Primary Care Liaisons:
Expanding Clinical-Community Partnerships for Older Adults

Elizabeth A. Phelan, MD, MS
Allison Boll, MSW
Melissa Ensey, MSEd

The NW GWEC is made possible by Grant Number U1QHP28742 from the Health Resources and Services Administration (HRSA), an operating division of the U.S. Department of Health and Human Services. Its contents are solely the responsibility of the investigators and do not necessarily represent the official views of HRSA or the U.S. Department of Health and Human Services.
Learning Objectives

> Identify barriers to primary care practices connecting older adults with community resources

> Describe ways in which a Primary Care Liaison (PCL) engages primary care teams and the intended outcomes (e.g., increased participation of older adults into Evidence Based Programs [EBPs] in the community)

> Describe strategies for collaborating with healthcare providers that can be readily implemented by AAAs on the local level
Northwest Geriatrics Workforce Enhancement Center

> One of 44 Centers funded through Health Resources and Services Administration’s (HRSA) GWEP initiative

> NW GWEC Objectives:
   1) Integrate geriatrics into primary care
   2) Prepare primary care providers to care for older adults
   3) Engage older adults, families, and caregivers
   4) Enhance Alzheimer’s Disease and Related Dementias (ADRD) knowledge

www.nwgwec.org
Northwest Geriatrics Workforce Enhancement Center

> NWGWEC Mission:

> To lead the Pacific Northwest in optimizing primary care of older adults through collaborative education, traineeships, client engagement, and enhanced community-clinical linkages.

www.nwgwec.org
Integrating Geriatrics into the Primary Care Workforce
Our Activities

- Geriatric Health Care Lecture Series
- Geriatric Grand Rounds
- Advanced Practice Nurse Traineeship
- Project ECHO – Geriatrics
- Practice-Based Quality Improvement Projects
- AAA-based Practicum
- Primary Care Liaison Positions
Primary Care Liaisons - Rationale

> The richness of community-based resources is often not being brought to bear as part of routine primary care of older adults.

> A small body of research on this topic has found low rates of referral to community-based programs by primary care provider (20-25% of patients overall).

> Barriers to primary care practices connecting older adults with community resources. For example:
  
  – Lack of primary care/medical home awareness of relevant community resources and lack of shared workflows
  – Focus on provision of services, not client engagement
  – Absence of shared-access, care-continuum-traversing communication modes (e.g., no shared electronic health records)

Primary Care Liaisons – “Silo-ing”

> “Silo-ing” of care
> Missed opportunities
> Patients and caregivers suffer
  – Disconnected
  – Uniformed
> Providers and community staff suffer
  – Overwhelmed
  – Alone
Building Community-Clinic Bridges

> Increase awareness
> Encourage referrals to community-based programming
> Encourage and facilitate bi-directional communication
Primary Care Liaison - Deliverables

- Onsite visits to primary care clinics
- Patient, family member, and/or caregiver enrollment into evidenced-based programs
- Integration of Alzheimer’s Disease and Related Dementia educational content into existing programs and services
- Training healthcare professionals via AAA-based practicum
Primary Care Liaison – Concept to Reality

- Outreach to primary care clinics
- Creating community-clinical linkages
- Increasing referrals to AAA programs and services
Evidence-based Health Promotion Programs

Promoting evidence-based health promotion programs serving older adults and their family caregivers:

- Project Enhance (EnhanceFitness and EnhanceWellness)
- A Matter of Balance
- PEARLS
- Powerful Tools for Caregivers
Self-Management Flags / Plans

> Facilitate use of self-management flags by patients and providers.

> Disseminate self-management flags for use by other organizations.

**Fall Prevention Self-Management Plan**
- Follow your medical providers’ directions regarding exercise, which is important particularly balance exercises.
- Ask your doctor or pharmacist to review your prescriptions and over-the-counter medications.
- Have your eyes checked by an eye doctor at least once a year.
- Wear appropriate footwear when walking inside and outside of your home.
- Reduce tripping hazards. Remove clutter, scatter rugs, extension cords, and other trip hazard items. Add grab bars and railings, if needed.
- Take the recommended dose of Vitamin D (600 IU daily) unless otherwise directed.
- Get screened and, if needed, treated for osteoporosis.
- Use a walking stick or other device to help you keep your balance.

**Green Flags — All Clear**
- No falls and are not afraid of falling
- Regularly exercise per primary care doctor instructions
- Feel steady on your feet when walking
- Use any assistive devices as recommended by your doctor or PT.
- Environment free of trip hazards.
- Good work!

**Yellow Flags — Caution**
- Problems taking your medications as prescribed by your medical provider (e.g., you miss or skip doses, have difficulty understanding directions, or take medications that cause dizziness, fatigue, or weakness)
- Lightheadedness when you stand up
- Reduced muscle strength in legs
- Painful or unstable ankles, knees, or hips
- Decreased sensation in your legs or feet
- Blurred vision
- Clutter and trip hazards in your home
- History of falls of any type
- Diagnosis of osteoporosis
- Difficulty walking

**Call your Home Care Nurse, Triage Nurse, or Clinic Coordinator at ___________ or**

**If you do not have Home Care, call your Primary Care Doctor at ___________ when you have:**
Anticipated Effects on Care

> Treatment plans that incorporate evidence-based programs:

- GH -- 78 yo female with falls who referred to EF; returned saying it was the best thing that ever happened to her and that every doctor should tell all their patients about EF, and that she was exercising regularly because of the class;

- JC -- 68 yo F with depression and diabetes who was unable to make changes to reduce her fall risk because her mood symptoms predominated, referred to PEARLS – with subsequent success in addressing her fall risk factors (and with improved depression sx)
Anticipated Effects on Care

> Shared "cases" / patients (community case managers and PCPs) and partnering in order to best address ongoing health and meet care needs
Anticipated Outcomes

> Better care (e.g., increased delivery of preventive services, geriatric syndrome screening and management)
> Better health outcomes (e.g., improved health behaviors, healthier caregivers)
> Better quality of life
> Fewer care transitions
> Fewer readmissions
> Fewer (preventable) ED visits and hospitalizations
> Higher provider (PCP, agency staff) satisfaction
Introducing Our Primary Care Liaisons

Melissa Ensey, MSEd

Allison Boll, MSW
Area Agencies on Aging

- Service areas and population
- Demographic shifts
- Centralized vs. Disseminated Model
Foundation for Collaboration

> Existing landscape of community orgs, health systems and academic programs
> History of AAA collaboration with universities and academic programs
> Existing relationships with health care systems
AAA Goals of GWEC Partnership

> Build *sustained* linkages so that AAA programs are recognized and utilized as an integral piece of an individual’s primary care

> Increase visibility and credibility of AAAs

*Bhutanese elders participating in an Aging and Disability Services forum. Photo by Karen Winston.*
PCL Role - Design Considerations

- Aging and Disability Resource Center (ADRC) models and functions
- External community-based provider outreach
- Availability and capacity of community-based programs
- Internal stakeholders
- Support from leadership
- Integration and sustainability

Cowlitz County Senior Expo. Photo by Kelli Sweet
Referral Form Example
PCL Role

- Outreach
- Follow Up
- QI:
  - Other NWGWE activities and meetings
- Internal Stakeholder Meetings
- Program Development
- Trainee Engagement
Collaborative Resource Creation

SERVICES AND PROGRAMS AVAILABLE TO SUPPORT YOU AND YOUR LOVED ONE

INFORMATION AND ASSISTANCE is here to help you navigate the maze of options, decisions and challenges that arise as you or a loved one age. Our caring staff can help with:
- Obtaining information and resources
- Accessing community, social, health and government services

GETTING YOU CONNECTED
To a full range of resources designed to offer you choice, respect your independence and support you in living and aging well!

EXAMPLES INCLUDE:
- Transportation Assistance
- Nutrition Programs
- Medicare Savings Program Assistance
- Case Management
- Help with Personal Care...AND MORE!

RESOURCES FOR FAMILY CAREGIVERS
Services for family and friends to allow them to continue to provide care at home for their loved ones.
- Family Caregiver Specialists - Case managers who help you develop personalized care plans that best support the caregiver’s needs and goals.
- Powerful Tools for Caregivers - Education on caring for yourself while you care for a loved one.
- Caring for Your Loved One at Home - Education on essential information you need to know. From bathing to managing medications. Day to day caregiving tips.
- Dementia Focused Education - Individual and small group interventions designed to support you while caring for someone living with Dementia.

SERVICES TO SUPPORT HEALTH & WELLNESS
- Living Well with Chronic Conditions - Practical ideas to manage your symptoms and communicate your needs.
- Enhance Fitness - FREE group exercise programs for older adults at all fitness levels.
- Transitional Care Services - Collaborative support for the transition from hospital to home

Clark County: 360-694-8144 or iaclark@dshs.wo.gov
Cowlitz & Wahkiakum Counties: 360-577-4929 or iakeilo@dshs.wa.gov
## Caregiver Stress

### Self-Management Plan

#### General Health Guidelines:
- Find ways to take a break
- Eat a healthy diet
- Exercise or walk when possible
- Ask for help from friends and family
- Get enough sleep

<table>
<thead>
<tr>
<th>Green Flags — On the Right Track</th>
<th>What this might mean:</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>If you have:</strong></td>
<td><strong>You are finding ways to balance being a caregiver with taking care of yourself</strong></td>
</tr>
<tr>
<td>A positive outlook on caregiving most days</td>
<td><strong>You are able to see the positive parts of being a caregiver</strong></td>
</tr>
<tr>
<td>Time to yourself to do things you enjoy</td>
<td><strong>You feel supported in your caregiving role</strong></td>
</tr>
<tr>
<td>Moments you feel happy while caregiving</td>
<td></td>
</tr>
<tr>
<td>Time to take care of your own medical needs</td>
<td></td>
</tr>
</tbody>
</table>

#### Yellow Flags — Caution

<table>
<thead>
<tr>
<th>If you:</th>
<th>What this means:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Feel “edgy” or irritable</td>
<td><strong>You may benefit from:</strong></td>
</tr>
<tr>
<td>Feel that you are unable to take time away from caregiving to do things you enjoy</td>
<td><strong>Taking time to do something nice for yourself</strong></td>
</tr>
<tr>
<td>Have trouble keeping your mind on what you are doing</td>
<td><strong>Breaks from caregiving</strong></td>
</tr>
<tr>
<td>Feel overwhelmed</td>
<td><strong>Asking for help from friends or family</strong></td>
</tr>
</tbody>
</table>

If you notice a Yellow Flag, you may benefit from calling Information and Assistance to learn about caregiver support services at 360-694-8144.

#### Red Flags — Stop and Think

<table>
<thead>
<tr>
<th>If you:</th>
<th>What this means:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Feel alone or hopeless</td>
<td><strong>You may benefit from:</strong></td>
</tr>
<tr>
<td>Feel uncertain about what to do with your loved one</td>
<td><strong>An appointment with a physician or counselor</strong></td>
</tr>
<tr>
<td>Have thoughts of “running away” from your caregiving responsibilities</td>
<td><strong>Ask family or friends for assistance with your caregiving duties</strong></td>
</tr>
<tr>
<td>Are neglecting the needs of your loved one</td>
<td><strong>If possible, notify your health care provider’s office:</strong></td>
</tr>
<tr>
<td>Are ignoring your own health needs</td>
<td><strong>Physician:</strong></td>
</tr>
<tr>
<td></td>
<td><strong>Number:</strong></td>
</tr>
</tbody>
</table>

If you notice a Red Flag, you may need a break from your caregiving duties or could benefit from support. Call your local Family Caregiver Support Program at 360-694-8144.

---

At the Area Agency on Aging & Disabilities, we believe every adult deserves to live with dignity. We connect seniors, adults with disabilities and family caregivers to a full range of free and other community resources designed to offer you choice, improve your quality of life and respect your independence.

*** Please see the reverse side of this document for further tools and information ***
Ongoing Benefits to the Area Agency on Aging

> PCL as source of momentum
> Increased healthcare and CBO interest in new partnerships and enhancing existing collaborative efforts
> Increased geriatric competency of professionals at the AAA and in the aging Network
> Decreased isolation of agency staff
Key Takeaways for Organizational Readiness

> Development of Internal Stakeholders
  – Breaking down internal “silos”
  – Avoid miscommunication
  – Establish legitimacy for the role

> Create Capacity
  – How will current processes change?
  – Tangible readiness

> Nurturing Champions in Healthcare
  – What relationships currently exist? How can they be deepened?
  – Bi-Directional Benefits

> Maintain the Momentum
  – PDSA
  – Be nimble and ready to respond to changes
Questions?
Resources


Contact us

Melissa Ensey, MSEd
Area Agency on Aging and Disabilities of Southwest Washington (AAADSW)
360.735.5726
enseymr@dshs.wa.gov

Allison Boll, MSW
Aging and Disability Services (ADS)
206.733.9925
Allison.Boll@seattle.gov

NWGWEC
1-855-744-9114
nwgwec@uw.edu