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OPERATIONAL GUIDELINES

ELDERLY CARE at HEALTH AND WELLNESS CENTRES

February 2021



Ministry of Health and Family Welfare
Government of India

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Background and Rationale:

- i) Population ageing is inevitable with socio-economic development. Declining fertility and increase in survival at older ages has resulted in the proportion of older people (60 years and above) in general population increasing substantially within a relatively short period of time. India recorded a significant improvement in life expectancy at birth, which was 47 years in 1969, growing to 60 years in 1994 and 69 years in 2019¹. The share of population of elderly was 8% in 2015 i.e. 106 million (10 crores plus) across the nation, making India the second largest global population of elderly citizens. Further, it has been projected that by 2050 the elderly population will increase to 19%²
- ii) As the elderly population continues to grow, elderly dependency ratio will rise dramatically from 0.12 to 0.31. Gender disparity has also been reported with 50% of women aged 75 years and older report difficulty with at least one Activity of Daily. Life (ADL) compared to only 24% of men, adding the focus towards female elderly care³.
- iii) Elderly populations have varying and complex social and health-care needs. For example, while dementia maybe addressed with health inputs, the social and financial insecurities that may co-exist require inputs from the social welfare and finance sectors. A multidisciplinary and multisectoral approach, comprising professionals and general staff from several relevant sectors, should be considered as the key mode of care delivery for the elderly populations.
- iv) National Policy on Older Person (NPOP)-1999 formulated by Ministry of Social Justice and Empowerment, seeks to assure older persons that their concerns are national concerns and they will not live unprotected, ignored or marginalized. The goal of the National Policy is the well-being of older persons. It aims to strengthen their legitimate place in society and help older persons to live the last phase of their life with purpose, dignity and peace. One of the principle areas of intervention in the NPOP 1999 is Health Care & Nutrition. India was also among the first countries to ratify UN Convention on the Rights of Persons with Disabilities (UNCRPD) which have come into effect from 3rd May, 2008. As per the provisions under Article 25 of UNCRPD, the health services needed by persons with disabilities should be provided as close to people's own communities, including in rural areas.
- v) Ministry of Health & Family Welfare launched "National Programme for the Health Care of Elderly" (NPCHE)⁷ in 2010 with an objective to provide dedicated health care facilities to the senior citizens (>60 year of age). The programme aims to provide accessible, affordable, and high-quality long-term, comprehensive and dedicated care services to an Ageing population; create a new "architecture" for Ageing; and build

a framework to create an enabling environment for “Society for all Ages”. It also promotes the concept of Active and Healthy Ageing. It also strives to deliver all round care by strengthening the convergence between various in line departments i.e. Ministry of Health and Family Welfare, Ministry of AYUSH, Ministry of Social Justice and Empowerment, Ministry of Rural Development, Ministry of Urban Development etc. Keeping in the view the exponential increase in the elderly population & requirement of providing multidisciplinary care to elderly the NPHCE strives to undertake a paradigm shift from provision of segregated Geriatric OPD, IPD, Physiotherapy services to delivery of Comprehensive Geriatric Care.

- vi) The Longitudinal Ageing Study in India (LASI) Wave 1, 2017-18, launched under the aegis of Ministry of Health and Family Welfare has enabled better understanding of India’s elderly health problems. The self reported prevalence of cardioavascular disease was 34% among those in age 60-74 which increases to 37% among those age 75 and above. 32% of the elderly reported hypertension, 14.2% reported diabetes, 4.7% reported anemia, 8.3% reported chronic lung disease, 5.9% reported asthma, 2.6% reported neurological and psychiatric problems, 55.3% reported vision related problems, 9.6% reported ear related problems. A higher proportion of elderly age 60 and above experienced difficulty in stooping, kneeling, or crouching (58%), followed by difficulty in climbing upstairs without resting (57%) and pulling/pushing large objects (53%). 11% of the elderly age 60 and above reported having at least one form of impairment (locomotor, mental, visual and hearing impairment). A quarter (24%) of the elderly age 60 and above reported having at least one Activity of Daily Living (ADL) limitation; Difficulty in using the toilet facility is the most common ADL limitation faced. Although 43.3% of elderly people use some kind of supportive device. However 37.5% uses spectacles/contact lens due to presbyopia, 3.1% uses dentures, 8.3% uses walker/walker sticks and 0.7% uses hearing aids. More than a third (36%) are widowed. The proportion of widowed is higher among older adult women (30%) than older adult men (10%).
- vii) World report on ageing and health (2015) defines goal of healthy ageing as “maintaining the functional ability in elderly to enable wellbeing. The concept of healthy ageing focuses on both intrinsic capacity as well as functional ability of elderly population. The concept of Comprehensive Geriatric Assessment takes in to account both intrinsic capacity and functional ability.
- viii) The guidelines on Elderly care at Health and Wellness Centres envisage strengthening of healthcare delivery for elderly patients in both rural and urban areas and to be included in the set of services being offered as part of Comprehensive Primary Health Care. This intervention would embody the objectives of NPHCE and deliver the Comprehensive Geriatric Care Services at all HWC’s.

- ix) The range of facilities and outreach mechanisms vary widely between and within States, and local context specific mechanisms would need to evolve through a process of piloting and study like need based assessment for delivering service, Human Resources rationalization etc. before being scaled up.
- x) These Operational Guidelines are intended for State and District Program Managers and service providers to strengthen health care services for the elderly at the primary health care level and enable a continuum of care to and from secondary and tertiary levels. Other companion documents include training manuals for different cadres of health care providers. The provision of geriatric care requires the involvement & active support of providers team, community volunteers and the most important primary care givers i.e. family members. These guidelines would be updated and disseminated on a periodic basis.

Service Delivery Framework:

Elderly individuals have distinct physical, emotional, social and economic needs that demand greater attention and they prefer to have services closer to their homes. With empathetic, age-friendly and comprehensive primary health care services, much can be done at the community level, which is cost effective for the providers as well as the beneficiaries. In addition, the multi-morbidity status consequent to chronic disease conditions can be minimized through promotive, preventive & rehabilitative care including screening, early detection, supportive and consistent follow up care for those undergoing treatment or with advanced disease conditions. Thus, Comprehensive Primary Health Care for elderly is needed not only to improve the access and affordability, but also to emotionally enable the elderly in the community.

The Operational Guidelines of Elderly care at Health and Wellness Centers envisage mobility-based classification of elderly with three main categories –

1. Mobile Elderly
2. Restricted mobility elderly(mobility only with personal assistance/device) and
3. Bed bound (assistance required in some form)/Home bound elderly for any reason and those requiring palliative care or end of life care.

Such categories would be used in the assessment of high-risk elderly who would be prioritized accordingly for service delivery.

Elderly services at different levels of care:

I. Individual/ Family/ Community level:

The Front-line workers – ASHA/ ASHA Facilitator, Multi-Purpose Workers (MPW -F/ M, Community Health Workers (CHW), where available, would provide assessment & care via community platforms. Services delivered at this level are:

ASHA / ASHA Facilitator would:

- Undertake household visits supported and supplemented by MPWs (F/M) for community mobilization, risk assessments, counseling, improved care seeking and increasing supportive environment in families and community.
- Generate awareness in the community about healthy lifestyle in the elderly to promote active and healthy ageing, recognizing signs and symptoms for common health problems affecting the elderly, basic diagnosis-Hb, Sugar, BP, Provision of medicine to restricted mobility elderly and Bed bound / Home bound elderly.
- Along with MPW, provide information to the community members at different interactive opportunities including VHSNC/MAS/RWA meetings, with special attention on families having elderly people, regarding promotive, preventive and rehabilitative care of the elderly, environmental modification, nutritional intervention, and physical activities including yoga, lifestyle and behavioral changes in favor of healthy ageing. Wherever possible, elderly to be actively involved in creating awareness amongst the populations and their peers.
- Identify elderly individuals in need of care in the Community. She would undertake mapping of elderly population under HWC in the category of bed bound, restricted and mobile elderly. In addition, ASHA would identify elderly poor and single elderly in her area and list them to establish a communication between the primary health care team and the identified elderly. Such individual would be visited by ANM/MPW/CHO.
- Provide support in family counselling and redressal of medical issues.
- Identify caregivers within or outside the family and link them to the nearest health care facility. During the household and follow up visits, frontline workers would support in developing the skills of the caregivers as well as provide tips to maintain their physical and mental wellbeing.

- ASHA facilitator will deliver passive physiotherapy services to bed bound elderly acting as a lay rehabilitation worker under the guidance of CHO & MRW from CHC.
- Facilitate environmental modification, nutritional intervention, and physical activities including yoga, lifestyle and behavioral changes at the family and individual level.
- Would work with the Gram Sabha, ULBs, SHGs, VHSNCs/MAS, JAS, Resident Welfare Associations (RWA) and local NGOs and self-help groups to enable creation of facilitatory environment for elderly in the community through inter-generational bonding.

Multi-Purpose Worker (F/M)/ Community Health Officers (CHO) would:

- Undertake initial screening of Comprehensive Geriatric Assessment for all elderly twice in a year and monitor them. Individuals identified with priority conditions associated with declined intrinsic capacity are to be referred to the linked HWC/PHC-MO for in-depth assessment and obtaining a personalized care plan.
- Facilitate the formation of Elderly Support Groups named “Sanjeevini” and Elderly Care-giver Support Groups to ensure engagement of elderly and caregivers as well as family members. Monthly meetings of these support groups would be held in the community and facilitated by them.
- Along with ASHA will use VHSNC & MAS to reinforce healthy ageing via adequate nutrition, physical activity as per persons capacity, regular checkups and rehabilitative care, timely redressal of acute , chronic conditions and improving the acceptance of assistive device among elderly and ensuring availability of assistive device
- ANM/MPW (Male) to undertake weekly visits to bed bound elderly.

II. Health and Wellness Centre – Sub Health Centre:

Community Health Officers (CHO) would:

- Undertake comprehensive Geriatric Assessment twice in a year for Cognitive decline, Limited mobility, Malnutrition, Visual impairment, hearing loss,

depressive symptoms etc. in addition to services like NCD screening ,assessment of rehabilitation and assistive devices. This would enable early identification of complications of chronic conditions in the elderly, prompt referral for treatment and follow up for treatment compliance. This would be done at the HWC for mobile elderly and at the home for bed bound and restricted mobility elderly.

- For common and emergency geriatric ailments, CHO would be providing immediate / primary management and refer to the Medical Officer at the linked PHC, if and when required or conduct a teleconsultation and manage as per MO-PHC instructions
- Develop and administer a personalized care plan for each elderly identified in the community in consultation with MO-PHC.
- Facilitate identification of the care giver and provide guidance regarding care to be given especially for the bed bound elderly. Primary Health Care team led by CHO to also ensure that a continuous psychological intervention, training and support is being offered to family members and other informal caregivers of care-dependent elderly people.
- Develop elderly support groups named “Sanjeevini” & ensure involvement of active and mobile elderly in various activities like awareness generation, assessment of fit elders.
- Undertake monthly visits to bedbound elderly.
- Ensure mobile elderly & restricted mobile elderly attend yoga / activity sessions at HWC/ community at-least twice a week for ½ hour.
- CHO would maintain a list of medicines required by the elderly which have been prescribed to them by Medical Officer or Specialist and dispense them at the HWC. For bed bound elderly, ASHA/AF would be engaged to provide medicines at their doorstep.
- Update the list annually, and conduct annual examination for comprehensive geriatric assessment.
- Maintain a record of attendance of elderly preferably through CPHC-NCD app, in general OPD, camps and their subsequent referral to higher centers and be alert to the possibility of multi-morbidity among the elderly. Promote elderly to come to OPD
- Conduct periodic home visits to bed bound elderly, sick elderly, and restricted mobility elderly requiring monitoring and provide necessary care & counselling.

- Harness Palliative care services & End of life care for the elderly requiring such services. Ensure such elderly's family is provided training for simple nursing tasks like wound management, bedsores etc.
- Undertake preliminary assessment for the need of assistive devices such as hearing aids, denture, spectacles, walkers, walking sticks etc. which would increase base of support, improve balance, and increase activity and independence. The required assistive devices could be procured from the linked PHC or relevant Government Departments. Prepare list of beneficiaries with such requirements.
 - Oral supplemental nutrition with dietary advice should be recommended for elderly affected by undernutrition.
 - Promote healthy behaviors. Adopting healthy lifestyles change is critical for prevention and control of chronic conditions including Non-Communicable diseases in the elderly. Undertake IEC activities pertaining to the associated risk factors such as;
 1. Non- compliance to regular medication of Diabetes Miletus, Hypertension & other illness.
 2. Tobacco and alcohol consumption, poor dietary habits, physical inactivity or restricted movement and various morbidities, and awareness material on the same shall be displayed at the HWCs.
 3. Non-Use of assistive devices.
 - Promote inter-generational bonding and involvement of elderly, ASHA & MPW to identify volunteers from Youth Groups, Mahila mandals, Cooperatives, NGOs etc. to assist the family caregiver to provide home based care to bedbound elderly. Award certificate to volunteers for providing home based care to bedbound elderly.
 - Where ever possible active elderly should be organised to form an Elderly Support Groups named "Sanjeevini" to be involved in peer group activities like adoption of assistive devices, environmental modification etc.

The Primary Health Care team led by CHO would

- Identify care givers and empower them to take care of bed bound elderly.
- Ensure continuous psychosocial support to family members and other informal caregivers, of care-dependent elderly people.

- Impart training to caregivers in basic nursing skills of care of bed ridden patients, wound care etc.
- Provide dietary advice like Oral supplemental nutrition etc for undernourished elderly.
- Support use of assistive devices.
- Deliver home based geriatric care on the line of home based palliative care & end of life care to those elderly requiring such services.
- Provide rehabilitative services at home for bed bound elderly, at HWC for others on a regular basis in consultation with physiotherapist at CHC/DH.
- Generate awareness in the community regarding modifications within the physical home environment to help reduce hazards that cause falls and fractures in the elderly. Individual and family counseling would be provided to households with bed-bound elderly individuals, and for psychosocial needs of the elderly including counseling for the caregivers.
- Organize health education camps to address basic issues like personal hygiene maintenance, nutritional counseling and explaining the associated risks to the caregiver. Local NGOs and Self-Help Groups could be utilized for imparting health education, providing support to open accounts and informing the authorities on any pending issues relating to fund transfer under existing National schemes.
- Other awareness generation activities by the Primary Health Care team would include:
 - o Sensitizing caregivers in identifying common elderly problems and orienting them to home-based care.
 - o Prevention of risks of fall, malnutrition and neglect of care which is very common in elderly through identifying and providing advice for geriatric friendly home settings.
 - o Awareness on various social security schemes, social entitlements for elderly and providing various aids under NPCHE programme.
 - o Support groups for elderly should be organized to improve motivation and share the challenges and success related to lifestyle changes, reduction in substance abuse and adherence to treatment for chronic diseases.
 - o Celebration of International Day for Older Persons on 1st October every year. Taking into consideration the importance of periodic screening in early detection of diseases and preventing complications, it is suggested that in October month

every year, a campaign called “Month of the Elderly” be undertaken, to assure identification and annual screening of all elderly people in the HWC area.

- Establish linkages with –
 - a) NGOs for support group meetings and health promotional activities;
 - b) VHSNC/JAS/RWAs to facilitate access to entitlements/schemes/programs for the benefit of the elderly through Government departments, such as Department of Empowerment of Persons with Disability, Social Justice and Empowerment, District Legal Services Authority, Panchayati Raj Institutions (PRIs), Urban Local Bodies (ULB), etc.;
 - c) other programs (elderly and palliative care, mental health, communicable diseases and NCDs program etc.) for coordinated care
- Camp approach for severally restricted elderly, single elderly.
- AYUSH centres shall also extend elderly care services. The elderly subgroup will have an option to consult AYUSH practitioners. Linkages with AYUSH/local NGOs for providing yoga, meditation and physical activities including multi modal exercise (balance, strength, flexibility and functional training) for elderly at risk of falls will be made. Panchkarma and other kriyas desirable by elderly should be made available by these AYUSH centres. Similarly Homeopathy & Siddha services to be also provided to elderly.

III. Primary Health Centre/Urban Primary Health Centre (Health and Wellness Centre) level:

Medical Officers at PHC/UPHC shall assure following elderly care services:

- Public awareness on promotional, preventive and rehabilitative aspects of geriatrics during health and village/urban sanitation day/camps.
- Weekly fixed day geriatric clinic for assured access for the elderly.
- Advanced Comprehensive geriatric assessment of the elderly. This would include Cognitive decline, Limited mobility, Malnutrition, Visual impairment, Hearing loss, Depressive symptoms Etc. Along With Multi-Morbidity Screening including NCDs, Tele-consultation for Bed bound elderly, Restricted mobility elderly, either directly or through CHO.

- Link up with the primary care team & conduct home visit for bedbound elderly at least on quarterly basis.
- Provision of diagnostics, equipment, consumables, medicines and services for Elderly leveraging other National Health Programmes
- Treatment including pain management as in palliative care for common geriatric ailments.
- Provision of medicines, counselling and Oral nutritional supplements with dietary advice should be recommended for elderly affected by undernutrition
- Fixed day rehabilitation services including physiotherapy & occupational therapy.
- Organize field camps with counselling services for life style modifications.
- Obtain required assistive devices for the elderly, and facilitate its distribution to the identified, disabled, elderly persons through various related departments
- Maintain a record of general OPD for elderly, camps and referrals preferably through CPHC-NCD MO app
- Provide Clinical support and supervision to HWC-SHCs through teleconsultation for continuous management of patients.
- Referral of elderly patient requiring secondary & tertiary care to higher centre .

IV. Secondary and Tertiary Centre level

At CHC/UCHC (first referral unit) the following services shall be available;

- Doctor led Geriatric clinic twice a week at the CHC level and regularly at DH/SDH levels
- Specialist services (General Medicine, Orthopedics, Ophthalmology; ENT, Dental, Psychiatry services etc.) for multi-disciplinary care for all referred elderly people. Conduct teleconsultation with CHO/MO at AB-HWC for specialist care for bed bound elderly and elderly females
- Facilities for laboratory investigations for diagnosis.
- Counseling services including diet & nutrition and medicines for all ailments including mental & psychological health.

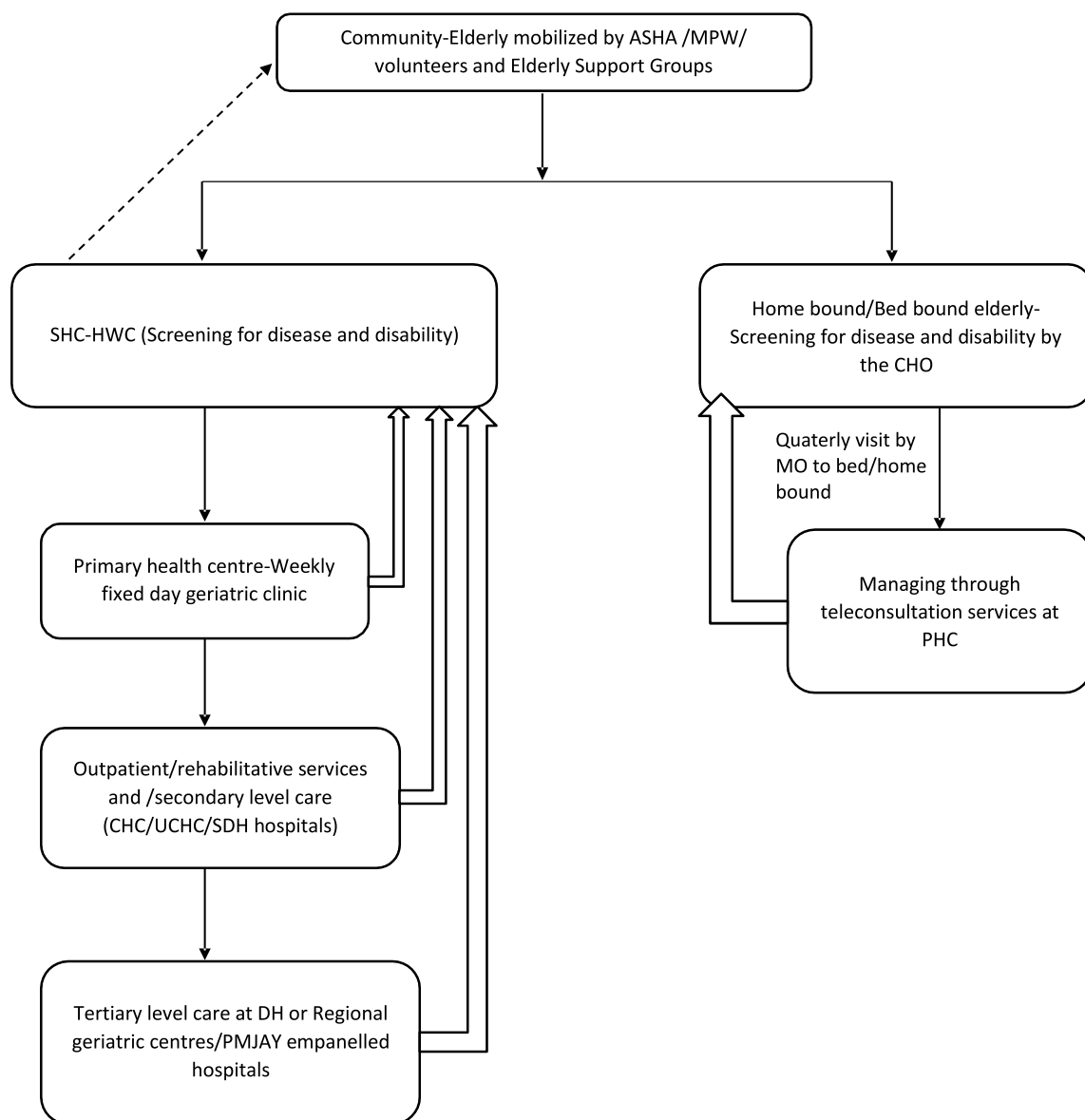
- Rehabilitation services like physiotherapy. Develop physiotherapy care plan to be followed by primary care team.
- Rehabilitation worker along with primary care team, to ensure domiciliary care support for bed-bound elderly, care givers and family members.
- Referrals to tertiary care facilities like DH/Regional Geriatric Centre for management of complications and surgical interventions.

Referral and treatment: Ensuring Continuum of Care:

- In patient services: 10 bedded ward at district Hospital & 30 bedded ward at Regional Geriatric centre.
- Bi-directional referral linkages covering all levels of health care facilities shall be established to assure care for unforeseen emergencies like Fall, Accidents, Acute Heart Attack, Stroke etc, home based care and follow up care.
- Whenever feasible and appropriate, teleconsultation services with higher centres would be organized by primary care team.
- Elderly with complications of acute or chronic diseases and chronic conditions would be referred from the HWC-SHC to the PHC Medical Officer.
- As required , referral to specialists at the secondary or tertiary level public health facilities shall be ensured. Such referrals shall be with specific instructions regarding facility name and location, day and time of visit, person to contact etc.
- For packages/services covered under the PMJAY – eligible patient will have the choice to opt to go to any PMJAY public/ private empanelled hospital. No referral shall be necessary for this.
- After EHR is implemented, the patients will also have access to their EHR. In case a PMJAY eligible patient opts to access PMJAY benefits and if such patient has been provided services from a public health facility, the available records for that patient may be provided to concerned PMJAY hospital on request, upon verification of such request being authenticated with the consent of the patient concerned. Until EHR becomes operational paper based discharged summary with details of symptoms, treatment, progress and follow up should be provided
- ASHA/MPHW would continue to follow up patients coming from the higher centers back to the community. Written treatment plan from the referral Centers will be followed up for treatment adherence.

- To enhance reach/access to services and continuum of care for people in remote locations, Mobile Medical Units would be coopted.
- Medical colleges with existing Elderly care set up i.e. Regional Geriatric Center or Department of Geriatrics in Medical colleges would act as tertiary referral Centre.

Referral Pathway for Elderly Care across all levels :



Drugs and diagnostics:

- All essentials drugs listed by the State for each level of public health shall be available
- The Drugs and Vaccines Distribution System (DVDMS) linked with Comprehensive Primary Health Care - IT application would support regular supply and availability of required medicines and diagnostics.
- The Medical Officer would prescribe medicines at the level of PHC/UPHC ensuring titration of dosages and restricting polypharmacy.
- Subsequent dispensing of medicines for patient who are being followed up in the community would be done at the level of the SHC-HWCs by the Community Health Officer on the recommendation of and in consultation with the MOs.
- MPW/CHO shall accord special attention for restricted mobile elderly, home bound / bedridden elderly persons and single elderly and ensure timely drug prescription, drug dispensing as well as assistive devices.
- HWC could supply prescribed drugs for bed-ridden patients through family members and care givers. However strict check for compliance to treatment shall be ensured.

HR- Service providers for delivering comprehensive geriatric care services.

- The Primary Health Care Team both at the Sub Centre- HWC and PHC-HWC would receive both induction training and periodic refresher training. The supportive supervision carried out by the District Program Officer would also focus on upgrading skills and collating content for refresher training.

Human Resource Responsibilities:

ASHA	- Undertake household visits for community mobilization, risk assessment, counselling improved care seeking and increasing supportive environment in families and community. - Generate awareness in the community about healthy lifestyle in the elderly to promote active and healthy ageing. - Identify elderly individuals in need of care in the community including mapping of elderly population - Provide support in family counselling and redressal of medical issues - Identify caregivers within or outside the family and link them to the nearest health care facility. - Facilitate environmental modification, nutritional intervention and physical activities including yoga, lifestyle and behavioural changes at the family and individual level. - Would work with Gram Sabha, ULB, SHG, VHSNC/MAS, JAS, RWA and local NGO to enable creation of facilitatory environment for elderly. - Support caregivers in learning a range of practical skills like transferring a bed bound elderly within house, support in daily routine activities like eating, bathing etc. - Facilitate services available for elderly at HWCs and referral centres. - Home based follow-up care for elderly discharged from higher facilities.
ASHA FACILITATOR	- All elements of ASHA (as above) - Deliver passive physiotherapy services to bed bound elderly acting as a lay rehabilitation worker under the guidance of CHO&MRW from CHC.- - Supportive supervision to ASHA
ANM/MPW-M	Undertake initial screening using preliminary Comprehensive Geriatric Assessment for all elderly twice in a year. - Facilitate formation of Elderly support groups named “Sanjeevini” and elderly care giver support groups - Reinforce healthy ageing via adequate nutrition, physical activity, regular check ups and rehabilitative care. - Undertake weekly visits to home bound/bed bound elderly
CHO	- Undertake comprehensive geriatric assessment twice a year - Providing immediate/primary management of common ailments of elderly and referring to MO at PHC or conducting teleconsultation services and manage as per MO-PHC instructions. - Develop and administer a personalized care plan for each elderly identified in the community in consultation with MO-PHC. - Facilitate identification and provide guidance to care givers regarding care given to bed bound elderly.

	- Develop elderly support groups named “Sanjeevini” - Conduct periodic home visit to bedbound elderly, sick elderly and restricted mobile elderly - Undertake preliminary assessment for the need of assistive devices. - Support rehabilitative services for the elderly
MEDICAL OFFICER	- Conduct weekly fixed day geriatric clinics - In-depth person-centered assessment of elderly; Undertake Advanced comprehensive geriatric assessment of the elderly. - Primary management of all common diseases of the elderly - Basics of counselling and physiotherapy - Referral and linkages - Assure public awareness on promotional, preventive and rehabilitative aspects of geriatrics during health and village - Conduct home visit for bed bound elderly atleast on quarterly basis. - Facilitate provision of assistive devices for the needy elderly and also train them to use it - Enable skills and competencies of the care-givers

Capacity Building Plan:

- Existing pool of State and District ASHA trainers would be trained to undertake training of ASHAs. Where necessary, additional services of additional Trainers would be enlisted.
- The services of reputed Geriatric care delivery organizations, NGOs, CBOs can be utilized for trainings.
- Regional Geriatric Centers (*Annexure II*) established under NPHCE would support in building skills and competencies of Medical Officers in Elderly care. In addition, they would also be used for training of trainers for state and national level trainers for different cadre of health workers across the level of care.
- One-day Orientation of Programme officers and BPM/DPM to be undertaken to ensure role clarity, appropriate planning, monitoring and inter-sectoral coordination.

Monitoring and Supervision:

The programme and monitoring data for Elderly services to be integrated and adopted in the existing monitoring system for the HWC. The following indicators would be used to monitor the programme:

- Percentage of elderly registered at the HWC
- Percentage of elderly population screened as a part of Comprehensive Geriatric Assessment by CHO
- Percentage of elderly on treatment at HWC provided cross referral to CHC/DH/RGC.
- Percentage of elderly provided physiotherapy services.
- Percentage of home bound (bed bound & restricted mobility) elderly visited by ASHA & ANM/MPW-M
- Percentage of needy elderly provided with supportive/assistive devices
- Percentage of single elderly (elderly living alone) visited by ASHA& MPW.
- Number of elderly support groups-“Sanjeevini” created

Annexure-I

Basic Rehabilitation Equipments to be kept at Health & Wellness centre under NPHCE

1. Shoulder Wheel*
2. Wall ladder finger Exerciser**
3. Finger Exerciser web
4. Free exercise weight cuff (0.5 kg , 1 kg, 1.5 kg)
5. Shoulder Pulley
6. Walking aid for training – Adjustable Walker, Reciprocal walker
7. Exercise Couch, pillow, towel
8. Floor patterns may be designed having alternate patterns different colour tiles (1 feet X 1 feet) so to help in teaching gait pattern/visual feedback for neurological impaired geriatric patients.
9. One wheel chair.
10. Charts for teaching basic exercise for neck, back, shoulder, knee joint etc.***
11. Chart for teaching basic positioning/posturing the patient suffering from hemi- neglect /GBS/ Spinal cord injury.***
12. Spiro meter with disposable mouth piece for those patient who need to perform breathing exercise multiple times in a day (Diagnosed cases of chronic bronchitis, emphysema, cystic fibrosis)

* Equipments to be wall mounted at HWC

**Included as part of branding of HWC and stickers to be placed on the already branded HWC

*** Displayed at HWC

Basic Rehabilitation Equipments for PHC and UPHC under NPHCE

1. Shoulder Wheel
2. Wall ladder finger Exerciser
3. Finger Exerciser web
4. Shoulder Pulley
5. Walking aid for training – Adjustable Walker, Reciprocal walker
6. Exercise Couch, pillow, towel

7. Floor patterns may be designed having alternate patterns different colour tiles (1 feet X 1 feet) so to help in teaching gait pattern/visual feedback for neurological impaired geriatric patients.
8. One wheel chair.
9. Exercise Charts for teaching basic exercise for neck, back, shoulder, knee joint etc.
10. Chart for showing positioning, lifting and carrying technique for elderly.
11. Spiro meter with disposable mouth piece for those patient who need to perform breathing exercise multiple times in a day (Diagnosed cases of chronic bronchitis, emphysema, cystic fibrosis)
12. Lower & upper extremity cycle/basic ergo meter.

Following are contents required in Comprehensive Geriatric Assessment kit to be available with PHC team

1. Vision- Snellen Chart
2. Hearing- Hand held audio scope
3. Nutrition- Mini-Nutritional Assessment Scale
4. Cognitive – MSME, Mini Cog
5. Affective- GDS, Hamilton Depression Scale
6. Functional- Katz
7. Home Safety Checklist
8. Blood Pressure Machine
9. Thermometer
10. Glucometer
11. HbA1C
12. Haemoglobin Meter
13. Pulse Oximeter
14. Spiro meter
15. Hand held dynamo meter.

Annexure-II

Questionnaires for Assessment for Elderly:

Risk Assessment of Falls:

S.No.	Item	Yes	No
1	Have you ever had a fall in last one year		
	Are you taking more than 4 types of medicines? (sedatives, antidepressants, anti-Parkinson's, antihypertensives, diuretics, etc)		
	Are you suffering from any of the following? (anxiety, depression, loss of judgement / cooperation / insight)		
	Did you have dizziness or lightheadedness on getting up from the bed in last one year?		

For positive response to >2 questions, refer to CHO. (Adapted from Falls Risk Assessment Tool)

Activity of Daily Living (CHO):

Activities Points (0 or 1)	Independence (1 point) NO supervision, direction or personal assistance	Dependence (0 point) WITH supervision, direction, personal assistance or total care
Bathing	(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
Dressing	(1 POINT) Gets clothes from closets 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	(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	(1 POINT) Moves in and out of bed or chair unassisted. Mechanical transferring aides are acceptable	(0 POINTS) Needs help in moving from bed to chair or requires a complete transfer.
Continence	(1 POINT) Exercises complete self-control over urination and defecation	(0 POINTS) Is partially or totally incontinent of bowel or bladder.
Feeding	(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)

Geriatric Depression Scale (CHO):

Item	Answer	Score
Are you basically satisfied with your life?	Yes/ No	
Have you dropped many of your activities and interests?	Yes/ No	
Do you feel that your life is empty?	Yes/ No	
Do you often get bored?	Yes/ No	
Are you in good spirits most of the time?	Yes/ No	
Are you afraid that something bad is going to happen to you?	Yes/ No	
Do you feel happy most of the time?	Yes/ No	
Do you often feel helpless?	Yes/ No	
Do you prefer to stay at home, rather than going out and doing new things?	Yes/ No	
Do you feel you have more problems with memory than most?	Yes/ No	
Do you think it is wonderful to be alive now?	Yes/ No	
Do you feel pretty worthless the way you are now?	Yes/ No	
Do you feel full of energy?	Yes/ No	
Do you feel that your situation is hopeless?	Yes/ No	
Do you think that most people are better off than you are?	Yes/ No	

Answers in bold indicate depression. Score 1 point for each bolded answer. A score > 5 points is suggestive of depression. A score 10 points is almost always indicative of depression.

A score > 5 points should warrant a referral to the PHC

Annexure III:

MMSE (Mini Mental Status Examination):

Mini-Mental State Examination (MMSE)

Patient's Name _____

Date _____

Instructions : Ask the questions in the order listed. Score one point for each correct response within each question or activity.

Maximum Score	Patient's Score	Questions
5		What is the year? Season? Date? Day of the week? Month?
5		Where are we now State? Country? Town/city? Hospital? Floor?
3		The examiner names three unrelated objects clearly and slowly, then asks the patient to name all three of them. The patient's response is used for scoring. The examiner repeats them until patient learns all of them, if possible Number of trials _____
5		I would like you to count backward from 100 by sevens. (93, 86, 79, 72, 65,). Stop after five answers. Alternative "Spell WORLD backwards" (D-L-R-O-W)
3		"Earlier I told you the names of three thins. Can you tell me that those were?"
2		Show the patient two simple objects such as a wristwatch and a pencil and ask the patient to name them
1		Repeat the phrase 'No ifs ands or buts'
3		"Take the paper in your right hand, fold it in half, and put it on the floor" (The examiner gives the patient a piece of blank paper)
1		"Please read this and do what it says." (Written instruction is "Close your eyes.")
1		Make up and write a sentence about anything." (This sentence must contain a noun and a verb.)
1		"Please copy this picture." (The examiner gives the patient a blank piece of paper and asks him/her to draw the symbol below. All 10 angles must be present and two must intersect.) 
30		TOTAL

(Adapted from Rovner & Folstein, 1987)

Source: www.medicine.uiowa.edu/igec/tools/cognitive/MMSE.pdf

If value < 24 refer the individual to PHC, if the individual has studied above 8th class If value < 21 refer the individual to PHC, if the individual has studied below 8 class

Annexure IV:

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