head of PHC:

Address:

A	**ACCESSIBILITY FROM PUBLIC TRANSPORTATION**	
	Is the centre served by public transportation ?	Yes/No
	Is the closer station less than 50 meters from the centre's entrance ?	Yes/No
	If No, how far is it ?	Distance:
B	**ENTRANCE**	
1	**Before main entrance**	
	Are there steps?	Yes/No How many?
	Do the steps have railings or grab bars?	Yes/No one/both sides
	Is there a ramp? Does the ramp have railings or grab bars?	Yes/No
	Does it have a gentle slope (1:10/12/14/16)	Ratio:
2	**Entrance**	
	Is the width of the entrance greater than or equal to 900 mm?	Yes/No Width:
	Type of door	Swing/Sliding

	Is the entrance accessible to wheelchair-users?	Yes/No
	Is the entrance landing area free of obstacles?	Yes/No
	Are emergency exits easily identifiable and accessible?	Yes/No
C	**PARKING**	
	Is there a dedicated parking lot for the disabled/older person near the main entrance?	Yes/No
	Size of parking lot.(Min. Size: 4800 mm x 3600 mm)	Dimension:
D	**LIFT – in case PHC centre has more than one floor**	
	Is the lift accessible to every floor?	Yes/No
	Is there an accessible path leading to the lift/elevator?	Yes/No
	Is the elevator door easy to identify?	Yes/No
	Is the clear door opening width more than 900 mm?	Yes/No Width:
E	**PUBLIC TELEPHONE**	
	Is there a public telephone near the entrance or waiting hall?	Yes/No
F	**FLOOR PLANS**	
	Is the reception counter near the entrance and easily identifiable?	Yes/No
	Are the rooms have been organized in logical manner so the user will be less stressed?	Yes/No
	Are all doors width greater than or equal to 900 mm?	Yes/No
	Are the sitting arrangements comfortable enough for	Yes/No

	the user?	
	Is the floor non-slippery and well maintained?	Yes/No
	Are the furniture and fittings well organized to reduce possible falls or injuries?	Yes/No
	Are staff supportive to the clients?	Yes/No
	Is there spare wheelchairs available?	Yes/No
	Are the rooms and corridors have enough light and ventilation?	Yes/No
G	**TOILETS**	
	Are toilets near the waiting hall?	Yes/No
	Is the entrance to the public toilet accessible to wheelchair users?	Yes/No
	Is there at least one accessible shower?	Yes/No
	Are there grab bars around the toilet?	Yes/No
	Are all the fittings easy to use and are of appropriate height?	Yes/No
	Is there any alarm system in case of emergency?	Yes/No
H	**EATING PLACE**	
	Is there an eating outlet located within the building?	Yes/No
	Is the eating outlet generally accessible – easy to reach?	Yes/No
	Is the water tap and basin easily accessible?	Yes/No
I	**STAIRCASE – in case PHC has more than one floor**	

	Are the steps friendly to elderly people – are these uniform and clearly identifiable?	Yes/No
	Are there handrails or grab bars ?	Yes/No
	Are the handrails or grab bars continuous?	Yes/No
	Is the height of hand rails or grab bars between 800and 900 mm from the floor?	Actual height:
J	**CORRIDORS**	
	Does the corridor have the minimum unobstructed width for wheelchair users?	Yes/No
	Is the corridor pathway obstruction-free?	Yes/No
	Are there handrails or grab bars?	Yes/No
	Remarks/Suggestions: Name of the team leader and signature	

IV.2 Guidelines for inside and outside signage for a PHC centre

IV.2.1 The principles of signage

Designing signage:

1. Characters and backgrounds of signs should be of an eggshell, matte or other non-glare finish.
2. Characters and symbols must contrast with their background – light background with dark letters or dark background with light letters.
3. Letters should be large enough and not overcrowded so that those from a distance can read them – use as few words and numerals as possible.
4. The visual display should be simple and easy to understand. Use only key words and phrases, simple shapes and lines, and a few well-chosen words. Do not crowd the display.
5. Use pictures whenever possible, preferably pictures that are common and familiar to the community in order to increase recognition for those with cognitive impairment.
6. Use colour as often as possible to increase the effectiveness of a picture and emphasize key points. Colour combinations or contrasts are important – the colours that attract most attention are red and blue.
7. When making signs by hand, use a heavy black felt-tip pen on a white, off-white, or light yellow non-glossy background.
8. Use non-glare glass for building directories mounted behind glass.
9. Provide Braille signage in line with local regulations.
10. Pay attention to the "tone" of the sign messages. Messages should be welcoming and cordial, inserting "please" and "thank you for your cooperation" where appropriate.

Placement of signage:

1. Place all signs at eye level, with large lettering.
2. Outside the building to identify buildings with accessible facilities.
3. At main lobbies or main traffic routes to indicate location of centre.
4. At specific areas of the building that are accessible and not only at specially designed toilets.
5. Develop a consistent room numbering system that is easy for the user to understand, and consider adding the floor number to reinforce locations in multi-floor buildings.
6. Directional signs should be displayed at places where there is a change of direction
7. Mark emergency exits clearly.

Size of letters in signage:

As a general rule it is suggested that the letter height should be at least 1% of the distance at which the message will usually be read, subject to a minimum height of 22mm. Table 1 below gives a general appreciation of this rule:

Table 1: Size of letters in signage according to the distance at which the message is to be red.

Viewing distance	Symbol size
3-6m	40mm
6-9m	60mm
9-12m	80mm
12-15m	100mm
15-18m	120mm
18-24m	160mm
24-30m	200mm
30-36m	240mm
36-48m	320mm
48-60m	400mm
60-72m	480mm
72-90m	600mm

Source: Improving Transportation Information: Design Guidelines for Making Travel More Accessible, Transport Canada, Montreal, Canada, 1996

Identifying personnel:

1. PHC centre staff should be easily identifiable using name badges and name boards.
   - Name badges should be large letters on contrasting background and should state name and job title.
   - Name badges can be colour-coded e.g. nurses green, doctors blue etc so that people who cannot read can identify staff categories with their job titles.
2. Name of boards should include all staff's names and job titles – including the receptionist – on duty that day.
3. If possible, name of doctor/nurse on duty that day should be displayed on consultation room door.
4. Staff should initiate an introduction to a patient who is blind, deaf-blind, or visually impaired by addressing the patient's name. They should always identify themselves by name and function and the reason why they are there as name badges or uniforms may not be seen by a visually impaired patient.

IV.2.2 PHC signage audit checklist

This audit may be conducted annually by a trained nurse or PHC worker in order to plan improving actions for the coming next year.

Name of the PHC centre: Date of audit: ___/___/_____

Name of the head of PHC:

Address:

Characters and backgrounds of signs are of an eggshell, matte or other non-glare finish.	Yes / No
Characters and symbols do contrast with their background – light background with dark letters or dark background with light letters.	Yes / No
The visual display is simple and easy to understand: only key words and phrases, simple shapes and lines, and a few well-chosen words.	Yes / No
Common and familiar pictures to the community are used whenever possible – in order to increase recognition for those with cognitive impairment.	Yes / No
Color are used as often as possible to increase the effectiveness of a picture and emphasize key points	Yes / No
When making signs by hand, heavy black felt-tip pen on a white, off-white, or light yellow, non-glossy background is used	Yes / No
Non-glare glass for building directories mounted behind glass is used.	Yes / No
Braille signage in line with local regulations is provided	Yes / No
The tone of the sign messages is welcoming and cordial	Yes / No

A	**DESIGNING SIGNAGE**
B	**PLACEMENT OF SIGNAGE**

	All signs are placed at eye level	Yes / No
	There are signs outside the building to identify buildings with accessible facilities	Yes / No
	There are signs at main lobbies or main traffic routes to indicate location of centre	Yes / No
	There are signs at specific areas of the building that are accessible and, not only, at specially designed toilets	Yes / No
	A consistent room numbering system – with added floor number in multi-floor buildings – that is easy for the user to understand is provided	Yes / No
	Directional signs are displayed at places where there is a change of direction	Yes / No
	Emergency exits are clearly marked	Yes / No
C	**SIZE OF LETTERS IN SIGNAGE**	
	Sizes of letters of all signs follow indications provided in table 1, page?	Yes / No
D	**IDENTIFYING PERSONNEL**	
	PHC centre staff are easily identifiable using name badges and name boards**	Yes / No
	There is a name board that includes all staff with job title on duty – including receptionist.***	Yes / No
	Staff initiates an introduction to a patient who is blind, deaf-blind, or visually impaired by addressing the patient's name. Staff have to always identify themselves by name and function and the reason why they are there, as name badges or uniforms may not be seen by a visually impaired patient	Yes / No
	Remarks/Suggestions:	

	Name of the team leader and signature

* Cf. See section on Size of letters in signage, page?

** Name badges should be large letters on contrasting background and state name and job title. Badges can be colour-coded e.g. nurses green, doctors blue, etc. so that people who cannot read can identify staff categories.

*** If possible, name of doctor/nurse on duty that day should be displayed on consultation room door.

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