GOVERNMENT OF KERALA
DEPARTMENT OF HEALTH & FAMILY WELFARE

COMPREHENSIVE ELDERLY CARE ACTION PLAN

Keralam

A state framework for healthy ageing, functional ability, social and mental well-being

2026



HEALTHY AGEING
INCLUSIVE CARE
STRONGER COMMUNITIES

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1. INTRODUCTION

1.1 Global Megatrend of Population Ageing

Population ageing refers to the shift in the distribution of a country's population towards older ages, driven by increasing life expectancy and declining fertility rates. The World Health Organization defines older persons as individuals aged 60 years and above. Currently, there are 1.4 billion people aged 60 years or older worldwide (1). Life expectancy at birth reached 73.3 years in 2024, an increase of 8.4 years since 1995 (2). The number of people aged 65 or older, currently 703 million, is projected to reach 1.5 billion by 2050, with 1 in 6 people globally over age 65 by that time (3).

While population ageing started in high-income countries (e.g., Japan where 30% of the population is already over 60 years), low- and middle-income countries are now experiencing the greatest change. By 2050, 80% of older people will be living in low- and middle-income countries, where health and social systems are least prepared . Unlike developed nations, which had decades to adapt policies and infrastructure, developing countries, including India, are ageing at a much faster rate with limited time and resources to respond(1).

The United Nations has declared 2021-2030 as the Decade of Healthy Ageing. The UN Decade of Healthy Ageing defines four action areas: combatting ageism, changing how we think, feel, and act towards age and ageing; age-friendly environments, ensuring communities foster the abilities of older people; integrated care, delivering person-centred integrated care; and long-term care, providing access to long-term care for older people who need it (2).

1.2 Kerala's Demographic Context

- Highest Elderly Population in India: Kerala has the highest proportion of elderly (60+ years) in India. The National Family Health Survey (NFHS-6) 2023-24 indicates that 20.7 per cent of Kerala's population is aged 60 years and above, up from 18.6 per cent recorded in NFHS-5 (2019-21).
- Rapid Ageing: According to the report Unravelling India's Demographic Future: Population Projections for States and Union Territories, 2021-2051, prepared by the International Institute of Migration and Development (IIMAD) and the Population Foundation of India (PFI), Kerala's elderly population (60+ years) is projected to reach 21 percent

by 2031. The Reserve Bank of India, in its report State Finances: A Study of Budgets of 2025-26, projects that the proportion of population above 60 in Kerala will reach 18.7 percent in 2026, 20.9 percent by 2031, and 22.8 percent by 2036. The NFHS-6 data confirming a 20.7 percent elderly population, significantly higher than the RBI's earlier projection of 18.7 percent for 2026, reflects that Kerala's demographic transition has accelerated even faster than anticipated.

- Old Age Dependency Ratio: According to the Kerala Economic Review 2021, the old-age dependency ratio defined as the number of elderly persons per 100 working-age population has risen from 19.6 percent in 2011 to 26.1 percent in 2021 and is projected to reach 34.3 percent by 2031. The RBI report notes that ageing states like Kerala allocate close to 30 percent of their total social sector spending to pensions, the highest among demographic cohorts . The RBI warned that demographic transition can weaken a state's fiscal sustainability through a "twin squeeze": slower revenue growth and higher expenditure needs (4).
- Working-Age Population Decline: Kerala's working-age population share, currently at 62 percent, is projected to decline to 60.8 percent in 2031 and further to 59.5 percent in 2036. The percentage of the productive-age population in Kerala, 41 percent, is the second lowest in the country.
- Fertility Decline: India's Total Fertility Rate (TFR) has fallen below replacement level (2.1) for the first time, according to the SRS Statistical Report 2024. Kerala's TFR has been well below replacement level for years, contributing to its rapid ageing. The state also has the lowest percentage of people below the age of 15 in the country: 20.3 percent.
- Migration and Care Gap: The Kerala Migration Survey 2023, conducted by the Gulati Institute of Finance Taxation (GIFT), estimates the number of emigrants from Kerala at 2.2 million, with student migration doubling from 1,29,763 in 2018 to about 2,50,000 in 2023 . Students constitute 11.3 percent of total emigrants . Two out of five households in Kerala were found to have non-resident Keralites . The 2002-03 Report on Survey of Aged in Kerala by the Department of Economics & Statistics noted that most migrants have left their old parents behind to fend for themselves, which is a worrying outcome of this trend. This indicates that the "poverty of care" experienced by Kerala's elderly is partly a consequence of large-scale migration, where younger generations move abroad or to other states, leaving elderly parents without adequate family support .

1.3 Implications for Kerala's Health System

- Increased Burden of Chronic Diseases: Ageing populations are more susceptible to non-communicable diseases (NCDs) like hypertension, diabetes, cardiovascular diseases, and stroke, increasing the demand for long-term care. Kerala enters the ageing transition already carrying one of the heaviest NCD burdens in India, with the World Bank noting that a rising burden of NCDs (hypertension, diabetes, cancer) and a rapidly aging population has strained the health system . Kerala's health system will need to strengthen long-term, caregiver-supported and home-based chronic disease management for older persons who are unable to adequately manage their own care.
- Geriatric Care Infrastructure: There is a higher need for specialized geriatric care services, including geriatric beds in all wards, geriatricians, and long-term care facilities. However, strengthening infrastructure alone is insufficient; clear referral and care pathways between general medical services, primary care, secondary/tertiary hospitals and specialised geriatric services are also required to ensure continuity of care. The health system will need to adapt by expanding home-based care, day-care centres, and palliative care services for bedridden and terminally ill patients.
- Strain on Healthcare Workforce: There is an increased demand for trained healthcare professionals in elderly care. This is also a shortage of skilled geriatric care workers, especially in rural areas.
- Financial Strain on Health System: Ageing populations will have higher healthcare costs which includes treatment, medicines, and long-term care. The Kerala Government's "Elderly Budget" 2026-27 has earmarked ₹46,236.52 crore for senior citizens, accounting for 19.07 percent of the State's total budget, underscoring the growing fiscal weight of an ageing population . Out-of-pocket health expenditure remains high in Kerala, particularly in relation to diagnostics, chronic medications, and long-term care .
- Mental Health Issues: There is an increasing prevalence of mental health disorders such as dementia, Alzheimer's, and depression in elderly populations. Hence, there is a need for integrating mental health services into primary healthcare and expanding support for caregivers. The policy address to the 16th Kerala Legislative Assembly announced the expansion of Smrithi Cafes, dementia day-care centers, and specialised memory clinics across the State .

- Social Support and Elderly Care: Diminished traditional family-based care systems due to urbanization, migration of younger generations, and nuclear family setups leads to loneliness among elderly. Kerala's "poverty of care" means social vulnerability is defined as much by the absence of caregivers as by a lack of financial resources . There is a need to develop proper mechanisms to address social and emotional support of the elderly.
- Special Care for Older Adults with Additional Needs: There is a need to address the specific health and social-care needs of older adults with disabilities, neurodiversity, transgender persons and other vulnerable groups. Hence, geriatric services should ensure inclusive, accessible and equitable care with appropriate rehabilitation, assistive devices, psychosocial support and social-protection linkages.
- Caregiver Support: Increasing dependency among older adults places considerable physical, emotional and financial burden on family and informal caregivers. Hence, caregiver education, counselling, respite support, training and linkage with social and health services should be integrated into geriatric care programmes.
- Health Infrastructure Adaptations: Health system will need to provide age-friendly healthcare infrastructure, including physical accessibility in hospitals, specialized transport, and assistive devices. The introduction of telemedicine services to provide regular monitoring and care to elderly may be prioritised in remote areas.
- Policy and Program Development: There is a need to strengthen health policies targeting elderly care, such as the National Programme for Health Care of the Elderly (NPHCE) and its adaptation to Kerala's needs. There is a need for integration of elderly care in primary healthcare through preventive services, health education, and promotion of active ageing.
- Inter-sectoral Collaboration: Cross-sectoral collaborations involving social welfare, housing, transportation, and health to ensure comprehensive care for the elderly. We need to engage civil society and community organizations in elderly care initiatives to promote age-friendly environments.

1.4 Broader Implications for Kerala's Society and Economy

- Pension and Social Welfare Systems: There will be a growing need for sustainable pension systems and social welfare programs to support the

ageing population. Ageing states allocate close to 30% of their total social sector spending to pensions, the highest among demographic cohorts.

- Economic Growth: A shrinking workforce and higher dependency ratio could slow economic growth unless Kerala invests in education, skill development, and health. RBI reports Kerala's working-age population share is projected to decline from 62% to 59.5% by 2036.
- Fiscal Sustainability: The demographic transition can weaken a state's fiscal sustainability through a "twin squeeze": slower revenue growth and higher expenditure needs.
- Policy Shift towards Promotive and Preventive Care: Prioritizing promotive and preventive healthcare for early detection and management of health conditions, not only among older persons but also among caregivers and adults who will enter old age in the coming years. Hence, a population-level approach to healthy ageing should be adopted.

1.5 Kerala's Health System Response

Kerala's health system is adapting impressively to the needs of its ageing population. The state's commitment to health equity, strong local governance, and innovative programs are key pillars in addressing the unique challenges posed by population ageing. Some of the key components of Kerala’s approach include:

1.5.1 Robust Palliative Care Network:

- Kerala's Palliative Care Model is globally recognized and provides a community-based approach to healthcare, emphasizing home-based palliative care for the elderly, especially for those suffering from chronic diseases and requiring end-of-life care(5).
- The Neighbourhood Network in Palliative Care (NNPC) is a decentralized, community-driven initiative that has helped make palliative care accessible even in rural areas. This model focuses on physical, emotional, and social support for elderly patients, ensuring care is available to those unable to travel to hospitals.
- Palliative care is integrated into primary health services, ensuring that elderly patients receive continued care in their homes, reducing hospital visits and offering comfort and dignity in the final stages of life.

1.5.2. Aardram Mission:

- The Aardram Mission is a flagship initiative aimed at transforming primary health centres into people-friendly Family Health Centres(FHCs) with a special focus on geriatric care.
- Aardram mission enhances healthcare access for the elderly by creating elderly-friendly facilities, introducing geriatric services, and ensuring comprehensive services for early diagnosis and management of NCDs.
- One of the goals of Aardram is to shift focus from illness to wellness, promoting preventive care, early diagnosis, and management of diseases common in older age groups like diabetes, hypertension, and cardiovascular diseases. This is being made possible through the Janakeeya Arogya Kendrams at the field level.
- Kerala is in the process of establishing a robust palliative care grid system for linking all facilities providing palliative care in both the private and public sector.
- Kerala also has established an annual health screening system whereby the health data of all persons above 30 years will be collected and follow up services provided.

1.5.3. State Elderly Policy:

- Kerala's State Policy for Senior Citizens aligns with India's National Policy on Senior Citizens but focuses on the state's unique demographic trends(6).
- The policy emphasizes the creation of elderly-friendly infrastructure, ensuring social security and financial independence for senior citizens, and expanding healthcare services tailored to their needs.
- The policy also promotes community-based care and aims to strengthen support networks, with a focus on both rural and urban areas where the traditional family-based care system is declining due to migration and nuclear family setups.

1.5.4. Elderly-Friendly Health Facilities:

- Kerala is leading efforts to make its healthcare facilities age-friendly by introducing accessibility features such as ramps, handrails, elevators, and age-specific services.
- Many government hospitals now have dedicated geriatric wards, elderly-friendly OPDs, and priority services for the elderly, ensuring that the infrastructure accommodates their physical limitations.

- The focus is on comprehensive geriatric care, where healthcare services not only address physical ailments but also mental health, ensuring screening for conditions like dementia and depression.

1.5.5. Strong Local Self-Governments and Decentralization:

- Kerala's system of decentralized governance has been a crucial factor in effectively addressing elderly care needs.
- Local self-governments (LSGs), such as gram panchayats and municipalities, play a central role in implementing health programs, tailoring services to local needs, and ensuring that elderly care is prioritized within the community.
- Role for the LSG in preventive and promotive interventions - these are best taken up by the LSG and not the health department alone.
- Through community-level interventions, LSGs provide assistance to the elderly, including support for palliative care, home visits, nutritional programs, and social engagement initiatives that aim to reduce isolation and improve mental well-being.
- Decentralization has enabled better resource allocation and community participation, with village health and sanitation committees working closely with local health workers to ensure healthcare reaches even the most remote elderly populations.
- The state aims to convert all its LSGs into elderly-friendly panchayaths through special initiatives with the support of the LSG department, health department and other line departments.

1.5.6. Integration of Geriatric Care in Public Health System:

- The National Programme for Health Care of the Elderly (NPHCE) has been integrated into Kerala’s health system, focusing on improving health services for older adults. This includes regular health screenings, specialized geriatric clinics, and home-based care.
- The program supports elderly patients in primary health centres (PHCs), community health centres (CHCs), and district hospitals, ensuring a continuum of care from basic to specialized treatment.

1.5.7. Telemedicine and Digital Health Initiatives:

- Through Kerala's own eHealth system, digital health records and services are being rolled out in the state to ensure hassle free access to services.
- Kerala's healthcare system is leveraging telemedicine to provide routine check-ups, medication monitoring, and consultations for elderly patients, especially those in rural and underserved areas.
- Digital health platforms allow for remote consultations, ensuring continuity of care for the elderly who may face mobility challenges.

1.6 FRAMEWORK FOR HEALTH CARE OF ELDERLY

Elderly population can be divided into 4 categories based on functional ability and presence of chronic diseases:

1. Bedbound elderly – those who need support of another person or equipment to get up from their bed
2. Homebound elderly – those who need support of another person to go out of their houses
3. Elderly with chronic diseases
4. Active elderly without chronic diseases

This categorisation can be easily done by the ASHAs during their annual home visit survey (SHAILI survey).

This categorisation provides a framework for planning and implementation of various healthcare services needed for the elderly. The detailed needs and plan for the four categories are as follows.

2. CARE OF BED-BOUND ELDERLY (CATEGORY 1)

Bed-bound older persons represent a particularly vulnerable group because severe limitations in mobility and functional ability can result in substantial dependence on others for daily care and support. Care of bed-bound older persons therefore requires an integrated approach that addresses not only the underlying medical conditions but also functional ability, nutrition, mobility, psychological and social needs, caregiver support and the need for appropriate health and social-care services(7).

The Care of Bed-Bound Elderly pathway will follow a comprehensive continuum of care beginning with the identification and registration of bed-bound older persons, followed by a comprehensive baseline assessment and priority/risk classification to determine individual care needs. Based on the assessment, an individualized care plan will be developed, followed by caregiver training and provision of home-based nursing and medical care. The care package will include symptom control, pressure-injury prevention, nutrition and hydration support, physiotherapy and rehabilitation, medication review, and provision or linkage to appropriate equipment and assistive devices. Telemedicine and remote follow-up, along with volunteer and social support, will be incorporated to ensure continuity of care. Older persons requiring higher levels of care will be provided timely emergency referral, while those with advanced illness or complex symptom needs will be linked to palliative or hospice services when required. The continuum will also include respite and end-of-life care, bereavement support for caregivers and families, and regular monitoring and programme review to ensure that care remains responsive to the changing health, functional and social needs of the older person.

2.1. Identification, Registration and Priority Classification

- Identify patients through community palliative nurses, FHC/CHC, Janakeeya Aarogya Kendram, ASHAs, LSG institutions, NGOs/CBOs, hospitals, doctors, volunteers and family members.
- Register name, age, sex, address/contact, diagnosis, comorbidities, duration of bedbound status, recent admissions, current treatment, devices, functional status, caregiver details and urgent needs.

- Priority A – uncontrolled symptoms, pressure injury, severe breathlessness/pain, delirium, recurrent aspiration, major feeding/device problems, severe caregiver distress or end-of-life phase.
- Priority B – completely bedbound with multiple comorbidities/devices/wounds, poor nutrition or high caregiver burden.
- Priority C – clinically stable bedbound patient with adequate caregiver support.
- Complete a comprehensive home assessment within 1 week of registration and prepare an individualized written care plan, the areas of assessment includes: General conditions, pain and symptoms, respiratory status, mobility and functions, skin and wounds, nutrition and hydration, bowel and bladder, cognition and psychosocial domain, medication, caregiver support, home environment, and goals of care.

2.2. Individualized Home-Care Action Plan

- Basic nursing and personal care: Bed bath, oral care, perineal care, skin care, grooming, linen/clothing changes, catheter care, feeding-tube care and medication support.
- Daily routine: Assess symptoms; hygiene; inspect skin; reposition according to individual need; bowel/bladder care; feeding and medicines; prescribed exercises; comfort and night-time safety.
- Pressure-injury prevention: Inspect pressure areas; keep skin clean/dry; avoid prolonged pressure, friction and shearing; manage incontinence; use pressure-relieving surfaces; document early changes.
- Wound management: Assess wound; provide appropriate dressing and pressure redistribution; manage pain; support nutrition; educate caregiver; refer complicated wounds.
- Nutrition and hydration: Individualized diet; small frequent feeds where suitable; feeding assistance; appropriate fluids; oral care; swallowing/dietetic referral when required.
- Ryle's tube/enteral feeding: Maintain patency; prescribed feeding; appropriate positioning; monitor vomiting/aspiration; tube/nasal care; caregiver training; refer tube problems according to local protocol.
- Bowel and bladder: Monitor bowel pattern and constipation; prescribed laxatives/diet/fluid/mobility; assess retention/continence/dysuria; maintain catheter drainage, avoid kinking, monitor urine, blockage, leakage and infection.

- Medication management: Maintain updated medication chart; check availability, adherence, remaining quantity, adverse effects, duplication/unnecessary medicines and continuity of supply.
- Physiotherapy/rehabilitation: Individualized passive/active-assisted ROM, positioning, bed mobility, sitting/transfer training, breathing exercises and chest physiotherapy when indicated.
- Psychological/social/spiritual care: Active listening, anxiety/fear/loneliness support, meaningful activities, social-security/LSG/NGO linkage, and spiritual support according to patient preference.
- Equipment/home environment: Assess need for air/water mattress, backrest, wheelchair, commode, transfer aids, oxygen equipment and other assistive devices; maintain a safe home environment.

2.3. Caregiver Empowerment and Community Support

- Identify a primary and secondary caregiver for every patient.
- Train caregivers in positioning, pressure-injury prevention, feeding, oral care, bowel/bladder care, catheter and Ryle's-tube care, medication support, safe transfers, prescribed exercises and recognition of warning signs.
- Use demonstration and return-demonstration to confirm competency; provide written/visual instructions where available.
- Assess caregiver burden, exhaustion, sleep deprivation, anxiety/distress, financial burden and need for respite.
- Link patients to volunteers, Kudumbashree/community groups, LSGD, NGOs/CSR and relevant social-security resources.
- Provide companionship and psychosocial support through community volunteers according to programme procedures and patient preference.

2.4. Multidisciplinary Team and Responsibilities

- Identification of bedbound elderly shall be done by community nurses, ASHAs, JAK teams, LSGs, and volunteers.
- Registration shall be done by the palliative care unit or the community team.
- Comprehensive assessment shall be conducted by nurses and doctors, with support from the multidisciplinary team.

- The individualized care plan shall be prepared by the community nurse in consultation with the doctor and the team.
- Nursing care shall be provided by the community nurse in coordination with the caregiver.
- Symptom management shall be done by the doctor in consultation with the nurse.
- Medication management shall be handled by the doctor and pharmacist, with support from the nurse.
- Physiotherapy shall be provided by the physiotherapist, with reinforcement by the nurse and caregiver.
- Nutritional support shall be provided by the nurse and doctor, with dietetic support wherever available.
- Wound care shall be managed by the nurse, with referral to the specialist team for complicated cases.
- Catheter and Ryle's tube care shall be provided by trained nurses or doctors, with training provided to caregivers.
- Equipment and assistive devices shall be arranged through the palliative team, LSGs, and NGOs.
- Psychosocial care shall be provided by the multidisciplinary team, with support from volunteers and family members.
- Caregiver support and counselling shall be provided by the multidisciplinary team, with support from volunteers and peer support groups to address the physical, emotional and mental health needs of caregivers.
- Emergency referral shall be coordinated by the doctor or nurse through the referral hospital.
- End-of-life care shall be provided by the palliative care team in collaboration with the family.
- Bereavement support shall be provided by the palliative care team, with support from the community and volunteers.

2.5. Home Visit Schedule and Monitoring

- Stable patient: scheduled nurse visits according to need, periodic doctor review and individualized physiotherapy.
- Patients requiring active symptom management: intensified home-care support; the supplied Kerala policy-based document specifies a minimum of three home-care days per week.

- Unstable/end-of-life patient: frequent nursing/medical review, anticipatory care and urgent referral pathway as required.
- High-risk patients receive more frequent visits; stable patients receive scheduled follow-up according to the care plan.
- Monthly clinical review: symptoms, pain, function, nutrition, wounds, catheter/tube, medicines, equipment, caregiver burden, social needs, visits, referrals, admissions and unmet needs.
- Quarterly programme review/evaluation and continuous training/refresher programmes for health workers, caregivers and volunteers.
- The Bedbound Patient Home-Care Visit Checklist (Annexure 1) shall be used during each home visit to ensure comprehensive assessment and documentation.

2.6. Telemedicine, Emergency Linkage and Referral

- Establish telemedicine consultation for patients unable to travel; train doctors and nurses in remote assessment.
- Maintain a secure mechanism for sharing relevant clinical information, medication lists and assessment findings.
- Maintain an emergency referral/shift mechanism and ambulance contact network; provide the family with a written emergency contact card.
- Link appropriate patients with hospice/palliative-care facilities and maintain communication between home-care and hospice teams.
- The supplied policy-based document identifies Taluk Hospitals as first-referral facilities for bedbound/homebound patients requiring admission for acute symptom management.

2.7. Emergency Red Flags / Immediate Escalation

- Sudden loss of consciousness or new severe confusion
- New weakness/paralysis or seizure
- Severe breathlessness, cyanosis or chest pain
- Persistent high fever or suspected sepsis
- Repeated vomiting or severe dehydration
- Significant bleeding
- Sudden severe abdominal pain
- Suspected DVT/PE

- Major fall or injury
- Rapidly worsening pressure wound
- New inability to swallow
- Sudden major clinical deterioration
- Uncontrolled pain, severe delirium, suspected spinal cord compression, intestinal obstruction, or other serious deterioration
- Caregiver burnout / caregiver distress

2.8. Advanced Care Planning and End-of-Life Care

- Prepare an individualized Advanced Care Plan when advanced illness/frailty or advanced-care needs are identified.
- Discuss goals of care, preferred place of care, emergency preferences and decision-making preferences with the patient/family as appropriate.
- Review the ACP every 3–6 months or whenever the condition changes.
- For end-of-life care, prioritize comfort, dignity and family support; provide symptom relief, mouth care, skin care, positioning, privacy and spiritual support according to preference.
- Ensure anticipatory medicines and a contact/referral plan are available when clinically appropriate.
- Arrange respite/end-of-life inpatient care when home care is insufficient.
- Provide bereavement support after death and update the patient register.

3. CARE OF HOMEBOUND ELDERLY (CATEGORY 2)

Home-bound elderly occupy the critical middle ground between active, independent older persons and the bed-bound. This is not a stable state, it is a transitional and largely one-way trajectory. Once a person slips from home-bound into bed-bound, there is generally no return, and the earlier this transition happens, the worse the eventual outcome. The window while a person is still home-bound is therefore the last real opportunity to intervene, preserve function and improve quality of life before that decline becomes irreversible (8–10).

Being home-bound carries its own compounding risks: fear of falling, anxiety, and depression are common, and these can accelerate cognitive impairment. Home-bound elderly are also disproportionately vulnerable to neglect and abuse, often invisible to the health system because they are, by definition, outside its usual reach. Reaching this group requires bringing assessment, care and support into the home, rather than expecting the person to come to the system (11).

The homebound state therefore represents an important window for early identification, prevention and maintenance of functional ability. Rather than waiting for deterioration, hospitalisation or transition to severe dependency, care should focus on identifying health and functional risks at home and providing appropriate interventions at the earliest opportunity. The WHO Integrated Care for Older People (ICOPE) approach emphasises person-centred assessment, early identification of declines in intrinsic capacity, development of individualised care plans and coordination of health and social-care interventions according to the person's needs (7, 12).

The Care of Homebound Elderly component of the Comprehensive Geriatric Care Plan proposes a structured continuum of care beginning with early identification and simplified home-based assessment, followed by periodic professional review, risk-specific interventions, rehabilitation, caregiver education, environmental modification, teleconsultation, community support and referral when required. The approach is designed to bring care closer to the older person, strengthen continuity between community and facility-based services, and support functional independence and quality of life for as long as possible.

3.1. Home-based comprehensive geriatric assessment

- Full comprehensive geriatric assessment requires professional skill, but for home-bound elderly the priority is a simplified assessment tool that can be administered by laypersons (family members, spouses, children), or frontline workers such as ASHA, Kudumbashree members and Anganwadi teachers.
- This tool, modelled on the WHO ICOPE (Integrated Care for Older People) approach, becomes the person's baseline health data and can be repeated periodically for review.
- Any abnormal finding is flagged and communicated to the Medical Officer when the person is next in contact with the Primary Health Centre or Family Health Centre, prompting further evaluation or referral.
- The tool covers, at a basic level: fall risk, frailty, nutrition, oral health, hearing, vision, depression and dementia screening.
- Screening results can automatically generate a simple, downloadable and printable care plan for the caregiver, noting what can be done immediately and what requires referral to a higher level.

3.2. Periodic home visits (Medical Officer, MLSP, JPHN, ASHA)

- Periodic home visits build on the layperson baseline assessment, allowing each cadre to evaluate further as per their skill level.
- The Government should publish a standardised repository of protocols for screening and management of geriatric conditions, so that there is no variation in standard of care across the state and every cadre (caregiver, nurse or doctor) works from the same reference.
- Tele-consultation can be integrated to extend the reach and value of these visits.

3.3. Medication review and adherence

- Medication review and adherence checks are built into both the baseline layperson tool and periodic home visits, escalated for professional review by the Medical Officer, MLSP, JPHN or ASHA as appropriate.

3.4. Screening for frailty, falls, vision, hearing, oral health

- These screenings can largely be delivered at grassroot level using simple, standardised tools rather than requiring specialist assessment for every case.
- Standard protocols for each condition, published by government, ensure consistent identification and response across the state.

3.5. Mental health screening (depression, dementia)

- Delirium, depression, dementia and mild cognitive impairment are common in home-bound elderly, but are frequently masked or go unidentified and by the time they are picked up, it is often already late.
- Mental health screening is therefore built into the baseline assessment tool and reinforced through caregiver education, so early signs are more likely to be noticed and flagged.
- Tele-Manaas, Disha, and such services to be promoted

3.6. Elderly living alone

- A Home Safety Audit is essential for this group, and should be simple enough for any trained frontline worker (ASHA, Anganwadi teacher or Kudumbashree member) to conduct during a routine visit.
- Government should publish a standard Home Safety Audit checklist usable at multiple levels.
- Alongside the home audit, the person's support system should be mapped: neighbourhood contacts, nearby facilities they can access, and specifically the nearest neighbour willing to help in an emergency.

3.7. Tele-consultation and digital health

- Tele-consultation supports timely follow-up on cases flagged through home-based screening, reducing the need for the person to physically travel for every review.
- A publicly available, standardised repository of health protocols and information with tiered access (professional login versus general public) should be published online so that accurate information is easily available and the spread of misinformation and myths through social media is reduced.

3.8. Physiotherapy and occasional rehabilitation at home

- At present, physiotherapy and occupational rehabilitation are usually accessed only after an incident, post-stroke or post-surgery, as secondary prevention or disability limitation, prescribed by a doctor.
- Primary-prevention physical activity, grounded in scientific/physiotherapy guidance, is largely inaccessible to the general

older population, even though a physiotherapist is available in every panchayat, and private physiotherapy is expensive.

- Proposal: a new trained cadre, "Physical Assistants", drawn from caregivers, nurses or volunteers, trained in physical activity promotion under the supervision of a doctor or physiotherapist.
- Physical Assistants deliver and follow up on specific exercises prescribed by a doctor or physiotherapist (e.g. frozen shoulder exercises), visiting the home to demonstrate, train and reinforce technique.
- They support people with fall risk or fear of falling, who may not qualify for daily physiotherapist care through home-based balance retraining and confidence building.
- They help prevent general deconditioning through regular, targeted physical activity and follow-up, filling the gap between one-off physiotherapy consultations and daily needs.
- Yoga, combined with breathing exercises, should be promoted as a primary prevention strategy, not only after an incident, for flexibility, muscle strength and balance retraining.
- Nutrition is equally critical: sarcopenia is common and, once it sets in for a home-bound person, functional decline can be rapid. Access to adequate protein (plant or animal based), guided where possible by a dietitian or nutritionist, should be treated as a core intervention alongside physical activity.

3.9. Caregiver education

- Caregivers should be trained on dementia, depression, delirium, falls, balance retraining and the specific exercises the person needs to continue at home.
- Every caregiver should ideally be trained in the basic ICOPE-based baseline evaluation, since this screening automatically generates a practical care plan they can follow, with clear notes on what to do immediately versus when to seek referral.
- Caregiver education should also cover legal and rights-related instruments relevant to older persons, such as the living will, as part of building broader awareness.

3.10. Referral to higher centres

- The baseline assessment and periodic home visits generate a clear flagging pathway to the Primary Health Centre, Family Health Centre or higher referral centres as needed.
- Findings from the home safety audit should similarly prompt urgent home modification such as grab bars, non-slip flooring, better lighting, orientation aids, in line with the WHO Age-Friendly Environments / Global Network for Age-Friendly Cities and Communities framework, since the home-bound person is already in decline and modification cannot wait.

3.11. Community support and volunteer networks

- Neighbourhood mapping and identification of a nearest emergency contact are central to building a community safety net for elderly living alone.
- Special attention is needed for marginalised sub-groups within this population:
- Identify and provide tailored support for older persons with disabilities, neurodiversity (including autism)
- Aging transgender persons, who already face multiple vulnerabilities across their life course and are likely to face severe jeopardy after 60–70 years of age due to physical decline compounded by social stigma their aging needs dedicated study and planning.
- Aging populations in tribal hamlets and resettlement areas, where high out-migration of younger generations leaves older residents alone; functional reserve, though currently adequate, tends to decline suddenly leading to unanticipated multi-morbidity, and health access is poorer than in cities or general villages. Data on aging in tribal areas is currently limited and needs to be built.

3.12. Monitoring indicators

- Data from the baseline assessment and periodic re-assessments should feed into a state-level monitoring system, supported by the standardised protocol repository to ensure uniform data collection across cadres and districts.
- Documentation of instruments such as the living will can be tracked as part of the broader monitoring and rights framework for this group.

4. CARE OF ELDERLY WITH CHRONIC ILLNESS (CATEGORY 3)

Multimorbidity among older adults is associated with increasing age and is particularly important because coexisting chronic conditions may adversely affect physical functioning and increase the complexity of health-care needs(13). The management of chronic illness in older adults is therefore more complex than the management of individual diseases in isolation, particularly when several conditions coexist and treatment regimens become increasingly complicated(14). Evidence from systematic reviews of interventions for older adults with multiple chronic conditions indicates that care-coordination, self-management support and medication-management interventions are among the approaches used to address the challenges of multimorbidity, although the effectiveness of individual intervention models varies across settings and outcomes(15). A community- and primary-care-oriented approach is particularly relevant for older adults with progressive multimorbidity because accessible primary healthcare can support continuity of care, early identification of deterioration and coordination with other levels of the health system(16).

The Care of Elderly with Chronic Illness component of the Comprehensive Geriatric Care Plan aims to institutionalise a coordinated, evidence-informed and community-anchored system of chronic disease care for older adults in Kerala, building upon existing health services, local self-government institutions, community resources and social-protection mechanisms. This approach is intended to strengthen continuity and coordination of care while addressing the clinical, functional, medication-related, psychosocial and social needs that frequently accompany chronic illness and multimorbidity in later life.

The strategic framework is proposed to be implemented through nine specific objectives or thematic pillars, comprising 30 actions developed from the deliberations and subsequent refinement. The nine-pillar framework provides an administrative structure for organizing the proposed actions, defining implementation priorities, assigning responsibilities and facilitating phased implementation within the existing health and social-care system.

4.1 NINE THEMATIC PILLARS

Pillar A - Clinical Care Standardisation&Individualised Treatment: Standardise disease-specific and referral protocols, and shift from identical targets to individualised, age-appropriate treatment goals for every older adult with chronic disease.

Pillar B - Community-Based Screening, Prevention & Functional Health: Embed geriatric, nutritional, frailty and functional screening into routine NCD care and community life, with physiotherapy/OT access and lifestyle interventions to delay decline.

Pillar C - Registry & Digital Health: Build an LSG-level chronic disease registry and ABHA-linked digital recordand consolidate all programme data into a single state dashboard.

Pillar D - Medication Safety: Institutionalise systematic medication reconciliation and monthly adherence audits for patients with multimorbidity and polypharmacy.

Pillar E - Mental & Cognitive Health: Strengthen early identification and referral for dementia, depression and other mental health conditions, and extend DMHP and Tele-MANAS reach.

Pillar F - Continuum of Care — Referral, Hospitalisation& Transition: Ensure safe, well-linked movement of patients between FHC, district hospital, geriatric services and medical college — including safe hospital discharge and Age-Friendly Hospital standards.

Pillar G - Social Protection & Vulnerable Elderly: Protect elderly patients against financial hardship and social vulnerability through insurance enrolment, legal aid linkage, interdepartmental convergence and targeted outreach to those living alone or destitute.

Pillar H - Workforce Development: Build a competency-based, standardised training pipeline for the health workforce and caregiver cadre delivering geriatric chronic disease care.

Pillar I - Public Awareness & Evidence Generation: Sustain public awareness on chronic disease and healthy ageing, and build a Kerala-specific evidence base to guide future policy.

4.2 IMPLEMENTATION MATRIX

The following present the detailed action matrix, organised by pillar.

Pillar A: Clinical Care Standardisation & Individualised Treatment

- Develop a Kerala Standardised Chronic Disease Care Package for Older Adults — disease-specific protocols for major chronic diseases (diabetes, hypertension, cardiovascular disease, CKD, COPD and other common conditions), with age-appropriate treatment goals.
- Develop a Kerala Standardised Chronic Disease Care Package for Older Adults — disease-specific protocols for major chronic diseases (diabetes, hypertension, cardiovascular disease, CKD, COPD and other common conditions), with age-appropriate treatment goals.
- Individualised Multimorbidity Care Plans — treatment goals individualised by age, frailty, functional status, comorbidity, treatment burden, life expectancy and patient preference, rather than identical targets for all older adults.
-

Pillar B: Community-Based Screening, Prevention & Functional Health

- Integrate Geriatric Assessment into NCD Clinics — geriatric syndrome screening incorporated into routine NCD clinics: frailty, visual impairment, hearing impairment, falls, cognition, depression, functional status, nutrition and polypharmacy.
- Annual Comprehensive Geriatric Health Assessment — periodic assessment of disease status, function, frailty, cognition, mental health, nutrition, falls, vision, hearing, oral health and social support, followed by an individualised care plan.
- Nutritional Screening and Disease-Specific Nutrition Support — regular screening of older adults with multiple chronic diseases for malnutrition, sarcopenia, obesity and other nutritional problems; disease-specific nutritional guidance; community kitchens for nutritionally vulnerable elderly.
- Frailty, Falls and Functional Assessment — screening for frailty, falls and functional decline with early intervention to prevent progression to home-bound and bed-bound status.

- Exercise and Lifestyle Modification Programme — small peer groups and community-based lifestyle interventions including strength, balance, walking, yoga and breathing exercises; open gyms promoted with LSG support.
- Improve Availability of Physiotherapy and Occupational Therapy — access for older adults with functional limitations, fall risk, musculoskeletal disease, neurological disease or deconditioning.
- Improve Vaccination Access for At-Risk Older Adults — easy access to recommended vaccines for older adults with chronic diseases and other high-risk conditions through public health facilities and outreach.

Pillar C: Registry & Digital Health

- Establish an Elderly Chronic Disease Line List / Registry — LSG-level line list of older adults with chronic disease, identifying multimorbidity, high-risk patients, vulnerable elderly and those requiring closer follow-up; regularly updated and linked with the health system.
- ABHA-Linked Digital Elderly Health Record — facilitate creation and integration of ABHA IDs and maintain relevant health information to enable continuity of care across FHCs, district hospitals and tertiary centres.
- State Geriatric Chronic Disease Monitoring Dashboard — line-listing, screening, disease control, medication adherence, frailty, falls, nutrition, vaccination, referrals, hospitalisation and functional outcomes.

Pillar D: Medication Safety

- Medication Adherence and Monthly Medication Audit — systematic medication reconciliation and adherence assessment, particularly in multimorbidity and polypharmacy; periodic audits to identify missed doses, duplication, inappropriate medications and adverse effects.

Pillar E: Mental & Cognitive Health

- Cognitive and Mental Health Screening within Chronic Disease Care — strengthen early identification of dementia, depression and other mental health problems among elderly with chronic disease, integrated into appropriate existing programmes and tools.

- Strengthen DMHP and Mental Health Referral Network — manpower and service capacity of the District Mental Health Programme extended to all wards for early identification, treatment and follow-up.
- Promote Tele-MANAS and Mental Health Helplines — increase awareness and appropriate utilisation among older adults, families and healthcare workers.
- Integrate Cognitive Health Activities into Elderly Peer Groups — memory-enhancing activities, cognitive stimulation, reading, group activities and social participation in community elderly groups.

Pillar F: Continuum of Care — Referral, Hospitalisation & Transition

- Promote e-Sanjeevani for Follow-up and Monitoring — for specialist consultation, review of chronic diseases, medication-related queries and follow-up, particularly where repeated physical travel is difficult.
- Prevent Avoidable Hospitalisation and Complications — identify high-risk older adults; proactive management, education on warning symptoms, medication optimisation, vaccination, nutrition, exercise and early review during acute illness.
- Hospital-to-Home / FHC Transition of Care — discharge information, medication reconciliation and follow-up linkage with the patient's FHC after hospitalisation for chronic disease complications.
- Strengthen Referral Linkages Across Levels of Care — clear referral pathways between FHCs, Taluk/District Hospitals, geriatric services and medical colleges, with feedback to the referring facility; progressively align participating hospitals with Age-Friendly Hospital standards (protocols, physical accessibility and quality certification).
- Multidisciplinary Geriatric/Multimorbidity Clinics — district and tertiary-level multidisciplinary clinics for complex multimorbidity, frailty, polypharmacy and geriatric syndromes, involving Geriatrics, Medicine, Rehabilitation, Nutrition, Mental Health, Pharmacy and other relevant specialties.

Pillar G: Social Protection & Vulnerable Elderly

- Insurance and Financial Protection — assess whether older adults with chronic diseases are covered by government or other health insurance schemes; support eligible uninsured persons to register and access benefits; provide linkage to legal aid and rights-awareness services (e.g.,

entitlements under the Maintenance and Welfare of Parents and Senior Citizens Act) for elderly facing financial or family disputes.

- Interdepartmental and Community Convergence — coordination between Health, LSGD, Social Justice, Nutrition, Rehabilitation, Mental Health, AYUSH, legal services and community organisations to address medical and social needs of elderly with chronic disease.
- Special Attention to Vulnerable Elderly with Chronic Disease — identify older adults living alone, socially vulnerable, destitute, disabled, or from geographically underserved populations; ensure linkage to health, social protection, legal and community support services.

Pillar H: Workforce Development

- Standardised Geriatric Training for Health Workers and Caregivers — competency-based training modules for Medical Officers, MLSPs, JPHNs, ASHAs, nurses, caregivers and other frontline workers, emphasising geriatric syndromes, chronic disease, medication safety, nutrition, falls and mental health.
- Strengthen General Duty Assistant / Caregiver Training —Create more Job opportunities for unemployed youth targeting care for the old and Old Old: Incorporate geriatric care into General Duty Assistant training, including practical skills(not just on nursing care but for all kinds of support that an elderly may need); standardise curriculum with teaching institutions and private sector.

Pillar I: Public Awareness & Evidence Generation

- Public Awareness on Chronic Disease and Healthy Ageing —IEC, television, radio and other public media to promote awareness on chronic disease management, medication adherence, falls, exercise, nutrition, cognitive health, and the misconception that poor health is a normal part of ageing.
- Research and Evidence Generation — Kerala-based research on multimorbidity, frailty, medication use, nutrition, hospitalisation, functional decline and models of community-based chronic disease care, to guide future policy and resource allocation.

5. CARE OF ACTIVE ELDERLY WITHOUT ANY CHRONIC ILLNESS (CATEGORY 4)

Within Kerala's elderly population, a significant proportion are active elderly persons who are ambulatory, independent in activities of daily living, and free from major chronic illness or disability at the time of assessment. This group, designated as Category 4 in the comprehensive action plan, is distinct from the other three categories: bedbound (1), homebound (2), and those with chronic illness (3). Their needs are qualitatively different. They do not require regular home-based medical care, nor do they need frequent hospitalisation. However, they are at risk of transitioning to Categories 3, 2, or 1 if appropriate preventive and promotive interventions are not implemented.

The rationale for a focused strategy for the active elderly is threefold:

- First, prevention is cost-effective. Investing in the health and well-being of active elderly is significantly more cost-effective than managing advanced disease, disability, and dependency. As society becomes more mobile and urban, functions once managed entirely within households now demand structured institutional support. The RBI recommends that ageing States like Kerala "prioritise healthcare financing reforms, preventive health systems, and public–private partnerships."

- Second, the burden of chronic disease is high even among those who consider themselves "active". A national population-based study using the Longitudinal Ageing Study in India (LASI) data found that two-thirds of the elderly in the Southern region reported at least one chronic health issue. The Healthy Ageing Index (HAI), constructed based on psychological health, functional health, cognitive ability, psychological wellbeing, and social wellbeing domains, showed that the proportion of healthier elderly in Kerala was 43.6 percent, the highest among Southern States, though it varied from 43.6 percent for Kerala to 20.7 percent for Telangana. The study further found that physically active elderly were two times more likely to attain healthy ageing compared to physically inactive aged people. These findings underscore the need for targeted preventive interventions.

- Third, the social and economic contribution of active elderly is substantial. The Kerala Government's "Elderly Budget" 2026-27, the first of its kind in India, has earmarked ₹46,236.52 crore for senior

citizens, accounting for 19.07 percent of the State's total budget, underscoring the growing fiscal weight of an ageing population . The budget places strong emphasis on the "Silver Economy" and "Care Economy", recognising seniors as both economic participants and care recipients.

The policy framework for the "Kerala Model of Ageing" focuses on promoting active ageing, supporting lifelong learning and health, and fostering environments that value older adults' contributions and enable full participation in society. This includes initiatives such as the Navajeevan scheme offering self-employment loans with a 50 percent subsidy for individuals aged 50 to 65 and the "New Innings" initiative under the Kerala Startup Mission to channel the professional expertise of retired individuals.

Estimation of Active Elderly Population:

While precise state-wide figures for Category 4 are not directly enumerated in existing data sources, available evidence allows for a reasonable estimation for planning purposes.

Based on NFHS-6 (2023-24) data, Kerala's elderly population of 20.7 percent translates to approximately 72 lakh persons. A study conducted among community-dwelling elderly in rural Kerala found that a significant majority are functionally independent. The Department of Economics and Statistics, Government of Kerala, in its Report on Survey of Aged in Kerala 2022-03, provides data on functional ability. The survey indicates that 85.28 percent of elderly persons reported no problem with mobility, while 7.91 percent reported walking with the help of a walker, 5.40 percent with the help of others, and 1.41 percent were unable to walk. Across different age groups, the proportion of those reporting no mobility problems was 93.13 percent in the 60-70 age group, 80.31 percent in the 70-80 age group, 59.90 percent in the 80-90 age group, and 36.08 percent in the above 90 age group.

Given that 85.28 percent of the elderly population reported no mobility problems, it is reasonable to estimate that the functionally independent elderly population excluding those who are bedbound or homebound constitutes approximately 85 percent of the elderly population, or roughly 61 to 62 lakh persons. This group includes both those with and without chronic illness (Categories 3 and 4). The active elderly without chronic illness (Category 4) would be a subset of this functionally independent population.

5.1 GUIDING PRINCIPLES

The interventions for the active elderly are guided by the following principles:

- Prevention as the primary strategy: The focus is on identifying risks early and preventing the onset of disease and disability.
- Community ownership: Interventions shall be community-led, with active participation of elderly persons, families, and neighbourhood groups through Community Voluntary Resource Groups (CVRGs).
- Life-course approach: Health and well-being in old age are determined by factors across the life course; interventions shall address physical, mental, social, and environmental determinants.
- Inter-sectoral coordination: No single department can address the needs of the active elderly. The Health Department, National Health Mission, Local Self Government Department, Social Justice Department, Sports Department, Kudumbashree, and Cultural Affairs Department shall work in an integrated manner.
- Equity and inclusion: Special attention shall be given to vulnerable subgroups within the active elderly population, including those living alone, those in urban slums, rural, coastal, and tribal areas, and transgender/intersex persons.

5.2 STRATEGIC INTERVENTIONS

The following ten strategic interventions were identified through expert consultations as priority actions for active elderly. It must be noted that while these ten points are the specific outcomes of Group 4 discussions among experts from various departments/agencies, several related activities for active elderly are also embedded in other sections of the comprehensive action plan, particularly under Personal and Family Level, Neighbourhood/Ward Level, ASHA, Primary Health Care Facilities, and LSGD Level activities.

5.2.1 Comprehensive Geriatric Assessment (CGA)

- Active elderly are often unaware of subclinical health conditions such as pre-hypertension, prediabetes, early cognitive decline, nutritional deficiencies, or sensory impairments. Data from the Longitudinal Ageing Study in India (LASI) Wave 1 (2017-18) shows that over half of Kerala's elderly have hypertension, 35 percent have diabetes, and approximately 25 percent have at least one functional disability. Annual CGA enables early detection of risks and timely intervention, preventing progression to chronic illness and functional decline.

- CGA shall be conducted annually for every active elderly person. The assessment shall include physical health status, mental health and cognitive function, functional ability (activities of daily living), nutritional status, vision and hearing, risk of falls, medication review, and sleep quality. Based on the assessment, an individualized healthcare plan shall be prepared. Health risks should be identified at an early stage through annual assessments, and timely interventions should be ensured.

- The State Health Department, through the State Health Systems Resource Centre-Kerala (SHSRC-K), shall develop standardised self-assessment tools and screening instruments. Initial screening may be self-administered; those who screen positive shall be assessed by ASHAs or MLSPs and referred to the sub-center or PHC team for confirmation and risk mitigation planning. The LSGD shall facilitate the formation of Community Voluntary Resource Groups (CVRGs) to support this process at the ward level. A minimum of 5 to 10 resource persons shall be identified in each ward to initiate home screening. The JAK team shall monitor the screening process and ensure that those with identified risks receive appropriate follow-up.

5.2.2 Promotion of Healthy Lifestyle

- The major non-communicable diseases of old age are largely preventable through lifestyle modifications. NFHS-6 data show that over 46 percent of women in Kerala are overweight . The Healthy Ageing Index study found that physically active elderly were two times more likely to attain healthy ageing compared to physically inactive aged people.

- Continuous scientific awareness programmes shall be organised at the ward and panchayat levels to reduce the future risk of diseases such as diabetes, hypertension, heart disease, osteoporosis, kidney disease, mental health disorders, and fall prevention and home modifications. Training shall be provided on healthy eating habits, regular physical exercise, proper sleep, safe use of medicines, immunization, and mental health promotion. Greater emphasis should be given to identifying and preventing health risks before the onset of disease.

- The Department of Health & Family Welfare shall develop modules and IEC materials in Malayalam, with the State Mass Media wing developing standard IEC materials and the District Mass Media wing

preparing and disseminating these materials at the district level. ASHAs and CVRG members shall be trained to deliver these messages. Digital resource materials shall be shared with CVRG/ASHAs. LSGDs shall facilitate community-level programmes, involving Kudumbashree, student volunteers, and local bodies. Monthly awareness programmes shall be conducted.

5.2.3 Physical Fitness Development

- Sarcopenia, the age-related loss of muscle mass and strength, is a major contributor to functional decline and loss of independence. Functional fitness is defined as the physical capacity to perform normal everyday activities safely and independently without undue fatigue. Regular physical activity, including muscle-strengthening, balance, and breathing exercises, can significantly delay or prevent this decline.

- To maintain functional ability and independent living during old age, yoga, walking exercises, muscle-strengthening exercises, balance training, and breathing exercises shall be organised under the supervision of physiotherapists. Permanent exercise groups shall be formed at the ward level to promote active ageing. The neighbourhood/ward-level intervention in the comprehensive action plan specifies the formation of neighbourhood groups for physical and cognitive activity promotion. These groups shall be supported by the Secondary Care team, which will provide physiotherapy services for the elderly referred from primary care. Existing community spaces, parks, school grounds, temple premises, and community halls shall be identified by LSGD for this purpose. Participation in farming and agriculture shall also be encouraged as a form of physical activity.

- SHSRC-K has developed exercise modules for elderly care as part of its research and capacity-building initiatives. These modules can be adapted by the Department of Health & Family Welfare and the National AYUSH Mission in consultation with SHSRC-K. Physiotherapists and AYUSH practitioners shall conduct training and supervision using these modules. LSGDs shall identify spaces and monitor the functioning of exercise groups. Kudumbashree and ward-level elderly groups shall ensure sustained participation. Regular weekly sessions shall be conducted.

5.2.4 Fall Prevention

- Falls are a leading cause of injury, hospitalisation, and loss of independence among the elderly. SHSRC-K has conducted an RCT on fall prevention among older adults in Kerala, which demonstrated that a multifactorial intervention comprising structured exercises, medication review, environmental modifications, and health education significantly improved functional independence and cognitive outcomes . SHSRC-K has also developed and validated a Home Fall Hazard Assessment Tool and an Individual Fall Risk Assessment Tool specifically for the Kerala context. Measures such as individual fall risk scores, home safety assessments, bathroom safety modifications, installation of grab bars, adequate lighting, provision of walking aids, medication review, and balance training are essential for reducing falls and fractures among older persons.

- Utilise the Individual Fall Risk Assessment Tool developed by SHSRC-K to screen and identify the risk of falls (Annexure 2). The Home Fall Hazard Assessment Tool, comprising items across eight domains: outdoor areas, hall/dining area, bedroom, kitchen, bathroom/toilet, steps, veranda/corridor, and others, may be utilised to assess environmental fall hazards during home visits (Annexure 3). Based on the assessment, necessary interventions such as bathroom safety modifications, installation of grab bars, adequate lighting, provision of walking aids, medication review, and balance training shall be implemented. In addition, there is a need for awareness programmes on fall prevention, including education on home modifications, proper footwear, and safe mobility practices.

- JAK team members (MLSPs) shall administer the Individual Fall Risk Assessment Tool during their annual comprehensive assessments to identify active elderly at risk of falls. ASHA and health workers shall conduct home safety assessments during their visits using the SHSRC-K Home Fall Hazard Assessment Tool. LSGDs shall facilitate necessary home modifications, particularly for those in need. Physiotherapists shall provide balance training and recommend walking aids. Medical Officers shall review medications that may contribute to falls. An awareness programme on fall prevention is to be integrated into the lifestyle promotion activities at the neighbourhood level.

5.2.5 Nutritional Security

- Anaemia, malnutrition, sarcopenia, and osteoporosis are common among the elderly, even among those who appear active. These conditions are often underdiagnosed and untreated, leading to gradual functional decline. LASI data confirm that elderly individuals with chronic illnesses face a significantly higher risk of functional disabilities.

- Regular screening shall be conducted for the early detection of anaemia, malnutrition, sarcopenia, and osteoporosis. Necessary laboratory investigations shall be carried out. ABCD (Anthropometric, Biochemical, Clinical, Dietary) assessment shall be done where indicated. Appropriate nutritional support: dietary counselling, supplements, and food supplementation shall be provided to those identified as at risk.

- Medical Officers and dietitians/nutritionists at PHCs and CHCs shall conduct nutritional assessments during annual health screenings. In care homes and hospices, the care home management shall ensure that nutritional assessments are conducted annually and dietary advice provided by health professionals is followed. Those identified with nutritional deficiencies shall receive dietary counselling and appropriate nutritional supplements. LSGDs shall facilitate access to nutritional support programmes for those in need. Linkages with existing nutrition schemes shall be explored to ensure sustained support for vulnerable elderly.

5.2.6 Brain Health

- Cognitive decline, including dementia, is one of the most feared consequences of ageing. The policy address to the 16th Kerala Legislative Assembly announced the expansion of Smrithi Cafes, dementia day-care centres, and specialised memory clinics across the state. Cognitive activities such as memory enhancement programmes, reading clubs, and dementia prevention awareness are essential for maintaining brain health among active elderly.

- Cognitive activities such as memory enhancement programmes, reading clubs, and dementia prevention awareness shall be organised as interventions. Brain gym activities shall be carried out in meetings or gatherings. The State's Smrithi Cafes and memory clinics shall be

expanded to reach active elderly at the ward level, in alignment with the policy address announcements. Care homes and hospices, facilities for maintaining and improving cognitive well-being, shall be ensured.

- The Department of Health & Family Welfare shall provide technical guidance and screening protocols. LSGDs and the Social Justice Department shall facilitate programme implementation at the ward level. Mental health professionals shall conduct assessments and interventions. Libraries and reading clubs shall be engaged for cognitive activities. The Cultural Affairs Department shall support music and arts-based activities. For care homes and hospices, the management shall ensure that facilities for cognitive stimulation and psychosocial well-being are available and that inmates are encouraged to participate in brain health activities.

5.2.7 Mental Health and Social Participation

- Loneliness and social isolation are significant risk factors for depression, anxiety, and cognitive decline among the elderly. A key feature of Kerala's ageing is the feminisation of ageing where women considerably outnumber men in higher age groups, producing a large number of widowed and solitary elderly women vulnerable to social isolation and insecurity. The erosion of traditional family-based systems of caregiving, nuclear families, and the migration of younger generations abroad have fundamentally altered the social experience of ageing . There is a need for ward-level elderly groups, neighbourhood support initiatives, counselling services, social engagement programmes, and identification of elderly living alone to promote mental well-being and reduce loneliness among active elderly.

- Ward-level elderly groups shall be formed and strengthened. Neighbourhood support initiatives shall be promoted. Counselling services shall be made available. Social engagement programmes, cultural events, group outings, and community festivals shall be organised. Training modules shall include a chapter on legal support and awareness for CVRGs. Identification of people living alone shall be done by CVRG/ASHA. Home visits and regular social contact shall be ensured by all stakeholders.

- LSGDs and Kudumbashree shall facilitate group formation. Social Justice Department shall provide policy and programme support. MSW

students shall be trained and deployed as volunteers for telephonic companionship, home visits, and social engagement activities Counsellors from the District Mental Health Programme shall provide services for those requiring higher-level support. Legal awareness shall be included as a component of the training module for CVRGs. For care homes and hospices, the management shall ensure that facilities for psychosocial well-being and social engagement are available and that inmates are encouraged to participate in social activities.

5.2.8 Digital Literacy

- The digital divide disproportionately affects the elderly. With the increasing digitisation of health services (telemedicine), banking, government services, and social communication, lack of digital literacy excludes the elderly from essential services and social connection. Kerala Police data shows that Malayalis have lost ₹1,200 crore to cyber fraud in the last three years, with senior citizens being increasingly targeted through 'digital arrest' scams, online trading fraud, and vishing. The modus operandi typically involves fraudsters impersonating law enforcement officials, threatening victims with fabricated criminal charges, and coercing them into transferring their savings. Kerala Police has acknowledged that current cyber awareness messages are limited to youngsters and fail to reach segments including the elderly. Training on the safe use of smartphones, online banking, telemedicine, and digital services is essential for active elderly, and the younger generation should be actively involved in this initiative to strengthen intergenerational interaction and communication between older and younger generations.

- Training shall be provided on the safe use of smartphones, online banking, telemedicine, and digital services. Digital literacy training shall also include awareness of common cyber frauds targeting senior citizens, including digital arrest scams, vishing, online trading fraud, and phishing and practical guidance on safe banking practices, grievance redressal mechanisms, and reporting cyber fraud. In care homes and hospices, digital literacy training shall also be made available to enable them to access telehealth services and stay connected with family members.

- LSGDs, the Social Justice Department, and IT agencies shall conduct quarterly training programmes. Educational institutions and youth groups shall be involved as trainers. The Department of Health &

Family Welfare shall provide telemedicine-specific training. Kerala Police's Cyber Cell and the Reserve Bank of India shall be engaged to deliver sessions on safe banking habits and cyber fraud awareness initiatives. For care homes and hospices, the management shall facilitate digital literacy training and access to digital devices for inmates. Awareness materials on cyber safety, including the cyber helpline numbers, shall be disseminated through community channels.

5.2.9 Productive Ageing

- The knowledge, skills, and experience of retired professionals and experts shall be effectively utilized once again for the development of society. Studies from Kerala indicate that senior citizens in rural areas, without considering their age and frailty, engage in economic activities and strive to make their lives economically independent. Kerala's elderly population is projected to rise to 22.8 per cent by 2036, and the Reserve Bank of India has observed that healthier ageing and tapping the productive potential of healthier elderly citizens can soften the labour shock caused by demographic transition. Retired professionals and experts shall be registered and engaged in community activities: mentoring youth, providing technical advice, participating in local governance, cultural activities, and skill-sharing.

- The Department of Senior Citizens' Welfare has proposed a Productive Ageing Register as part of its initiatives. The Kerala Budget 2026-27 announced the formulation of a comprehensive Silver Economic Policy as a long-term roadmap for addressing the needs of Kerala's growing elderly population. The 'New Innings' initiative under the Kerala Startup Mission aims to support citizens aged 50 and above with professional skills and experience to become entrepreneurs and mentors in the startup ecosystem, with the potential to engage over 1,000 retired professionals as advisors and mentors.

- LSGDs shall coordinate this initiative. Professional associations and community organisations shall be involved. Kudumbashree and Cultural Affairs Department shall facilitate engagement opportunities. The Department of Senior Citizens' Welfare shall establish and maintain the Productive Ageing Register. The 'New Innings' initiative under the Kerala Startup Mission shall be leveraged for entrepreneurship and mentorship programmes. The Silver Economic Policy and related

initiatives shall be implemented to create an enabling ecosystem for productive ageing.

5.2.10 Silver Parks

- Safe, accessible, and dedicated spaces for walking, exercise, relaxation, and social interaction are essential for active ageing. While public parks exist, they are often not designed with the needs of the elderly in mind. The policy addressed to the 16th Kerala Legislative Assembly announced that all cities in the State will be made elderly-friendly in a phased manner. The Kerala Budget 2026-27 announced the establishment of dedicated elderly parks, day-care centres, and fitness centres across the state to help senior citizens remain socially connected and physically active.

- Silver Parks shall be established to provide older persons with dedicated spaces for walking, exercise, relaxation, reading, and social interaction. All public spaces proposed as Silver Parks shall be assessed for geriatric-friendliness. In care homes and hospices, access to safe outdoor spaces and recreational facilities shall be ensured as part of the facilities for maintaining physical and psychosocial well-being.

- LSGDs shall plan and establish Silver Parks in collaboration with the Sports Department and Social Justice Department. Existing public spaces shall be identified and assessed for geriatric-friendliness using the AMCHSS-SCTIMST assessment tool (Annexure 4). The Department of Health & Family Welfare shall support health promotion activities within these parks. The Cultural Affairs Department shall organise events. For care homes and hospices, the management shall ensure that inmates have access to safe outdoor spaces and recreational facilities as part of their physical and psychosocial well-being programmes.

5.3 RESEARCH AND MONITORING

Integrated planning and guidance among various departments shall be ensured at the district level, with activities coordinated at the ward level and monitored through local self-government institutions. Local governments shall maintain a comprehensive database of eligible elders and draft annual status reports with the support of elder neighbourhood groups, which shall evolve into local annual action plans and individual care plans for vulnerable elders. SHSRC-K,

being the nodal agency for research within the Department of Health & Family Welfare, shall be in charge of research activities and shall coordinate with other research and academic institutions to strengthen the evidence base for elderly care interventions. A district-level coordination mechanism shall be established, bringing together Health, LSGD, Social Justice, Women and Child Development, Sports, Kudumbashree, and Cultural Affairs, with quarterly monitoring meetings and annual programme evaluations. The CARE platform shall be adapted to capture relevant data for active elderly, including CGA results, participation in physical activity groups, digital literacy training, and nutritional screening, and the State government may publish a ‘state of elderly report’ every five years to assess demographic trends and evaluate service delivery gaps.

6. CARE OF VULNERABLE ELDERLY

While the four-category framework addresses the functional and clinical needs of the elderly population as a whole, certain groups within this population face compounded vulnerabilities that require explicit recognition and targeted attention. These groups are not a separate category in themselves; rather, they constitute an explicit vulnerability layer that cuts across all four functional categories. An elderly person living alone, for instance, may be active, chronically ill, homebound, or bedbound, and their vulnerability adds a dimension that the category-based approach alone may not fully capture. The care of vulnerable elderly must therefore be approached with additional sensitivity, ensuring that they are not left behind while activities under each category are conducted.

6.1 Definition and Scope

Among the elderly, specific groups such as those above 80 years, elderly living alone, those with dementia or cognitive impairment, tribal and coastal populations, destitutes, and intersex and transgender older adults need special attention and care. These groups constitute an explicit vulnerability layer that cuts across the four functional categories of elderly care. They may fall into any of the four categories- bedbound, homebound, chronic illness, or active, but their vulnerability requires tailored attention regardless of category.

6.2 Care Approaches

- The active elderly and those living with chronic illnesses benefit from the general measures for these categories. Care must be taken to ensure they are not left out while these activities are conducted.
- They might need additional motivation, support for transportation, etc., which can be provided by the neighbourhood groups around them.
- The care of those belonging to the bedbound and homebound categories in these vulnerable groups is a community responsibility which must be tailored to the individual patient's needs and wishes.
- In some cases, institutions dedicated to the care of such individuals might be necessary, while in some cases the service of full-time caregivers may be useful.

6.3 Monitoring Mechanisms

- Vulnerable elderly shall be identified during the SHAILI annual home visit survey and flagged in the CARE platform for priority follow-up.
- ASHAs shall maintain a line list of vulnerable elderly, including those living alone and above 80 years, transgender persons, and tribal elderly, and visit them at least once in three months.
- The Elder Vulnerability Register under the Department of Senior Citizens Welfare shall track vulnerable elderly across the State.

7. TIME-BOUND COMPREHENSIVE ELDERLY CARE ACTION PLAN

All of the above plan and sevices are to be implemented in the community with the support of health care delivery systems at various levels in the government and non-government sector. The individual, family, community volunteers and neighbourhood are the main stakeholders. They have to be properly supported and guided by the primary health system including ASHAs, Janakeeya Arogya Kendram, Family Health Centers in all systems of medicine, Local Self Governments and small clinics and hospitals in private sector. Community Based Organisations (CBO) and Non-Government Organisations (NGO) have to identify gaps in services and find possible solutions with the support of community. The primary care system is to be properly guided by the secondary health system at community health centers and major hospitals in both government and private sector. There are many co-ordination and facilitation activities to be done at district and state level by various stakeholder departments. Following is a time-bound action plan of such activities to be done at different levels of care by the stakeholders (table 7.1).

Table 7.1 : Timebound Action Plan - Activities to be done at different levels of care by the stakeholders

Sl. No.	Level of intervention in Geriatric Care	Activity	Facilitating / Responsible Persons / Department	Timeline	Remarks
1	**Personal and Family Level Intervention**	Develop capacity for self-assessment using standard tools	Neighbourhood groups, primary-level team, LSGD	Continuous	To be initiated by January 2027
		Undergo annual health screening	Elderly individuals and families	Continuous	January 2027 onwards
		Develop awareness regarding health risks/illness, risks related to climate change and available health programmes	Neighbourhood groups, primary-level team, LSGD	Continuous	
		Ensure a conducive home environment for elderly persons, including necessary modifications for fall prevention	Elderly individuals and families	Continuous	

		Ensure adequate personalised care and resources, including nutrition, medicines and social-security measures	Neighbourhood groups, primary-level team, LSGD	Continuous	
		Encourage physical and cognitive activities	Neighbourhood groups, primary-level team, LSGD	Continuous	
		Develop awareness regarding legal rights of elderly persons	Neighbourhood groups, primary-level team, LSGD	Continuous	
		Learn and utilise basic digital technology for daily living	Neighbourhood groups, primary-level team, LSGD	Continuous	
		Create awareness regarding living wills and encourage family discussion on end-of-life preferences and nomination of healthcare proxy	Neighbourhood groups, primary-level team, LSGD	Continuous	

2	**Neighbourhood/ Ward Level Intervention**	Encourage social engagement programmes for elderly	Neighbourhood groups with support of Ward and JAK team	Continuous	
		Build capacity of elderly persons and families for self-assessment and awareness of health risks/illnesses including risks related to climate change such as heat, humidity, natural disasters etc.	Neighbourhood groups with support of Ward and JAK team	Continuous	
		Facilitate and follow up physiotherapist/doctor-prescribed home exercises, yoga and breathing exercises for primary prevention	Neighbourhood groups with support of Ward and JAK team	Continuous	
		Develop awareness regarding financial fraud, safe banking practices, nominations and will making	Neighbourhood groups with support of Ward and JAK team	Continuous	

		Identify volunteers willing to participate in elderly-care activities	Neighbourhood groups with support of Ward and JAK team	December 2026	
		Form neighbourhood groups for physical and cognitive activity promotion	Community-based groups with support of Ward and JAK team	January 2027 (initiation)	
		Form patient support groups	Neighbourhood groups with support of Ward and JAK team	January 2027 (initiation)	
		Identify elderly persons lacking adequate personal care, including those living alone, and resources and link them with support mechanisms	Neighbourhood groups with support of Ward and JAK team	January 2027 (initiation)	
		Promote caregiver support groups	Neighbourhood groups with support of Ward and JAK team	February 2027 (initiation)	

		Map neighbourhood support systems and identify an emergency contact for every elderly person living alone	Neighbourhood groups with support of Ward and JAK team	April 2027	
		Ensure transport mechanisms for emergency care and consultation	Neighbourhood groups with support of Ward and JAK team	December 2027	
		Ensure public spaces in the neighbourhood are elderly-friendly	Neighbourhood groups with support of Ward and JAK team	December 2028	
3	**Ward Team (Coordinated by ASHA)**	Support elderly-care group activities of JAK team	Ward team	Continuous	
		Link elderly persons lacking adequate personal care/resources and social-security measures with available support mechanisms	Ward team, NGOs	Continuous	

		Facilitate community-level programmes	Ward team	Continuous	
		Conduct annual health screening using SHAILI.	ASHA	Annually from 2026	Vulnerable elderly living alone should be specifically flagged.
		Monthly home visit for all bedbound elderly	ASHA	October 2026	
		Maintain line list of bedbound, homebound and vulnerable elderly, including those living alone, aged >80 years, transgender persons and tribal elderly	ASHA	January 2027	
		Visit homebound and vulnerable elderly once in three months	ASHA	February 2027	

4	**JAK Team (Coordinated by MLSP)**	Annual comprehensive assessment of homebound elderly, elderly with SHS and vulnerable elderly, with follow-up visits for those requiring additional support through CARE platform	MLSP	January 2027	Annual screening from 2027 onwards
		Identify red-flag signs in elderly, including elder abuse	MLSP	March 2027	
		Link/refer persons requiring consultation to appropriate systems of medicine or other agencies; use teleconsultation wherever possible	MLSP	Continuous	From January 2027
		Provide comfort devices, dressing materials and services available through Janakeeya Aarogya Kendram	JAK Team, NGO	Continuous	From January 2027

		Facilitate neighbourhood/patient support groups and link with Structured Lifestyle Modification Intervention Programme	JAK Team, NGO	Continuous	From January 2027
		Monthly visit to care homes/hospices and empower carers for care of inmates	JAK Team	Continuous	From January 2027
		Facilitate use of available teleconsultation platforms	JAK Team	Continuous	From February 2027
		Conduct health-promotion activities in coordination with other agencies, health professionals and NGOs	JAK Team, NGOs	Continuous	
5	**Primary Health Care Facilities**	Detailed assessment of screened-positive elderly in the impaired domain identified through screening	Medical Officer	Continuous	From January 2027

		Screening for complications among elderly with chronic illness as per protocol	Medical Officer	Continuous	From May 2027
		Provide comfort and assistive devices when required	Medical Officer, Community Nurse-led Home Care Team, JAK Team	Continuous	From January 2027
		Support health and wellness activities in the field area	Medical Officer, Field Staff, ASHA	Continuous	
		Promote elderly-friendly construction and design of houses	LSGD, PWD	Continuous	
		Establish a system to prioritise outpatient care for dependent elderly	Medical Officer	January 2027	
		Monthly assessment and follow-up visits, as per need, for all bedbound elderly by Community Nurse-led Home Care Team	Medical Officer, Community Nurse-led Home Care Team	January 2027	

		Referral and follow-up of elderly requiring specialist consultation/inpatient care across systems of medicine	Medical Officer with Primary Palliative Care Team	January 2027	
		Ensure uninterrupted supply of appropriate medicines and consumables following standard protocols, prioritising BPL and vulnerable individuals	Charge Medical Officer	April 2027	
		Start home-care unit for homebound elderly and elderly with SHS	Medical Officer	April 2027	
		Doctor visit for homebound and bedbound patients referred by MLSP/Community Nurse	Charge Medical Officer	April 2027	
		Ensure all healthcare facilities are elderly-friendly	Medical Officer	April 2027	

		Ensure all staff are trained in comprehensive elderly care	Medical Officer	May 2027	
		Conduct prescription audit to prevent inappropriate polypharmacy	Medical Officer, Pharmacist	May 2027	
		Supply medicines and consumables once a month at home for homebound elderly living alone	Charge Medical Officer	May 2027	
		Provide home-based laboratory sample collection for homebound elderly when required	Charge Medical Officer	December 2027	
		Ensure elderly persons receive immunisation as per Government protocol, prioritising BPL and vulnerable elderly	Medical Officer	January 2028	

6	**LSGD Level**	Develop a system for providing trained caregivers for those in need (Santhwanamithram), with provision for subsidised care for economically vulnerable persons	LSGD, Kudumbashree	January 2027	
		Conduct regular coordination meetings of all agencies providing care for elderly	LSGD	January 2027	
		Develop an LSGD-level resource group to facilitate activities of ward-level groups	LSGD	January 2027	
		Ensure neighbourhood support systems and identify an emergency contact for every elderly person living alone	LSGD, NGO	April 2027	

		Monitor functioning of care homes as per guidelines	LSGD, Social Justice Department	June 2027	
		Develop mechanism for safe collection, transport, treatment, and disposal of biomedical waste from home-based care in line with the State guideline	LSGD	August 2027	
		Arrange transportation facilities for emergency care/specialist consultation, prioritising BPL	LSGD Secretary	December 2027	
		Arrange nutrition support for elderly at risk of malnutrition, prioritising BPL and vulnerable persons	LSGD, Social Justice Department, NGO	April 2028	
		Ensure all public places are elderly-friendly	LSGD, PWD	December 2028	

		Form and implement projects for elderly persons based on need in consultation with relevant departments/agencies	LSGD	Continuous	
		Form and implement projects using the skills and knowledge of elderly persons for developmental and social activities	LSGD	Continuous	
		Ensure provision of social-security schemes and healthcare programmes to all elderly persons	LSGD, Social Justice Department	Continuous	
		Protect the legal rights and security of elderly persons	LSGD, Social Justice Department	Continuous	

7	**Secondary Care Team / Block Level**	Provide physiotherapy for all newly registered bedbound elderly to prepare a physiotherapy plan in primary units, with details recorded in CARE platform	Block MO, Physiotherapist	October 2026	
		Provide physiotherapy for elderly referred from primary care	Block MO	December 2026	
		Referral and follow-up of elderly requiring specialist consultation/inpatient care across systems of medicine	Secondary Palliative Care Team	January 2027	
		Ensure adequate nutrition for vulnerable elderly, including economically vulnerable persons	Hospital Management with support of LSGD/NGO	January 2027	
		Establish system to prioritise outpatient care for dependent elderly	Block MO	January 2027	

		Provide caregivers for elderly admitted without caregivers in coordination with Santhwanamithram Programme	Hospital Management with support of LSGD/Kudumbashree	January 2027	
		Link discharged patients to home-care units/primary or secondary hospitals with a specific follow-up plan	Hospital Management – Nursing Department	January 2027	
		Ensure all healthcare facilities are elderly-friendly	Block MO/Block Panchayat	April 2027	
		Provide specialised home-care services by Nursing Officer and Doctor for elderly referred from JAK and home-care teams, with details recorded in CARE platform	Block MO	April 2027	

		Utilise inpatient beds in CHC for physiotherapy, wound care, end-of-life care and respite care	Block MO, Secondary Palliative Care Team	April 2027	
		Ensure all staff are trained in comprehensive elderly care	Block MO	May 2027	
		Conduct prescription audit to prevent inappropriate polypharmacy	Block MO, Pharmacist	May 2027	
		Train all carers in care homes/hospices in comprehensive elderly care and end-of-life care	Secondary Palliative Care Team	December 2027	
		Develop specialised services such as ophthalmology, dental, mental-health and specialist geriatric-care services	Block MO	December 2029	

8	**Major Hospitals – Including Private Hospitals**	Establish system to prioritise outpatient consultation, laboratory/imaging services and drug dispensing for dependent elderly	Hospital Management	January 2027	
		Ensure appropriate medicines and devices for end-of-life care in wards and casualty	Hospital Management – Pharmacy Department	January 2027	
		Improve dietary services for inpatients according to requirements	Hospital Management – Dietary Department	February 2027	
		Ensure disease-specific protocols are followed for elderly care across systems of medicine	Hospital Management	April 2027	
		Conduct prescription audit to prevent inappropriate polypharmacy	Hospital Management – Pharmacy Department	May 2027	

		Ensure all healthcare facilities are elderly-friendly	Hospital Management	October 2027	
		Ensure all staff are trained in comprehensive elderly care	Hospital Management	October 2027	
		Arrange specialised cots, comfort/assistive devices, privacy and facilities for caregivers in all wards admitting elderly	Hospital Management	October 2027	
9	**NGO/CBO**	Identify gaps in elderly care and plan programmes to bridge gaps with community support	NGO/CBO	Continuous	
		Facilitate neighbourhood/patient support groups formed by the community	NGO/CBO	Continuous	
		Facilitate activities at LSGD and district levels	NGO/CBO	Continuous	

		Train volunteers in elderly care	NGO/CBO	January 2027	
		Ensure all staff providing clinical care for elderly are adequately trained	NGO/CBO	June 2027	
		Enter all details of care provided in CARE portal	NGO/CBO	July 2027	
10	**Care Homes and Hospices**	Follow dietary advice provided by health professionals	Care Home Management	November 2026	
		Encourage inmates to prepare advance care directives	KeLSA (Vayonanma)	March 2027	
		Register all inmates in CARE portal using a standardised form	Care Home Management	April 2027	
		Ensure annual comprehensive geriatric assessment for all elderly inmates	Care Home Management	April 2027 (initiation)	

		Ensure adequate number of carers in proportion to number of inmates	Care Home Management	July 2027	
		Ensure all care homes and hospices are elderly-friendly	Care Home Management	August 2027	
		Ensure all carers are trained in comprehensive elderly care and end-of-life care	Care Home Management	December 2027	
		Provide facilities for maintaining and improving physical, cognitive and psychosocial well-being	Care Home Management	December 2027	
		Ensure availability of required medicines, consumables and comfort/assistive devices	Care Home Management	Continuous	
11	**District Level**	Conduct district- and block-level ToT for MLSPs	DMO/DPMSU	October 2026	

		Prepare and disseminate IEC materials to promote healthy ageing	District Mass Media Wing	November 2026	
		Develop district-level platform for coordination among stakeholders	DMO with District Administration and District Planning Office	November 2026	
		Conduct district-level ToT for ASHA and volunteer training	DMO/DPMSU/NGOs	December 2026	
		Prepare plan for comprehensive elderly-care training for health professionals and staff across systems of medicine	DMO/DPMSU	January 2027	
		Conduct district-level training for doctors across systems of medicine	DMO/DPMSU	January 2027	
		Conduct district-level ToT for other health professionals across systems of medicine	DMO/DPMSU	February 2027	

		Conduct workshop for NGO/CBOs on comprehensive elderly care	DMO and District Administration	February 2027	
		Conduct workshop for care-home administrators on comprehensive elderly care	DMO and District Administration	February 2027	Including staff of NGO/CBOs providing clinical care
		Monitor whether all health facilities are elderly-friendly	DMO and District Administration	October 2027	
		Disseminate guidelines and protocols for elderly care provided by the State	District Mass Media Wing with District Administration	Continuous	
12	**State Level**	Prepare module for comprehensive assessment of elderly for use by MLSPs/Nursing Officers	KSIHFW	August 2026	
		Prepare caregiver (homenurse) training module (Santhwana Mithram)	KSIHFW	August 2026	

		Conduct state-level ToT for MLSPs	KSIHFW	September 2026	
		Develop state-level SOP for medical and nursing procedures to be undertaken at home	SHSRC	September 2026	
		Conduct state-level meeting of research agencies to develop research plans	SHSRC	September 2026	
		Prepare therapeutic diet plan for care homes and hospices	State Nutrition Wing	September 2026	
		Build state-level resource pool of experts from government and non-government stakeholders, including geriatric specialists/geriatricians	KSIHFW in consultation with Department of Health and Family Welfare	October 2026	With support of NHM
		Develop tool for home-safety audit	SHSRC	October 2026	

		Modify CARE platform to meet the needs of elderly-care programme	NHM	October 2026	
		Develop guideline for elderly-friendly healthcare facilities	SHSRC	October 2026	May adapt from the model provided as Annexure 5- prepared by Social Justice Department
		Develop self-assessment tools for elderly	SHSRC	November 2026	With support of State Resource Pool
		Prepare training module for volunteers and ASHA	KSIHFW	November 2026	With support of NHM
		Prepare SOP for preventive, supportive and therapeutic services provided by AYUSH	ISM and Homeo Department	November 2026	

		Prepare monitoring and evaluation system, including KPIs at various levels of care incorporating quality and equity	SHSRC	November 2026	With support of other research agencies
		Develop state-level platform for coordination among multidisciplinary/interdisciplinary stakeholders	Health and Family Welfare Department, Department for Senior Citizens Welfare, Social Justice Department	November 2026	
		Develop standard IEC materials for promoting healthy ageing	State Mass Media Wing	November 2026	Coordinating with State Resource Pool
		Prepare training module for carers in hospices and care homes	KSIHFW	December 2026	Coordinating with State Resource Pool
		Prepare learning modules for doctors, nurses and health professionals for LMS across systems of medicine	NHM, NAM	December 2026	With support of State Resource Pool

		Prepare module for comprehensive assessment of elderly for doctors/general practitioners – Foundation Course in Primary Care Geriatrics	KSIHFW	December 2026	Coordinating with State Resource Pool
		Prepare module for comprehensive assessment for doctors and health providers of ISM and Homeopathy departments	ISM and Homeo Department	December 2026	
		Prepare educational videos for elderly persons, families and general public	State Mass Media Wing, KILA	December 2026	
		Prepare guidelines for improvement of dietary services for inpatients according to requirements	State Nutrition Wing	December 2026	
		Prepare guideline for elderly care in casualty and wards of major hospitals	SHSRC	December 2026	Coordinating with State Resource Pool

		Prepare guideline for end-of-life care in casualty and wards of major hospitals	SHSRC	December 2026	Coordinating with State Resource Pool
		Prepare guideline for caregiver support	State Resource Pool facilitated by SHSRC	December 2026	
		Collate and disseminate social-security schemes and programmes available for elderly	Population Research Centre, Kerala	December 2026	Through Department of Senior Citizens Welfare
		Develop guidelines for safe collection, transport, treatment, and disposal of biomedical waste from home-based care	SHSRC	January 2027	In consultation with Heath Dept and LSGD
		Develop facilitating guidelines for NGO/CBO involved in healthcare programs of elderly	SHSRC	January 2027	In consulation with Health Dept, LSGD and state level bodies of NGO/CBO

		Conduct state-level ToT for doctors in Health Services	KSIHFW	January 2027	With support of State Resource Pool
		Plan and launch Age-Friendly Hospital Initiative with special focus on older persons	Department of Health and Family Welfare	January 2027	With support of State Resource Pool
		Conduct state-level ToT for professionals in medical colleges on elderly care across systems of medicine	DME, DAME, DHME	February 2027	
		Prepare framework for longitudinal studies on active ageing	SHSRC	February 2027	
		Develop human-resource guideline for care homes/hospices considering physical and mental functional capacity of inmates	Social Justice Department and SHSRC	March 2027	

		Prepare module for 8-week training in comprehensive elderly care for MD General Medicine doctors	KSIHFW with State Resource Pool	March 2027	
		Prepare protocol for management of multimorbidity in elderly	State Resource Pool facilitated by SHSRC	March 2027	
		Prepare protocol for prevention, assessment and management of dementia	State Resource Pool facilitated by SHSRC	April 2027	
		Establish geriatric care unit attached to General Medicine Department in all Medical Colleges, Government and private, led by doctors with MD Geriatrics or General Medicine doctors trained in geriatrics	DME, KUHS, DAME, DHME	April 2027	

		Conduct 8-week training in comprehensive elderly care for MD General Medicine doctors	KSIHFW	April 2027	
		Develop guideline for elderly-friendly public spaces and houses	Department of Senior Citizens Welfare	April 2027	Through Department of Senior Citizens Welfare
		Develop elderly-specific prescription audit tool for each system of medicine	SHSRC, ISM and Homeo	April 2027	With support of State Resource Pool
		Integrate teleconsultation platforms and helplines into home-visit and referral workflow for flagged cases	NHM	April 2027	
		Ensure all health staff across systems of medicine complete online training on elderly care through LMS	DHS, DISM, DAME, DHME, DME	May 2027	

		Ensure that all disaster management plans include practical advice on managing risks related to heat, humidity, and other climate hazards specifically for elderly	KSDMA, Health Dept, SHSRC, LSGD	October 2027	
		Commission an equity study and care plan for ageing transgender persons and ageing populations in tribal hamlets/resettlement areas	SHSRC	December 2027	
		Develop protocol for immunisation of elderly	State Resource Pool facilitated by SHSRC	December 2027	With support of State Resource Pool
		Include care of elderly in the syllabus of all healthcare professional courses across systems of medicine	KUHS coordinated by State Resource Pool	Continuous	DME representation required

8. CONCLUSION

The Comprehensive Elderly Care Action Plan for Kerala is a landmark policy document that addresses the multifaceted healthcare needs of the State's rapidly ageing population. With Kerala having the highest proportion of elderly citizens in India and this demographic projected to reach nearly 23 percent of the State's population by 2036, the urgency of a structured, multi-level response cannot be overstated.

This Action Plan is built on a four-category framework: bedbound elderly, homebound elderly, elderly with chronic illness, and active elderly, each with distinct care pathways tailored to their specific needs. By adopting this categorisation, the plan ensures that no elderly person is left behind, regardless of their functional ability or health status. It moves beyond a one-size-fits-all approach and establishes a continuum of care that ranges from preventive and promotive interventions for the active elderly to comprehensive home-based care, palliative support, and end-of-life care for the most vulnerable.

The success of this Action Plan depends on the collective commitment of multiple stakeholders. The Department of Health and Family Welfare, Local Self Government Institutions, the Department of Senior Citizens Welfare, Kudumbashree, the Social Justice Department, other stakeholder bodies, and community-based organisations must work in synergy. The community must be empowered to take ownership of elderly care at the neighbourhood level, while healthcare professionals at all levels must be adequately trained and supported to deliver age-appropriate, compassionate, and evidence-based care.

The Timebound Action Plan provides a clear roadmap for implementation across eleven levels of intervention from the individual and family level to the State level. With defined responsibilities, timelines, and monitoring mechanisms, the plan is designed to be actionable, measurable, and adaptable to the evolving needs of Kerala's elderly population.

Kerala has always been a pioneer in social and health sector reforms. This Action Plan reaffirms the State's commitment to ensuring that every senior citizen lives with dignity, independence, and access to quality healthcare. It is not merely a document but a promise to the elderly who have contributed to building this society that their later years will be met with care, respect, and support.

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10. ABBREVIATIONS

ABHA	Ayushman Bharat Health Account
ACP	Advanced Care Plan
AMCHSS	Achutha Menon Centre for Health Science Studies
ASHA	Accredited Social Health Activist
AYUSH	Ayurveda, Yoga and Naturopathy, Unani, Siddha, and Homeopathy
BPL	Below Poverty Line
CBO	Community-Based Organization
CGA	Controller General of Accounts
CHC	Community Health Centre
CKD	Chronic Kidney Disease
CMD	Centre for Management Development
COPD	Chronic Obstructive Pulmonary Disease
CPHC	Comprehensive Primary Health Care
CSR	Corporate Social Responsibility
CVRG	Community Voluntary Resource Groups
DAME	Directorate of Ayurveda Medical Education
DCFS	District Controller of Food Saftey
DD	Deputy Director
DHME	Directorate of Homoeopathic Medical Education
DHS	Directorate of Health Services
DISM	Department of Indian System of Medicine
DME	Directorate of Medical Education
DMHP	District Mental Health Programme
DMO	District Medical Officer
DPMSU	District Programme Management and Support Unit
DVT	Deep Vein Thrombosis
FHC	Family Health Centre
GH	General Hospital
GIFT	Gulati Institute of Finance and Taxation
HAI	Healthy Ageing Index
IAPC	Indian Association of Palliative Care

ICOPE	Integrated Care for Older People
IEC	Information, Education and Communication
IIMAD	International Institute of Migration and Development
ISM	Indian System of Medicine
IT	Information Technology
JAK	Janakeeya Arogya Kendram
JPHN	Junior Public Health Nurse
KPI	Key Performance Indicator
KSIHFW	Kerala State Institute of Health and Family Welfare
KSSM	Kerala Social Security Mission
KUHS	Kerala University Of Health Sciences
LASI	Longitudinal Ageing Study in India
LMS	Learning Management System
KELSA	Kerala State Legal Services Authority
LSGD	Local Self Government Department
MD	Doctor of Medicine
MLSP	Mid-Level Service Provider
MO	Medical Officer
MSW	Master of Social Work
NAM	National AYUSH Mission
NCD	Non Communicable Diseases
NFHS	National Family Health Survey
NGO	Non-Governmental Organization
NHM	National Health Mission
NNPC	Neighbourhood Network in Palliative Care
NPCCHH	National Programme on Climate Change and Human Health
NPHCE	National Programme for Health Care of Elderly
OPD	Out Patient Department
OT	Operation Theatre
PE	Pulmonary Embolism
PFI	Population Foundation of India
PHC	Primary Health Centre
PHN	Public Health Nurse

PRC	Population Research Centre
PWD	Public Works Department
RBI	Reserve Bank of India
RCT	Randomized Controlled Trial
ROM	Range Of Movement
SCTIMST	Sree Chitra Tirunal Institute for Medical Sciences and Technology
SHS	State Health Society
SHSRC	State Health Systems Resource Centre
SNO	State Nodal Officer
SOP	Standard Operating Procedure
SPM	State Programme Manager
SRS	Sample Registration System
TFR	Total Fertility Rate
UN	United Nations
WHO	World Health Organization

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12	Dr Aravind Chandru B	Research Officer, SHSRC-K

ANNEXURE 1

Bedbound Patient Home-Care Visit Checklist

Patient assessment

- Diagnosis reviewed
- Functional status assessed
- Pain assessed
- Breathlessness assessed
- Nutrition assessed
- Hydration assessed
- Bowel assessed
- Bladder assessed
- Skin/pressure injury assessed
- Oral cavity assessed
- Psychological needs assessed
- Social needs assessed

Nursing

- Bed bath
- Oral care
- Perineal care
- Skin care
- Positioning
- Pressure-injury prevention
- Wound dressing if required
- Catheter care
- Feeding-tube care
- Medication review

Rehabilitation

- ROM
- Contracture prevention
- Positioning
- Bed mobility
- Transfer assessment

- Physiotherapy referral

Equipment

- Air/water mattress
- Backrest
- Wheelchair
- Commode
- Oxygen if indicated
- Other assistive device

Family

- Caregiver trained
- Caregiver burden assessed
- Emergency signs explained
- Contact number provided
- Volunteer linked

Social

- Pension checked
- Financial problems assessed
- Welfare benefits checked
- NGO/LSG support linked

Follow-up

- Next nurse visit
- Doctor review
- Physiotherapy review
- Referral if needed
- Care plan updated

ANNEXURE 2

Individual Fall Risk Screening Form

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(To be filled by a trained Staff Nurse)

Name:	**Address:**
Age:	
OP No:	
Date:	**Contact:**

SECTION A: Multifactorial Elderly Fall Risk Assessment Scale - Kerala

SL NO	ITEM	OPTIONS	SCORE (0,1,2)
A1	**Dizziness** **Do you feel dizzy while getting up or turning your head or while ill?**	**0 -** Never **1 -** Occasional **2 -** Often	
A2	**Assistive device** **Do you use any assistive devices for walking or moving around?** [Any device that assist movement inside or outside house is called assistive devices]	**0 –** Walk without any assistive device **1 –** Use prescribed assistive device **2 –** Self prescribed assistive device/ Hold on to any support for walking	
A3	**Physical Activity** **How often do you engage in physical activity?**	**0 –** Most Days in a week **1 –** Some Days in a week **2 -** Never	
A4	**Fall** **Have you had any falls in the last two years?**	**0 –** No **1-** One non-injurious in last 2 years **2 –** Multiple/ Injurious in last 2 years	

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A5	**Quality of Life (EQ5D5L)**	**0 –** Best **1 –** Moderate **2 –** Poor	
A6	**Fear of fall (FES)**	**0 –** Low **1 –** Medium **2 -** High	
		TOTAL	**/12**

SECTION B: Extended with theoretical items

SL NO	ITEM	OPTIONS		SCORE (0,1)
B1	**Age group**	0-60 to 69 years	1-70 years or above	
B2	**Sex**	0-Male	1-Female	
C3	**Vision**	0-No problem	1-Any problem	
D4	**Hearing**	0-No problem	1-Any problem	
E5	**Chronic diseases**	0-None/Single	1-Two or more	
			TOTAL	**/5**

If total score more than four in section A, or more than three in section B, label as moderate to high risk refer for exercise intervention evaluation

Risk level: 0- Low risk / 1- Moderate to high risk

A5. EQ5D5L

MO) MOBILITY

1) **I have no problems in walking about**
2) **I have slight problems in walking about**
3) **I have moderate problems in walking about**
4) **I have severe problems in walking about**
5) **I am unable to walk about**

SC) SELF-CARE

1) **I have no problems washing or dressing myself**
2) **I have slight problems washing or dressing myself**
3) **I have moderate problems washing or dressing myself**
4) **I have severe problems washing or dressing myself**

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5) **I am unable to wash or dress myself**

UA) USUAL ACTIVITIES (e.g. work, study, housework, family or leisure activities)

1) **I have no problems doing my usual activities**
2) **I have slight problems doing my usual activities**
3) **I have moderate problems doing my usual activities**
4) **I have severe problems doing my usual activities**
5) **I am unable to do my usual activities**

PD) PAIN / DISCOMFORT

1) **I have no pain or discomfort**
2) **I have slight pain or discomfort**
3) **I have moderate pain or discomfort**
4) **I have severe pain or discomfort**
5) **I have extreme pain or discomfort**

AD) ANXIETY / DEPRESSION

1) **I am not anxious or depressed**
2) **I am slightly anxious or depressed**
3) **I am moderately anxious or depressed**
4) **I am severely anxious or depressed**
5) **I am extremely anxious or depressed**

*Scoring EQ5D5L:

- ☐ **0- Score of 1 in all items - Low risk**
- ☐ **1- Score more than 1 in any item, but less than 4 in all items - Medium risk**
- ☐ **2- Score of 4 or 5 in any item - High risk**

* Tick in the box against low or moderate or high risk

A6. Short FES

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Short FES-I

Now we would like to ask some questions about how concerned you are about the possibility of falling. Please reply thinking about how you usually do the activity. If you currently don't do the activity, please answer to show whether you think you would be concerned about falling IF you did the activity. For each of the following activities, please tick the box which is closest to your own opinion to show how concerned you are that you might fall if you did this activity.

		Not at all concerned 1	*Somewhat concerned 2*	*Fairly concerned 3*	*Very concerned 4*
1	Getting dressed or undressed	*1* ☐	*2* ☐	*3* ☐	*4* ☐
2	Taking a bath or shower	*1* ☐	*2* ☐	*3* ☐	*4* ☐
3	Getting in or out of a chair	*1* ☐	*2* ☐	*3* ☐	*4* ☐
4	Going up or down stairs	*1* ☐	*2* ☐	*3* ☐	*4* ☐
5	Reaching for something above your head or on the ground	*1* ☐	*2* ☐	*3* ☐	*4* ☐
6	Walking up or down a slope	*1* ☐	*2* ☐	*3* ☐	*4* ☐
7	Going out to a social event (e.g. religious service, family gathering or club meeting)	*1* ☐	*2* ☐	*3* ☐	*4* ☐

*Scoring Short FES:

☐ **0- Score up to 7 - Low risk**

☐ **1- Score of 8 to 14 - Medium risk**

☐ **2- Score of 15 to 28 - High risk**

* Tick in the box against low or moderate or high risk

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ANNEXURE 3

SCREENING TOOL FOR IDENTIFYING HOME FALL HAZARDS AMONG OLDER PERSONS IN KERALA

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Instructions for ASHAs/Health Worker

1. **Observe the areas of the home that the older person regularly uses.**
2. **Ask questions to the older person or their caregiver regarding each item.**
3. **For each item, mark "Yes" if the hazard is present, "No" if absent, or "NA" if not applicable.**
4. **Each "Yes" response scores 1 point.**
5. **Total score indicates the number of hazards present.**
6. **Use the Risk Category table at the end to classify the level of risk.**

Sl No	Description	Yes	No
	OUTDOOR		
	Does the person who uses the space have access to other areas?	Yes	No
	If yes, please indicate the extent of access, otherwise mark as no		
1	Lack of availability of required light outside the house and environment		
2	Yard/walkway is wet/soggy/muddy		
3	Door steps (carpet) / mats are found to be loose or slippery.		
4	Shoes and sandals are scattered on the steps/walkway		

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5	Hoses or tools used for gardening or outdoor work are lying neglected on sidewalks		
6	Wires/ropes/loose mats/carpets/brooms/mops carelessly placed in the shed or on the walkway to obstruct movement.		
7	Untidy outdoor areas, overhanging trees/plants obstructing the yard		
8	Loose gravel/bricks/sharp stone/floor lying in or around the house		
9	Electric wire/rope lying neglected in the yard		
HALL / DINING AREA			
Does the person who uses the space have access to other areas?		Yes	No
If yes, please indicate the extent of access, otherwise mark as no			
1	The floor gets wet due to mopping / any type of leakage / due to rain.		
2	Carelessly placing shoes/sandals and furniture in such a way as to obstruct the walking path.		
3	Unsecured/armless chairs that tip over when seated		
4	Broken or wobbly furniture		
5	Furniture such as table/teapoy/cabinet/TV stand/cloth stand/chairs/table/cot etc.with sharp edges or protruding legs		
6	Difference in floor level in hall / Sloped surface floors		
7	Difference in floor height when entering from hall to another room		

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8	Stairs between rooms		
9	In the door, in the play / in the walking path Slip-on type feet (without rubber backing) / Cloths/sacks/toys are also available		
BEDROOM			
Does the person who uses the space have access to other areas?		Yes	No
If yes, please indicate the extent of access, otherwise mark as no			
1	Lack of adequate lighting in the bedroom during the day		
2	Floor gets wet due to mopping / any floor leakage / due to rain		
3	Furniture such as chairs/tables/beds with legs pushed to the sides in such a way as to obstruct the walking path		
4	Retractable shoes/slide-type shoes (without rubber backing)/cloths/sacks/play mats left unattended		
KITCHEN			
Does the person who uses the space have access to other areas?		Yes	No
If yes, please indicate the extent of access, otherwise mark as no			
1	The dishwashing area and surroundings get wet		

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2	Furniture / other items are placed carelessly in store rooms or kitchens in an obstructing manner.		
3	Vegetables, dishes or objects are scattered on the floor		
4	Folded mats/cloths/sack lying neglected		
5	Lack of non-slip treads (no rubber backing)		
6	Essentials are stored very high/low		
BATHROOM			
Does the person who uses the space have access to other areas?		Yes	No
If yes, please indicate the extent of access, otherwise mark as no			
1	Items such as soap, oil, shampoo or grease are left on the floor in the bathroom or changing room		
2	The floor in the toilet/bathroom is covered with moss		
3	Lack of adequate lighting in toilet/bathroom		
4	There are no facilities for sit down shower in the bathroom		
5	There are no grab bars in the toilet/bathroom		
6	Bathrooms/toilets have essential items placed too high/low		
7	Recumbent treads / Slip-type treads (without rubber backing) / Fabrics / Sack lying neglected		
8	Is the floor in the bathroom separated from the wet area so that it is not wet?		

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STEPS			
Does the person who uses the space have access to other areas?		Yes	No
If yes, please indicate the extent of access, otherwise mark as no			
No.	Description	Yes	No
1.	No handrail		
2.	Handrails are not in a convenient position for support (neither at the right height nor angle)		
3.	Steps are either too high, too low, or uneven, making them difficult to navigate safely		
4	The edges of the steps are not marked, leading to confusion		
5	Obstacles such as shoes, slippers, toys, or clothes are present on the steps, creating a tripping hazard.		
VERANDA			

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Does the person who uses the space have access to other areas?		Yes	No
If yes, please indicate the extent of access, otherwise mark as no			
No.	Description	Yes	No
1.	Absence of adequate lighting on the pathway during the day / in the corridor		
2.	Furniture is obstructing the walking path		
3.	Steps that are either too high or too low		
4	Variations in the height of the ground in the corridor		
5	On the stairs / walking path, obstacles like toys, shoes, or slippers, and tripping hazards such as wet or loose floor coverings are present.		
OTHERS			
Does the person who uses the space have access to other areas?		Yes	No

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If yes, please indicate the extent of access, otherwise mark as no			
No.	Description	Yes	No
1.	Surrounding areas are not maintained or cleaned.		
2.	Domesticated animals may obstruct or interfere with the individual, such as jumping on them or climbing on furniture while being fed, and may also distract the person's movements.		
3.	Domesticated animals can enter the house		

Home Fall Hazard Risk Score

Calculation	**Value**
Total number of hazardous items (Yes)	
Total number of applicable items (Yes+No)	
Home fall hazards risk score (Yes/Applicable)	
Percentage (Score * 100)	

***Risk category: Low risk- 0 to 5 (0-10%), Moderate risk- 6 to 15 (11-30%), High risk- 16 to 25 (31-50%), Very high risk- 25 to 49 (51-100%)**

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ANNEXURE 4

PERCEIVED AGE FRIENDLINESS SCALE

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Anusha CP. Development and validation of a tool on perceptions of elderly on age friendliness of their neighbourhood (Master of Public Health dissertation, SCTIMST) Available from URL https://dspace.sctimst.ac.in/handle/123456789/11302

PERCEIVED AGE FRIENDLINESS SCALE

Scale appended

Administration

By any health care and allied worker to community living persons 0f age 60 years or older

Scale development summary statistics

12 item scale with each item scored 0 to 4; no reverse scored or negatively scored items; Mean (SD) = 34.08 (10.570)

The point of inflection at +1SD was taken as high perceived elderly friendliness and point of inflection at -1SD was taken as low perceived elderly friendliness.

Scale Interpretation

0-23 – low perceived elderly friendliness

24-44 – moderate perceived elderly friendliness

45 and above – high perceived elderly friendliness

THE PERCEIVED AGE FRIENDLINESS SCALE	
Administering instructions: Read out the instructions, statements and response options to the participants. **Instruction to the participants:** Please listen to the following statements and state how much you agree or disagree with them.	
ITEMS	**Responses**

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	Strongly disagree	Disagree	No opinion	Agree	Strongly agree
	0	1	2	3	4
I. COMMUNITY PARTICIPATION					
1. I can engage in any meaningful work I prefer without worrying about any special requirements I may have.	□	□	□	□	□
2. I have enough opportunities to interact with younger generations	□	□	□	□	□
3. I have easy access to information regarding the local community.	□	□	□	□	□
4. Posters and papers from panchayats and other social institutions are easy to read in terms of font and size are written in understandable language.	□	□	□	□	□
5. Electronic equipment such as mobile phones, televisions, and bank and ticket machines, have large buttons and big lettering.	□	□	□	□	□
6. There are opportunities to attend theatres, museums, and other events in my community for the elderly	□	□	□	□	□
II. PHYSICAL ACCESS					
7. I am able to access local services such as shops, restaurants, or GP clinics without any issue.	□	□	□	□	□
8. I have access to public transportation that is sufficiently frequent.	□	□	□	□	□
9. My house is located in close proximity to services.	□	□	□	□	□
10. Activities and events are organized in places that are accessible and easily reached by public transport.	□	□	□	□	□
III. HEALTH SYSTEM AND SUPPORT					
11. I have easy access to information and services regarding health.	□	□	□	□	□
12. If necessary, I can easily reach health care services by telephone and in person.	□	□	□	□	□

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ANNEXURE 5

ELDER-FRIENDLY HOSPITAL AND HEALTH INFRASTRUCTURE STANDARD

Developed by: *Department of Social Justice, Government of Kerala*

Contributed to: *Department of Health and Family Welfare, Government of Kerala, for adoption as a standard for elderly-friendly healthcare facilities*

Basis: *The criteria have been developed by the Department of Social Justice drawing on international and national practice, including Taiwan's Age-Friendly Hospital Certification, the WHO ICOPE approach, the IHI 4Ms framework, the NICHE programme, Japan's community-based integrated care system, and the Harmonised Guidelines and Standards for Universal Accessibility, 2021. The tool is proposed for adoption by the Health Department, subject to pilot and refinement.*

Instructions for Use

1. This tool is to be used for self-assessment by the facility and for verification by the assessing authority.
2. Each criterion is scored as: 0 = Not met | 1 = Partially met | 2 = Fully met
3. Items marked M are essential. A facility scoring 0 on any essential item shall be referred for remedial action regardless of the overall score.
4. The facility's aggregate score shall be calculated as per the Scoring Summary at the end.
5. Recognition category shall be assigned based on the aggregate score and domain floors.

Facility Details

Items	**Details**
Name of Facility	
Type (District Hospital / General Hospital / Medical College / CHC / PHC)	
District	
Name of Nodal Officer	
Date of Assessment	
Assessor Name	

DOMAIN 1: INSTITUTIONAL POLICY AND LEADERSHIP

Weight: 15% | Maximum Raw Score: 12

No.	Criterion	M	Score (0/1/2)	Remarks
1.1	A Geriatric Nodal Officer is designated for the facility, with defined responsibilities	M		
1.2	A written policy or charter on elder-friendly care exists, approved by the facility head	M		
1.3	An annual budget allocation is earmarked for elder-friendly infrastructure or training			
1.4	Elder-friendly performance indicators (screening coverage, fall incidents, etc.) are reviewed by facility management at least quarterly			
1.5	There is a mechanism to identify and share good elder-friendly practice within the facility			
1.6	Senior citizens or caregiver representatives were consulted in any ward renovation or process change in the last 3 years			

Domain 1 Raw Score: ____ / 12

DOMAIN 2: PHYSICAL AND BUILT ENVIRONMENT

Weight: 25% | Maximum Raw Score: 20

No.	Criterion	M	Score (0/1/2)	Remarks
2.1	A step-free entrance or ramp (gradient not exceeding 1:12, minimum clear width 1200 mm) is available at the OPD and casualty entrances	M		
2.2	The geriatric OPD, laboratory and pharmacy counters are on the ground floor, or otherwise reachable by lift	M		

2.3	Grab bars and non-slip flooring are provided in patient toilets and bathing areas	M		
2.4	OPD waiting areas have adequate seating, including a share of seats with armrests			
2.5	Corridors and staircases used by patients have handrails on both sides			
2.6	Corridors, ramps and staircases are adequately lit			
2.7	Bed height and ward layout in general wards allow safe transfer for frail or low-mobility patients			
2.8	Reserved parking and a covered drop-off point are available near the main entrance			
2.9	Wards used by geriatric patients incorporate basic fall-prevention design — clear pathways, night lighting, and either bed alarms or low beds			
2.10	Wheelchairs, and at least one stretcher-trolley, are available and in working order at all times	M		

Domain 2 Raw Score: ____ / 20

DOMAIN 3: CLINICAL CARE PROCESSES

Weight: 30% | Maximum Raw Score: 18

No.	**Criterion**	**M**	**Score (0/1/2)**	**Remarks**
3.1	Patients aged 60 and above are offered a basic screening for decline in mobility, cognition, vision, hearing, vitality and psychological wellbeing at first OPD contact, following the WHO ICOPE approach	M		
3.2	A defined pathway exists for further assessment and referral where such screening indicates a decline			

3.3	Admitted patients aged 60 and above undergo medication reconciliation and a review for unnecessary polypharmacy	M		
3.4	A protocol exists for screening admitted geriatric patients for delirium or cognitive change			
3.5	A fall-risk assessment and mobility care plan is completed within 24 hours of admission for patients aged 60 and above	M		
3.6	For admitted geriatric patients with serious or chronic illness, a conversation on the patient's or family's goals of care is documented			
3.7	A pressure-injury risk assessment and prevention protocol is followed for bedridden or low-mobility patients			
3.8	A structured discharge plan is prepared for patients aged 60 and above, including a medication list, a follow-up date, and a briefing for the caregiver	M		
3.9	Nursing staff have completed a geriatric-care training module in the last two years			

Domain 3 Raw Score: ____ / 18

DOMAIN 4: COMMUNICATION AND PATIENT EXPERIENCE

Weight: 15% | Maximum Raw Score: 12

No.	Criterion	M	Score (0/1/2)	Remarks
4.1	Signage is provided in Malayalam and English, in large, clearly legible font, visible from the entrance and at each department			
4.2	A priority queue or token system exists for patients aged 60 and above at registration, OPD, laboratory and pharmacy counters	M		

4.3	Discharge summaries and medication instructions can be provided in large print, or read aloud, on request			
4.4	A staffed help desk or volunteer is available to orient a first-time elderly patient			
4.5	Some hearing-assistance provision — a hearing loop, or a quieter consultation option — is available at the main registration or reception point			
4.6	A grievance-redress mechanism specific to patient experience is displayed, with a named contact			

Domain 4 Raw Score: ____ / 12

DOMAIN 5: COMMUNITY LINKAGE AND CONTINUITY OF CARE

Weight: 15% | Maximum Raw Score: 10

No.	Criterion	M	Score (0/1/2)	Remarks
5.1	A defined referral pathway exists from discharge home or community-care service	M		
5.2	High-risk geriatric discharges receive a follow-up contact, by call or visit, within 7 days			
5.3	A tele-consultation or telephone follow-up option is available for stable elderly patients			
5.4	Caregivers of patients with significant functional decline are given training or briefing material			
5.5	A working linkage exists with palliative-care or home-based-care services for patients needing longer-term support			

Domain 5 Raw Score: ____ / 10

SCORING SUMMARY

Domain	Weight	Max Raw Score	Raw Score Obtained	Weighted Score
1. Institutional Policy and Leadership	15%	12		
2. Physical and Built Environment	25%	20		
3. Clinical Care Processes	30%	18		
4. Communication and Patient Experience	15%	12		
5. Community Linkage and Continuity of Care	15%	10		
Total	100%	72		

Aggregate Score (sum of weighted scores): ____ / 100

RECOGNITION CATEGORY

Aggregate Score	Category	Validity
85% and above, no domain below 60%	Gold	5 years
70% - 84%, no domain below 50%	Silver	5 years
60%-69%, no domain below 40%	Bronze (provisional)	2 years, with re-assessment
Below 60%, or any domain below its floor	Not yet recognised	Reapply after remedial steps

Category Assigned: _____

Remedial Steps Required (if any):

1.

2.

3.

4.

CERTIFICATION

Role	Signature	Date
Geriatric Nodal Officer		
Facility Head		
Assessing Authority		