Appendix B: Step-by-step implementation plan checklist

Designated clinicians (DC) are selected based on the clinic or primary care office. A DC can include, but is not limited to, Doctors, Nurses, Nurse Practitioners, Social Workers, Pharmacists, Occupational Therapists, Physiotherapists.

Step	Action	Details
1	**Select screener**	Review the available screening tools (e.g., interRAI Preliminary Screener (AUA), Clinical Frailty Scale), and select the tool that is best suited for your clinic. Seek permission to use the tool, as needed. For the purposes of this checklist, the selected screener is the interRAI Preliminary Screener (AUA).*
2	**Set-up screener**	Build Screener into EMR or database; ensure a seamless process for adding it to the patient's record.
3	**Identify patients over 70 years old**	SELECT ONE: 1. Designated staff member identifies patients with upcoming appointments who need to complete screener, and flags these patients in the patient record or other system set up within the clinic (see options for administration in step 4). 2. Designated clinician identifies patients over 70 years old who have upcoming appointments (done weekly or monthly) to administer screener over the phone in advance of in-person appointment. 3. Designated clinician proactively identifies patients over 70 years old who are due for a wellness check.
4	**Screening and assessment**	SELECT ONE: 1. Pre-appointment screening done over the phone by designated clinician up to 2 weeks prior to upcoming appointment. Designated clinician discusses results of screener with patient and/or caregiver at the appointment. 2. Phone screening proactively done with all eligible patients over 70 years old. Designated clinician discusses results of screener with patient and/or caregiver, and either determines no follow up is needed, schedules a follow up appointment and/or identifies Decision Boxes to be administered at a follow up appointment. 3. Screener completed independently by patient in waiting room on tablet, when the patient arrives for their appointment (even if the appointment is not related to aging or frailty concerns). Designated clinician discusses results of screener with patient and/or caregiver. 4. Primary care practitioner completes the screener with the patient (and caregiver) in a clinic room as part of the appointment (even if the appointment is not related to aging or frailty concern).

* Alternative tools include: Pictoral Fit Frailty Scale, Clinical Frailty Scale. Please note, these tools were not tested in this approach as part of this research study.

Appendix B: Step-by-step implementation plan checklist

Step	Action	Details
5	**Care planning and shared decision making with patient and caregiver**	SELECT BASED ON RISK LEVEL (example based on interRAI Preliminary Screener (AUA)): 1. AUA risk level 1 & 2 (low risk): using clinical judgment, discuss self-management and/or education, and discuss Decision Boxes, if appropriate; reassess in 1-year or earlier if there are major changes with the patient. 2. AUA risk level 3 & 4 (moderate risk): using clinical judgment and screener results, discuss results and suggest referrals and/or further assessment with patient and/or caregiver. 3. AUA risk level 3 & 4 (moderate risk): using clinical judgment and screener results, discuss results, suggest referrals and/or further assessment with patient and/or caregiver. Recommend Decision Boxes to complete together (clinician and patient) at current appointment (time permitting), or at a follow-up appointment. 4. AUA risk level 5 & 6 (high risk): using clinical judgment and screener results, discuss results and suggest referrals and/or further assessment with patient and/or caregiver. 5. AUA risk level 5 & 6 (high risk): using clinical judgment and screener results, discuss results, suggest referrals and/or further assessment with patient and/or caregiver. Recommend Decision Boxes to complete together (clinician and patient) at current appointment (time permitting), or at a follow-up appointment.
6	**Care coordination and system navigation**	SELECT ALL THAT APPLY: 1. Designated clinician makes recommendations for self-management and/or education. 2. Designated clinician makes referrals for further assessment by home and community care, community support service or services known to primary care professionals. 3. Designated clinician makes referrals directly through Caredove or through other provincial resources (e.g., thehealthline.ca, 211) for community support services or home care. 4. Physician makes referral to specialized geriatric services (those requiring a physician's signature).
7	**Ongoing monitoring**	Frequency determined by primary care practitioner.