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.