

Screening: GP practice sends GFI to older persons (≥ 70).
GFI score ≥ 5 : PN calls for home visit.



Assessment: home visit

PN conducts assessment with older person (and informal caregiver) followed by decision making with GP about necessity for:

- Assessment GP.
 - Assessment OT and/or PT (advised in case of concerns or problems in performing activities).
 - Additional assessments.
- 

Analyses and action plan: Perspective GP and PN (or extended team including OT, PT and others) on current problems in performing activities and risk factors for developing disability.



Agreement on action plan: home visit

PN negotiates with older person (and informal caregiver) on goals, actions and toolbox parts.



Execution of action plan

- ***Meaningful activities*** (OT): increasing client's awareness of capacities, interests and self-efficacy in performing activities.
- ***Adaptation of environment, skills or activities*** (PT and OT): adapting the environment (e.g. technology), learning new skills or new ways of performing activities. A tailor-made physical exercise program can be applied in case improvements in strength, balance, flexibility and endurance are believed to contribute to reducing the risk of disability.
- ***Social network and social activities*** (PN): organizing the social network and resources to fulfil needs for social contact/support.
- ***Physical activity*** (PT): increasing physical activity in daily life.
- ***Stimulate health*** (GP and PN): measures that will increase health and maintenance of a healthy lifestyle.

Other interventions can be applied besides the toolbox.

PN is case manager monitoring progress and satisfaction.



Evaluation and follow-up:

PN and older person (and caregiver) evaluate progress and agree on follow-up.