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Evaluating Successful Implementation of the Geriatric Assessment and Intervention Network as a Model for Dementia Assessment in the Community

A Documentary Analysis

Part of the ROSA-LHIN Research Study

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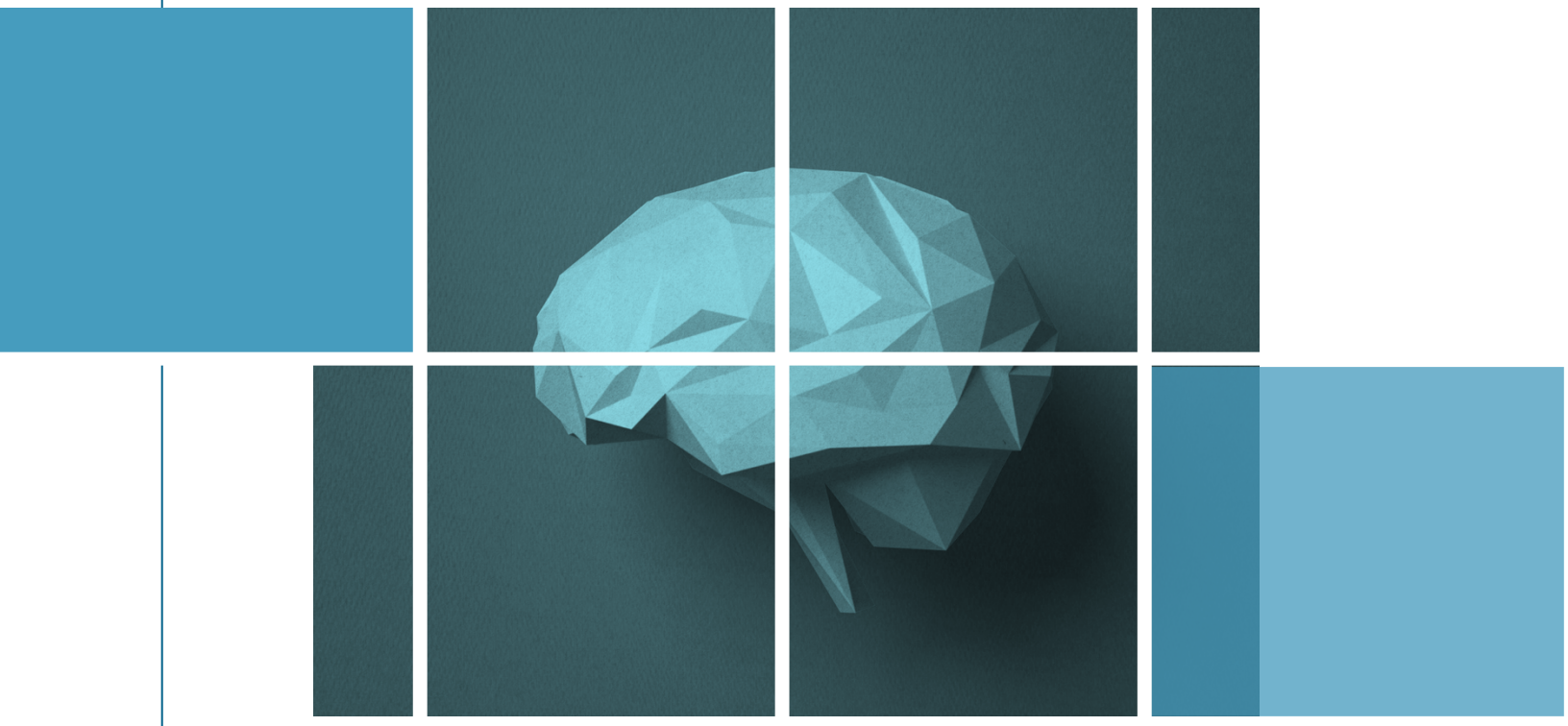


Introduction

In Ontario's Central East Region, the Geriatric Assessment and Intervention Network (GAIN) was established to address the rising demand for community-based, specialized, frailty assessment and intervention services, a type of specialized geriatric service (SGS).

Led by Nurse Practitioners (NP), these interprofessional teams of geriatric assessors provide interprofessional comprehensive geriatric assessments (iCGA) and targeted interventions to older adults and their care partners. Since their introduction in 2010, GAIN teams have been a dedicated resource for approximately 67 000 frail seniors in the Central East Region, offering diagnosis and ongoing management of geriatric syndromes (including frailty and dementia) within the community.

GAIN teams are a specialist service that supports primary care providers, and GAIN teams serve to augment the medical care provided by physician specialists (i.e. Geriatricians, Geriatric Psychiatrists, and Care of the Elderly Physicians), of which there are an insufficient number available to meet the current and growing demand. In some teams, geriatric physician specialists work together with GAIN to provide enhanced diagnostic support for patients/clients with particularly complex medical needs.

Despite the widespread adoption of this model and the growing prevalence of dementia, there has yet to be a systematic evaluation of community-based dementia care in the Region.

Objectives

Overall Study Objectives

This study was designed as part of a larger mixed-methods research study that included including implementation and observational research components. The design and methods were based on the Canadian Consortium on Neurodegeneration and Aging (CCNA) Team 19 protocol *Assessing care models implemented in primary health care for persons with Alzheimer's disease and related disorders* (Bergman & Vedel), more commonly known as the Research on Organization of Healthcare Services for Alzheimer's (ROSA) Study. Recognizing that GAIN Teams have historically been assessing and diagnosing individuals with dementia (often at the request of primary care providers), the present research was designed as an extension study to the ROSA Study.

The overall objective of the ROSA-LHIN Extension Study was to assess and compare collaborative care models (collCM) of dementia care services between primary care and specialist geriatric care (i.e. GAIN) sites in the Central East Region, to identify key factors for quality of care and successful implementation. The objectives of the implementation and observational components of this study were as follows:

1) Implementation Component

    i) Describe the implementation strategies used;

    ii) Identify the necessary elements for successful development and implementation for regional dementia care services.

2) Observational Component

    i) Compare care models, including individual, clinical, and organizational characteristics;

    ii) Compare outcomes of successful management, including: diagnosis, quality of follow-up care, continuity of care, use of medication for dementia, and coordination of dementia care between and across dementia care services.

The findings from this research will be used to improve the quality and coordination of dementia care services for older adults within the Central East Region.

Documentation Study Objectives

The documentary review presented in this report contributes to the implementation component of the ROSA-LHIN Study. The purpose of the documentary analysis was to the answer the following primary and secondary research questions:

1) What is the collCM model that has been implemented to improve care of patients with Alzheimer's disease and related disorders and their care partners specialist geriatric care (i.e. GAIN Teams) in the Central East Region?
    a) what patient population is being served?
    b) what clinical processes are included in the model?
    c) what policies and procedures are in place?
    d) what types of health professionals are employed?
    e) what is the local context of the collCM model e.g., rural/urban, proximity to other dementia care services?
2) How has this collCM been developed and implemented?
    a) what strategies have been used; what was required in terms of resources, training and leadership?
    b) what role did champions play?
    c) what are the key elements for successful implementation?
    d) what barriers were faced and how were these addressed?
    e) what strategies/conditions are necessary for regional implementation?
3) How has this collCM evolved over time?
    a) how was the model initially conceived and how has it actually been implemented?
4) How does this collCM coordinate their services in the Central East Region?

Methods

Design

Key documents were obtained from GAIN Regional Offices and Seniors Care Network to understand the context, implementation, and evolution of the collCM (i.e. GAIN). Documents covered 2010 (prior to program implementation) to 2019, and included policy papers, briefing notes, planning documents, project management materials, organizational policies, job descriptions, meeting minutes, annual reports, organizational charts, operating guidelines, evaluation reports, quality improvement materials, and operational reports.

All documents were screened and reviewed using Bowen's (2009) approach to document analysis, which included critically assessing: (1) the quality of the documents; and (2) the relevance and utility of the documents in support of the research questions. Checks of quality included determining the credibility, accuracy, representativeness, and completeness of the source materials. These documents were determined to be sufficiently relevant if they contained information that addressed the research questions, and they were determined to be sufficiently useful if they enabled a detailed description of the development, implementation and evolution of the GAIN model.

Following this review and appraisal, nine key documents were identified for inclusion and full review. Information from each document was recorded in a review table for ease of analysis. Once this was completed, key elements were themed and organized against the research objectives.

Ethics

Ethical approval for this study was obtained from the Hamilton integrated Research Ethics Board (#2017-2224), the University of Waterloo Research Ethics Committee (#40866), Scarborough Health Network Research Ethics Board (#MED-18-023), and Peterborough Regional Health Centre Research Ethics Board and Ethics Committee (February 26, 2019). For sites that did not have a research ethics committee or ethical review process, management approval was obtained and Letters of Understanding were developed and signed by the following GAIN host organizations: Haliburton Highlands Health Services; Campbellford Memorial Hospital, Community Care City of Kawartha Lakes, Port Hope Community Health Centre, Carea Community Health Centre, St. Paul's L'Amereaux Centre, and CareFirst Seniors Services.

Results

Nine documents were included in this analysis and are listed in the table below.

	Document Title	Research Objective
1	Proposed Logic Model (2010)	Q3
2	Examining the GEM/GAIN Continuum (Schwartz & Hawkins, 2013)	Q3
3	GAIN Formative Evaluation (Hawkins, 2013)	Q1, Q3
4	GAIN Design Project Plan (2014)	Q2, Q3, Q4
5	GAIN Design Project Update (2014)	Q2, Q3
6	GAIN Operating Guidelines (2017)	Q1, Q4
7	GAIN Logic Model (Gutmanis & Hillier, 2017)	Q3
8	2017/2018 GAIN Evaluation (Hawkins, 2018)	Q1, Q3
9	2018/2019 GAIN Evaluation (Ehsan & Hawkins, 2019)	Q1, Q3

OBJECTIVE 1

Patient Population Served

GAIN provides services to frail seniors living at home, [1] who are typically 65 years of age or older, [2] and whose health, dignity, and independence are at risk due to multiple complex chronic medical and psycho-social problems, a decline in health and/or level of function, and/or a decline in their ability to live independently.

GAIN services include a comprehensive geriatric assessment (CGA), diagnostic evaluations, coordinated care planning, and interventions. These interventions typically include medical treatment, enhanced system navigation, education, short term counselling, caregiver support, health prevention activities (to mitigate the risk of adverse outcomes), advance care planning, collaborative/shared care, and advocacy. GAIN Teams are Nurse Practitioner lead (NP-lead) teams (i.e. NP as Most Responsible Provider [MRP]), with physician consultants (primarily Geriatricians) providing clinical support (where available).

According to a recent evaluation of the GAIN patient (Hawkins, 2018), the average age of patients is 79.85 (*SD*=8.5), with the majority being between the age of 75 and 84. Cognitive decline or assessment for cognitive decline are among the most common reasons for referral (Ehsan & Hawkins, 2019).

Clinical Processes

Triage

Triage Includes vetting of the referral for appropriateness, a determination of level of urgency, and a preliminary assessment planning (e.g. documentation retrieval review, inclusion of requisite team members, and etc.).

Assessment and Care Planning

CGA is the standard of care for specialized geriatric services for older adults living with frailty. It employs an interprofessional, patient-focused approach to integrated assessment and interventions. At GAIN, each referred client undergoes a CGA covering 13 domains of assessment, namely:

1) Medical and Surgical History (Hx.)
2) Medications Hx.
3) Social Hx.
4) Mood

[1] Does not include Long Term Care home
[2] Younger clients also seen

5) Fall Risk
6) Function
7) Cognition
8) Continence
9) Pain
10) Sleep
11) Nutrition
12) Physical
13) Response to the Reason for Referral

The CGA is supported by a NP-lead, trained interprofessional team that uses expert clinical judgment, technology, and tools to gather, assess, synthesize, and interpret the information needed. Dementia stage and frailty status are identified for each patient.

The outcome of an interprofessional CGA is an integrated clinical picture, which is further refined by physical assessments conducted by NPs, and (where available) physician specialists (usually geriatricians). Practical interventions integrate patient goals and address function, independence, restorative potential and/or palliation and the team supports the patient and caregivers to implement individualized recommendations that emerge, balancing risk and autonomy while supporting choice.

Case Management

A Coordinated Care Plan is initiated for every patient requiring Intensive Case Management (ICM). ICM is for patients who require interventional services, beyond what can be provided by the GAIN team. In addition to concurrent conditions (including frailty), these patients usually have moderate to severe dementia. GAIN provides time-limited supports but continues to collaborate with the lead agency for these patients.

There is ongoing access to an interprofessional team of geriatric assessors/specialists, including a behavioural supports clinician, and – in some locations – support of a geriatric medicine specialist. Interprofessional team members provide system navigation to patients and caregivers to ensure they are linked to appropriate services.

There is flexibility in the level and duration of case management, which is provided in response to need, complexity, risk and change in patient and/or caregiver status. The ideal trajectory for ICM patients is moving from intensive to light case management, but pathways may be initiated at any level. Also, some patients may return to light, moderate, or intensive levels, based on changes to their medical conditions or needs, as determined through reassessment.

Coordination, system navigation, advocacy, and education are provided to all patients to optimize community supports.

All patients are reviewed regularly by the entire interprofessional team through a Clinical Rounds process. The frequency with which a patient's care is reviewed, varies from weekly, monthly, or quarterly, depending on patient status and the intensity of case management being provided.

Policies and Procedures

GAIN Operating Guidelines outline the service standards, procedures, and/or general guidelines regarding:

a) Intake of referrals and catchment (the process for determining the appropriate team, based on patient location/proximity);

b) Clerical Intake, Clinical Triage, and Level of Urgency (3 days to prepare for triage, and 5 days to complete the clinical triage and communicate the appointment date);

c) Comprehensive Geriatric Assessment[3] and Goal-based Care Planning;

d) Case Management (including criteria and general guidelines for Intensive, Moderate and Light case management); and

e) Discharge processes.

Health Professionals Employed

As of Oct 2017, the following clinical staff were employed at GAIN (full time equivalent [FTE] of all teams, combined):

Profession	FTEs
Nurse Practitioner	16.9
Physiotherapist	4
Occupational Therapist	11.73
Social Worker	10.23
Pharmacist	8.44
Community Support Worker/Personal Support Worker	9.57
Speech Language Pathologist	0.6
Registered Dietitian	0.9
Behavioural Supports Clinician	12.0

[3] The CGA is also conducted in accordance to the standards outlined in the *Competency Framework for Inter-professional Comprehensive Geriatric Assessment* (CGA) (Kay et al., 2017).

Registered Nurse/Registered Practical Nurse	3.1
Care Coordinator	8.0
GAIN Nurse Care Coordinator	14.0

The above table does not include consulting physician specialists like Geriatricians, who receive remuneration via OHIP billing, and – where available - salaries or stipends offered by healthcare organizations (e.g. hospitals).

Local Context

As of Aug 2019, there were twelve GAIN teams (six in North-East cluster, four in Scarborough cluster, and two in Durham cluster), hosted at different hospital and community health and social services organizations, including:

- 4 hospital-based teams in Peterborough (Peterborough Regional Health Center [PRHC]), Oshawa (Lakeridge Health) and Scarborough (Scarborough Health Network [SHN]; General and Centenary sites). Hospital-based teams provide ambulatory services through outpatient clinics; clients and caregivers travel to the clinics for their scheduled appointments.
- 8 community teams providing ambulatory services and conduct home-visits, located in both urban and rural settings, including: Peterborough (PRHC), Trent Hills (Campbellford Memorial Hospital [CMH], Minden (Haliburton Highlands Health Services [HHHS], Lindsay (Community Care City of Kawartha Lakes [CCCKL]), Port Hope (Port Hope Community Health Centre [PHCHC]), Whitby (Carea Community Health Centre [CCHC]), and Scarborough (Senior Persons Living Connected [SPLC]; CareFirst Seniors Services).

OBJECTIVE 2

Implementation and Ongoing Development

Seniors Care Network (formerly known as Regional Specialized Geriatric Services [RSGS]) was established in 2012 by the Central East LHIN to improve the organization, coordination and governance of regional Specialized Geriatric Services (SGS) for frail seniors.

The primary mandate of the initial RSGS was to strengthen and coordinate existing SGS, including GAIN. RSGS' annual work plan also included the facilitation of improving equitable access to GAIN across the Central East LHIN.

In 2013, RSGS consulted GAIN Clinic managers to set the future strategic priorities for the Program by conducting an environmental scan that included a SWOT analysis (Schwartz & Hawkins, 2013) . Program strengths (standardized assessments, access to geriatricians, and provision of patient and caregiver focused services) and challenges (retention and recruitment of team members, time-consuming assessments, and local variation in access to community services) were identified, and the results were shared with GAIN in June 2013

Concurrently, a Formative Evaluation of the GAIN Program was conducted by RSGS (Hawkins, 2013) at the request of CE LHIN, and findings were presented to the LHIN leadership and the RSGS Governance Authority in August 2013. The goal of the evaluation was to generate information to develop or improve the program. It was inferred that there was a significant focus on clinic staff's participation in on-going training and educational activities, such as the *Interprofessional Geriatric Services (IGS) Fellowship Program,* which included two weeks training on conducting CGAs. In addition to other findings, the evaluation uncovered significant issues regarding geographic 'reach', and recommendations were made to revisit the original 'network' model and/or explore alternate modes of service delivery.

In response to these findings, the Central East LHIN announced the development of six new community-based GAIN teams as a part of Community Sector Investments (October 2013), and a GAIN '(Re)Design Project' was initiated. Both the Central East LHIN and Seniors Care Network (formerly RSGS) were Project Sponsors. Seniors Care Network was tasked with leading the project, and a Design Team, comprising of seven working groups, was created. Significant milestones were achieved in 2014, including development of:

- Operating Guidelines (including Definitions, Values and Principles)
- Model of Care Framework
- Standardized Metrics for Program Monitoring and Evaluation (and related data dictionary and tools)
- Learning Modules
- Quality Improvement Framework

An application to renew a portion of the GAIN funding agreement with Lakeridge Health Corporation (that had expired March 31, 2012) was submitted to the Central East LHIN by Seniors Care Network in 2014. The application pertained to the re-provisioning of a GAIN

Regional Office consisting of a GAIN Regional Manager (which was currently vacant) and an Administrative Assistant position, hosted at Lakeridge Health. The managerial position was later filled by the end of 2014. Currently, GAIN Regional provides a leadership and coordination role. This includes program standardization, reporting, and quality improvement activities across GAIN Teams, and advancing the reach of GAIN in the Central East LHIN.

At the recommendation of Seniors Care Network, the Central East LHIN funded an additional two community teams in Haliburton and Trent Hills in 2015. These teams are hosted by HHHS and CMH.

The GAIN Design Project formally concluded in 2015.

To enable a central intake and referral system, a funding request for a Coordinated Access Model was submitted by Seniors Care Network and GAIN Regional in 2017.

GAIN has been formally evaluated three times by Seniors Care Network. These evaluations led to the identification of various quality improvement opportunities and expansion of services.

Barriers to Implementation

Initial barriers (2010-2013)

- Partial funding of the proposed model (Hawkins, 2013)
- Challenges identified by GAIN Managers (Schwartz & Hawkins, 2013): Retention and recruitment of team members, time-consuming assessments, and local variation in access to community services
- Barriers and recommendations identified in the Formative GAIN Evaluation (Hawkins, 2013):
    - Barriers: Limited service capacity (staffing issues), access (clients identified transportation issues, travel distance issues, length of appointments, and parking costs as barriers to accessing GAIN), contextual barriers (GAIN Clinic Managers identified geographic barriers and data collection barriers)
    - Recommendations: Address access related issues, including revisiting the original 'network' model and/or explore alternate modes of service delivery (such as, satellite clinics, outreach teams, and OTN consultations etc.)

GAIN Re-Design/Expansion (2014-15)

- Challenges:
    - Staffing issues, training, skills and experience of select newly hired clinicians not sufficient to ensure the delivery of competent and quality service to clients
    - Delays with enrolling clients in Intensive Case Management due to multiple reasons, such as late hiring of GAIN Nurse Care Coordinators, differences in legislated service areas for the CCAC and other LHIN-funded HSPs), insufficient BSO Human Resources, inadequate client-data (PHI) sharing

between teams/organizations, lack of addictions services in the region, and inadequate relationship/integration between GAIN and Health Links.

- Response to Challenges:
    - Knowledge/skills enhancement of the newly hired staff:
      Establishment of a *Clinical Supervision and Support for Geriatric Assessment and Intervention Task Group* was mandated to set guidelines for the teams regarding clinical education, training, and supervision. The task group recommended that:
        - all teams needed to arrange for the on-going provision of clinical supervision for clinical staff
        - for the first six months of conducting CGAs, all completed CGAs must be subjected to peer review
    - Intensive Case Management:
      A set of reference documents were collaboratively created by Seniors Care Network, GAIN, and the CCAC, to help clarify the roles and responsibilities of GAIN Nurse Care Coordinators. These documents also included *Guidelines for Decision-making for ICM*.

OBJECTIVE 3

The original GAIN service model was suggested in the '2010/2011 Detailed Service Plan' submitted by the Central East LHIN as part of its 'Aging at Home Strategy'. The model (which included a program logic model) outlined both hospital and community-based services for frail seniors in the Region, and six service components, which included:

1) Local Community Interprofessional Team (MIGHT); Mobile Teams
2) Health Career Case Manager for Frail Seniors
3) Specialized Geriatric Services (SGS) Team
4) Urgent/Emergent Clinics
5) Direct Hospital Access at Lakeridge Health Oshawa (LHO), and
6) Technology and Tools (enabler)

Only selective components of the proposed model received funding which resulted in the implementation of four hospital-based 'GAIN Clinics' in 2011:

1) Health Career Case Manager for Frail Seniors (fully implemented)
2) SGS Team (partially implemented; hospital based out-patient teams)
3) Urgent Emergent Clinics (partially implemented; not in ED, but within GAIN clinics)
4) Technology and Tools (partially implemented)

The four hospital-based clinics were located in PRHC, SHN (General and Centenary sites[4]), and LHO

In October 2013, the Central East LHIN announced six new community-based GAIN teams as a part of Community Sector Investments. These teams were to be located at, CareFirst Seniors and Community Services Association (Scarborough), Community Care City of Kawartha Lakes, Oshawa Community Health Centre[5], Peterborough Regional Health Centre[6], Port Hope Community Health Centre, and, St. Paul's L'Amoreaux Centre[7] (Scarborough).

The intention of this new investment was to expand GAIN services from clinics offering "treatment, assessment (and follow-up)" to include a "community based managed care" approach supporting *Primary Care Models within a Health Link*. To enable this, the 'GAIN Design Project' was initiated.

From then onwards, the 'GAIN Clinics' were renamed 'GAIN Teams' (i.e. Hospital and Community based GAIN Teams). Additionally, seven behavioural support specialists were

[4] Previously called TSH-General and RVHS-Centenary
[5] Now Carea Community Health Centre
[6] In addition to the hospital-based team
[7] Now Senior Persons Living Connected (SPLC)

incorporated into community-based GAIN teams. Community teams received training on conducting CGAs from hospital teams. The training included job shadowing and supervised practice.

According to the GAIN Operating Guidelines, 2017, the Program is now described as:

> *A network of twelve hospital and community-based health professional teams providing comprehensive assessments and creating care plans with patients to optimize function and independence, and to keep older people living at home.*

As of 2017, the GAIN Model of Care Framework has four processes: Engagement, Assessment, Integrated Care Planning, and Metrics, Monitoring and Evaluation

The most updated version of GAIN Logic Model is available in the *Seniors Care Network Evaluation Framework* (Gutmanis & Hillier, 2017). The model has three components: Advocacy for Age-related Needs, Improving Care (intake, assessment, follow-up, care-coordination), and Fostering Excellence (capacity development and networking).

These are aligned with Seniors Care Network's current Vision and Mission Statements:

> *Better health outcomes for seniors living with or at risk of frailty in the Central East LHIN.*
>
> *Working as a coordinated network of senior friendly, high-quality systems of health care that address complexity and optimize quality of life*

OBJECTIVE 4

GAIN receives referrals from Primary Care Providers, including Central East LHIN-funded Primary Care Collaborative Memory Services, for dementia assessment.

Central East PCCMCs operate in close collaboration with GAIN. These LHIN enabled connections between PCCMCs and GAIN, in order to facilitate timely access to dementia assessment services, enable review of complex dementia cases by specialist physicians, and facilitate effective transitions between PCCMCs and GAIN.

GAIN Behavioural Support clinicians provide direct support and expertise to clients and their caregivers, and work with GAIN teams and other health professionals (e.g. psychogeriatric resource consultants, geriatric mental health outreach teams) to coordinate community-based care to support these persons living with dementia to remain living at home.

Conclusions

Some key inferences are as follows:

1) The original GAIN service model outlined six service components and proposed both hospital and community-based services for frail seniors in the Region. Only selective components received funding from the Central East LHIN, which resulted in the implementation of four hospital-based GAIN Clinics in 2011 in Oshawa, Peterborough and Scarborough.
2) Seniors Care Network (formerly RSGS) was established in 2012 by the Central East LHIN to improve the organization, coordination and governance of SGS in the. This mandate included activities to strengthen and coordinate existing SGS services, including GAIN. Early activities included:
    - A 2013 Environmental Scan (Schwartz & Hawkins, 2013): Findings from a SWOT analysis included GAIN program strengths (standardized assessments, access to geriatricians, and provision of patient and caregiver focused services), and challenges (retention and recruitment of team members, time-consuming assessments, and local variation in access to community services).
    - A 2013 Formative Evaluation (Hawkins, 2013): Findings uncovered significant issues regarding geographic 'reach' (i.e. equitable access to GAIN services), and recommendations were made to revisit the original network model and/or explore alternate modes of service delivery. In response to these findings, the Central East LHIN announced the development of six new community-based GAIN teams as a part of Community Sector Investments (October 2013), and a GAIN '(Re)Design Project' was initiated.
3) The Central East LHIN's 2013 expansion of GAIN to include six new community-based teams was intended to expand GAIN services throughout the Region, and to move away from the hospital-based clinic model (i.e. offering 'treatment, assessment (and follow-up)' in-clinic), to a 'community based, managed care' approach that would support Primary Care models within a Health Link.
4) The GAIN Design Project lead by Seniors Care Network, and sponsored by the Central East LHIN and Seniors Care Network. Significant project milestones/deliverables included development and implementation of a GAIN Model of Care Framework, Operating Guidelines, and standardized metrics to support ongoing monitoring and evaluation.
5) Since the 2014 re-provisioning of the GAIN Regional Offices (consisting of a GAIN Regional Manager and Administrative Assistant position), and later the funding of a Regional Clinical Lead (NP), GAIN Regional has provided a leadership and coordination role. This includes program standardization, reporting, and quality improvement activities across GAIN Teams.
6) At the recommendation of Seniors Care Network, the Central East LHIN funded an additional two community-based teams in Haliburton and Trent Hills in 2015. The

GAIN Design Project formally concluded in 2015.

7) GAIN has further expanded over time and is now described as *"A network of twelve hospital and community-based health professional teams providing comprehensive assessments and creating care plans with patients to optimize function and independence, and to keep older people living at home."* GAIN provides eleven types of services to its clients, including cognitive testing.

8) A standardized interprofessional Comprehensive Geriatric Assessment (CGA) is a key component of GAIN services. The integration of specialized geriatric assessment and intervention competencies, with interprofessional collaborative practice, and profession-specific competencies, differentiates GAIN practice from a multidisciplinary model.

9) The average age of GAIN patients is 79.85 (*SD*=8.5), with the majority being between the age of 75 and 84 (Hawkins, 2018). Cognitive decline or assessment for cognitive decline are among the most common reasons for referral (Ehsan & Hawkins, 2019).

GAIN continues to evolve to address the rising demand for community-based, specialized geriatric service in the Central East. These NP-led, interprofessional teams of geriatric assessors continue to provide iCGA and targeted interventions to older adults and their care partners. Since their introduction in 2010, GAIN teams have been a dedicated community-based, specialized resource for the ~67 000 frail seniors in the Central East Region.

GAIN teams are a specialist service that supports primary care providers, and serves to augment the medical care provided by physician specialists (i.e. Geriatricians, Geriatric Psychiatrists, and Care of the Elderly Physicians), of which there is an insufficient number to meet current and growing population needs. In some teams, geriatric physician specialists work together with GAIN teams to provide enhanced diagnostic support for patients/clients with particularly complex medical needs.

References

Bowen, G. A. (2009). Document Analysis as a Qualitative Research Method. *Qualitative Research Journal*, *9*(2), 27–40. https://doi.org/10.3316/QRJ0902027

Ehsan, S., & Hawkins, S. (2019). *Central East GAIN Evaluation 2018-2019: Final Evaluation Report* [Evaluation Report]. Seniors Care Network.

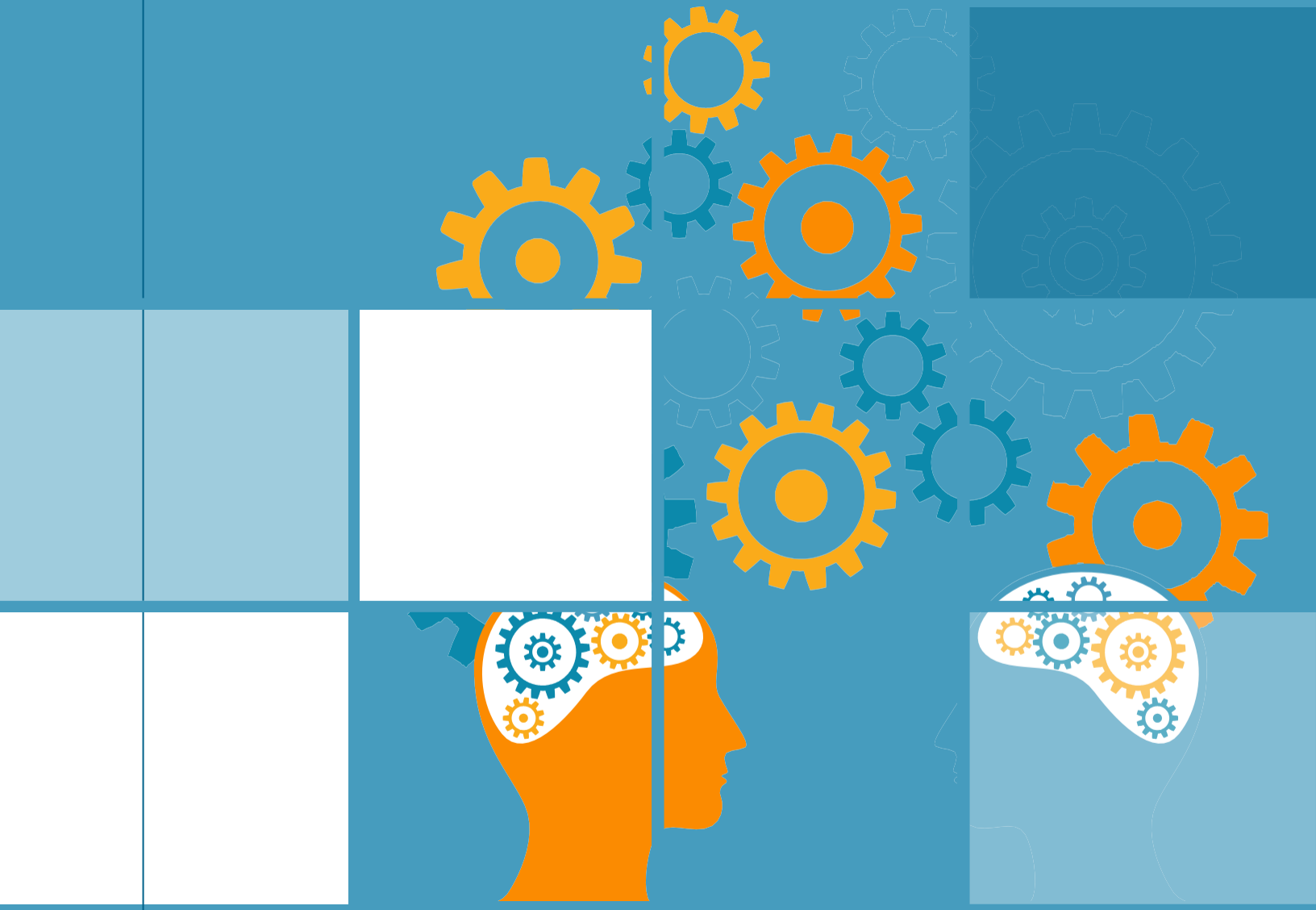
Gutmanis, I., & Hillier, L. M. (2017). *Evaluation Focusing: Development of an Evaluation Framework for Specialized Geriatric Services in the Central East Local Health Integration Network: Final Report* (p. 153). Seniors Care Network.

Hawkins, S. A. (2013). *A formative evaluation of the Geriatric Assessment and Intervention Network (GAIN)* (pp. 1–31). Central East Regional Specialized Geriatric Services. None

Hawkins, S. A. (2018). *Geriatric Assessment and Intervention Network (GAIN) Evaluation 2017/2018: Final Report* [Evaluation Report]. Seniors Care Network.

Kay, K., Hawkins, S. A., Day, A. M. B., Briscoe, M., Daly, D., & Wong, K. (2017). *A Competency Framework for Interprofessional Comprehensive Geriatric Assessment* (pp. 1–24). Regional Geriatric Programs (RGP) of Ontario. https://rgps.on.ca/resources/a-competency-framework-for-interprofessional-comprehensive-geriatric-assessment/

Schwartz, R., & Hawkins, S. A. (2013). *Examining the GEM/GAIN Continuum in the CE LHIN: Summary of Findings* (p. 59). Regional Specialized Geriatric Services.



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