Appendix 3 (as supplied by the authors): GRADE basis of recommendation decision table for screening for cognitive impairment

Questions: 1. Does screening for cognitive impairment improve outcomes? 2. Does treatment for MCI improve outcomes?		
Population: Asymptomatic community-dwelling adults 65 years of age and older		
Interventions: 1. Screening tools (e.g., Mini Mental State Examination (MMSE), the Montreal Cognitive Assessment (MoCA) and Alzheimer's Disease Assessment Scale−cognition subscale (ADAS-Cog)) 2. Pharmacological treatments (e.g., donepezil, rivastigmine, galantamine, dietary supplements/vitamins) and non-pharmacological treatments (e.g., exercise, cognitive training/rehabilitation)		
Setting (if relevant): Primary care practice		
Decision domain	Summary of reason for decision	Subdomains influencing decision
Quality of evidence (QoE) for screening studies *Is there high or moderate quality of evidence* Yes☐ No ☒	**QoE for benefits of screening:** Very Low No RCT evidence identified on benefits of screening. **QoE for harms of screening:** Very Low No RCT evidence on harms of screening.	Key reasons for downgrading or upgrading: **QoE for benefits of screening:** No RCT evidence identified for direct benefits of screening. **QoE for harms of screening:** No RCT evidence for direct harms of screening.
Quality of evidence (QoE) for treatment studies *Is there high or moderate quality of evidence* Yes☐ No ☒	**QoE for benefits of treatment:** Low Pharmacological treatments: Low quality of evidence from trials showed no difference in effect vs control. Non-pharmacological treatments: Moderate quality of evidence from 5 trials showed a small benefit with exercise or cognitive training/rehabilitation, however, non-clinically significant.	Key reasons for downgrading or upgrading: **QoE for benefits of treatment:** Evidence showed no difference in effect between intervention and controls. There was serious imprecision and serious risk of bias in the measures of effect of pharmacological treatment studies, thus, these studies were downgraded to low quality. For non-pharmacological treatment studies, the 5 RCTs showing a small statistically signficiant benefit (but unlikely clinically significant) on cognition from non-pharmacologic interventions, studies werealthough rated as moderate quality, were downgraded due to serious

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	QoE for harms of treatment: Low Pharmacological treatments: Low quality of evidence from trials showed no difference in effect vs control. Non-pharmacological treatments: no serious adverse events reported.	study design limitations. **QoE for harms of treatment:** Reasons for downgrading the evidence were largely due to concerns over risk of bias and imprecision with pharmacological treatment studies.
Balance of benefits and harms *Is there certainty that the benefits outweigh the harms?* Yes☐ No ☒	There was no RCT evidence of benefit for screening. RCTs suggested no benefit for pharmacological treatment of people with identified MCI and small benefit for non-pharmacological treatment of people with identified MCI (although non-clinically significant). Therefore, there is no certainty that the benefits outweigh the harms.	Is the baseline risk for benefit similar across subgroups? Yes☒ No☐ *No evidence for screening that show benefits are different in subgroups* Should there be separate recommendations for subgroups based on risk levels? Yes☐ No☒ *No – no evidence for screening that show benefit for any risk level* Is the baseline risk for harm similar across subgroups? Yes☒ No☐ *No evidence for screening that show harms would be different for subgroups* Should there be separate recommendations for subgroups based on harms? Yes☐ No☒ *No evidence for harms in subgroups*
Values and preferences *Is there confidence in the estimate of relative importance of outcomes and patient preferences?*	Regarding the willingness to be screened one international study found no statistically significant differences in participants' willingness to be screened during the next year (31.9%) or during the next five years (42.1%). The study also found that results of a screening would help participants plan for future treatments and help them deal with the problem if there was one. Participants also mentioned that screening would be time	Perspective taken: Patient Source of values and preferences: Community interviews, cohort study, and before and after study designs. Source of variability, if any: Some variability in patient preference for screening

Yes☒ No ☐	consuming (performing an evaluation is time-consuming or it takes time to go see a physician for screening) and costly (performing an evaluation is costly) and other things that are more important for them.	Method for determining values satisfactory for this recommendation? Yes☒ No☐ All critical outcomes measured? Yes☒ No☐
Resource implications *Are the resources worth the expected net benefit?* Yes☐ No ☒	Since there are no clear benefits of screening, additional resources to support screening are not warranted.	Feasibility: Is this intervention generally available? Yes☒ No ☐ Opportunity cost: Is this intervention and its effects worth withdrawing or not allocating resources from other interventions? Yes☐ No ☒ Is there lots of variability in resource requirements across settings? Yes☐ No ☒ Unknown – no effect of screening so did not look into this issue, however, the screening instruments are generally questionnaires and therefore requirements likely not variable
Overall strength of recommendation: STRONG	Based on the lack of direct evidence about the benefits and harms of screening for cognitive impairment in adults, and the lack of efficacious treatments for identified MCI, the CTFPHC recommends strongly against screening for cognitive impairment.	
Remarks and values and preference statement	Quality of Evidence Low. No evidence was found on the effectiveness of screening, the RCTs evaluating the effectiveness of pharmacological treatment were all rated as low quality, and the five RCTs showing a small benefit (non-clinically significant) on cognition from non-pharmacologic interventions, although rated as moderate quality, were downgraded due to serious study limitations.	