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

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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

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.

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www.nwgwec.org

Integrating Geriatrics into the Primary Care Workforce

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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

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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)

Porterfield DS et al. Linkages between clinical practices and community organizations for prevention. Am J Prev Med 2012;42(6S2): S163-171

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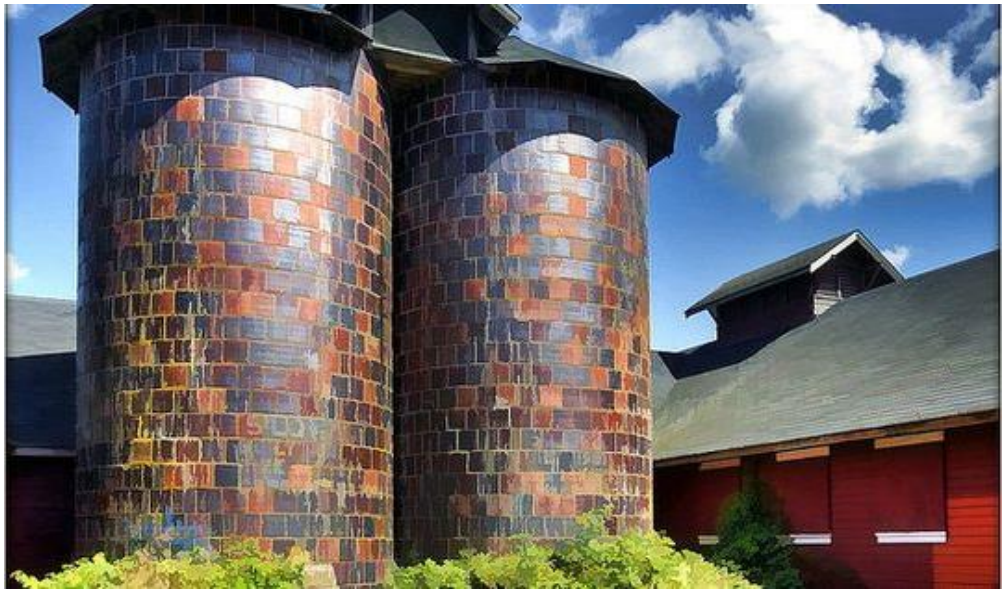
Primary Care Liaisons – “Silo-ing”



- “Silo-ing” of care
- Missed opportunities
- Patients and care-givers suffer
  - Disconnected
  - Uniformed
- Providers and community staff suffer
  - Overwhelmed
  - Alone

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Building Community-Clinic Bridges

Suspension bridge in Mount Rainier

> Increase awareness

> Encourage referrals to community-based programming

> Encourage and facilitate bi-directional communication

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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

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Primary Care Liaison – Concept to Reality

- Outreach to primary care clinics
- Creating community-clinical linkages
- Increasing referrals to AAA programs and services

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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

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Self-Management Flags / Plans

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 (800 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	What this means ...
If you have: • 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!
Keep up the great work!	
Yellow Flags — Caution	**What this means ...**
If you have: • 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	• You are at a higher risk for falls. • Your medication may need to be adjusted • You may need to take Vitamin D • You may need an eye exam • You may need a physical therapist • You may benefit from a home safety evaluation **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:

- Facilitate use of self-management flags by patients and providers.
- Disseminate self-management flags for use by other organizations

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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)

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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

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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

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Introducing Our Primary Care Liaisons

AREA AGENCY ON Aging & Disabilities OF SOUTHWEST WASHINGTON

ads Aging and Disability Services
Area Agency on Aging for Seattle and King County
Advocacy. Action. Answers on Aging

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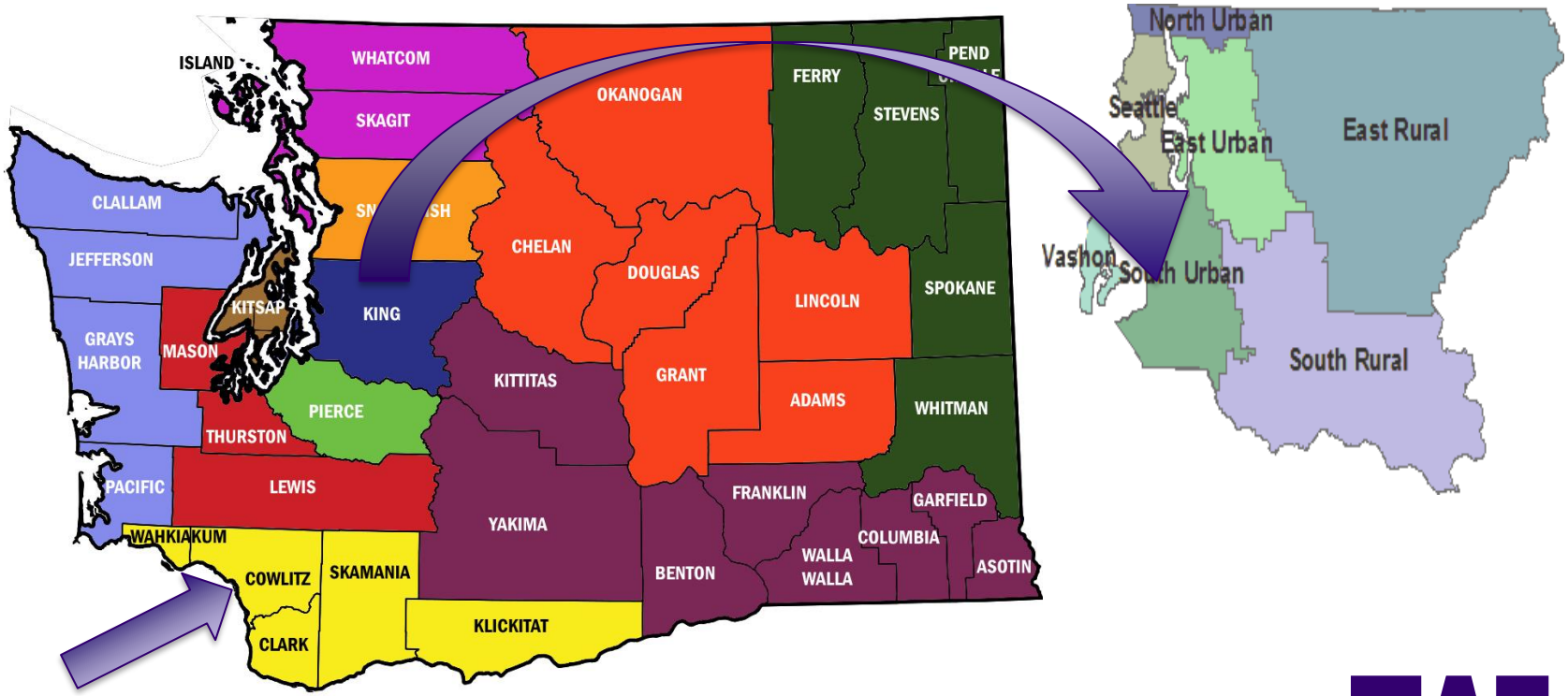
Area Agencies on Aging

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



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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

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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.

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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

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Referral Form Example

Northwest Geriatrics Workforce Enhancement Center

Referral Form

Email or Fax Completed Form to:
EnseyMR@dshs.wa.gov OR Fax to 360-696-4905

Date:_____

Provider Name: _____ Clinic Name:_____

Contact Phone Number: _____ Email: _____

PATIENT INFORMATION:

Patient Name: _____ DOB:_____ Male/Female

Patient Phone Number:_____ County of Residence: _____

Key Learner (If different from patient)_____ Does key learner live with patient? Yes/No

Relationship:_____ Phone Number: _____ (If primary contact is not patient)

Additional Patient/Key Learner Information:

_____

_____

_____

REASON FOR REFERRAL: (check all that apply)

☐ Help with ADLs	☐ Transitional Care (ONLY for patients currently hospitalized or discharged within the last week)
☐ Mental Health Issues	☐ Food Stamps/Food Bank Resources
☐ Help with IADLs	☐Alzheimer's/Dementia Resources
☐ Housing/Energy Assistance	☐ Transportation Information
☐ Resources for Key Learner/Caregiver Stress	☐ OTHER (explain below)

COMMENTS: _____

_____

_____

PERMISSION TO RELEASE INFORMATION TO AGENCY ON AGING & DISABILITIES I, do hereby give my permission to release the above information to the Area Agency on Aging & Disabilities of SW WA (AAADSW), Information & Assistance Program, to follow up with services that may assist me in meeting my current needs. I also give permission for AAADSW to follow up with my health care provider, to share information and provide the most comprehensive resources. I understand this does not obligate me to participate in any program and/or services. My authorization can be revoked at any time and there is no charge for this service.

Patient Signature:_____ Date:_____

Staff Name Completing Form: _____

Phone: _____ Email:_____
Preferred Contact Method: Phone/Email

AREA AGENCY ON Aging & Disabilities OF SOUTHWEST WASHINGTON

PCL Role


QI
Other NWGWEC activities and meetings
Internal Stakeholder Meetings
Program Development
Trainee Engagement
Follow Up
Outreach

Collaborative Resource Creation

AREA AGENCY ON
Aging & Disabilities
OF SOUTHWEST WASHINGTON

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!

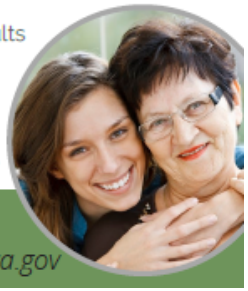
RESOURCES FOR FAMILY CAREGIVERS

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.

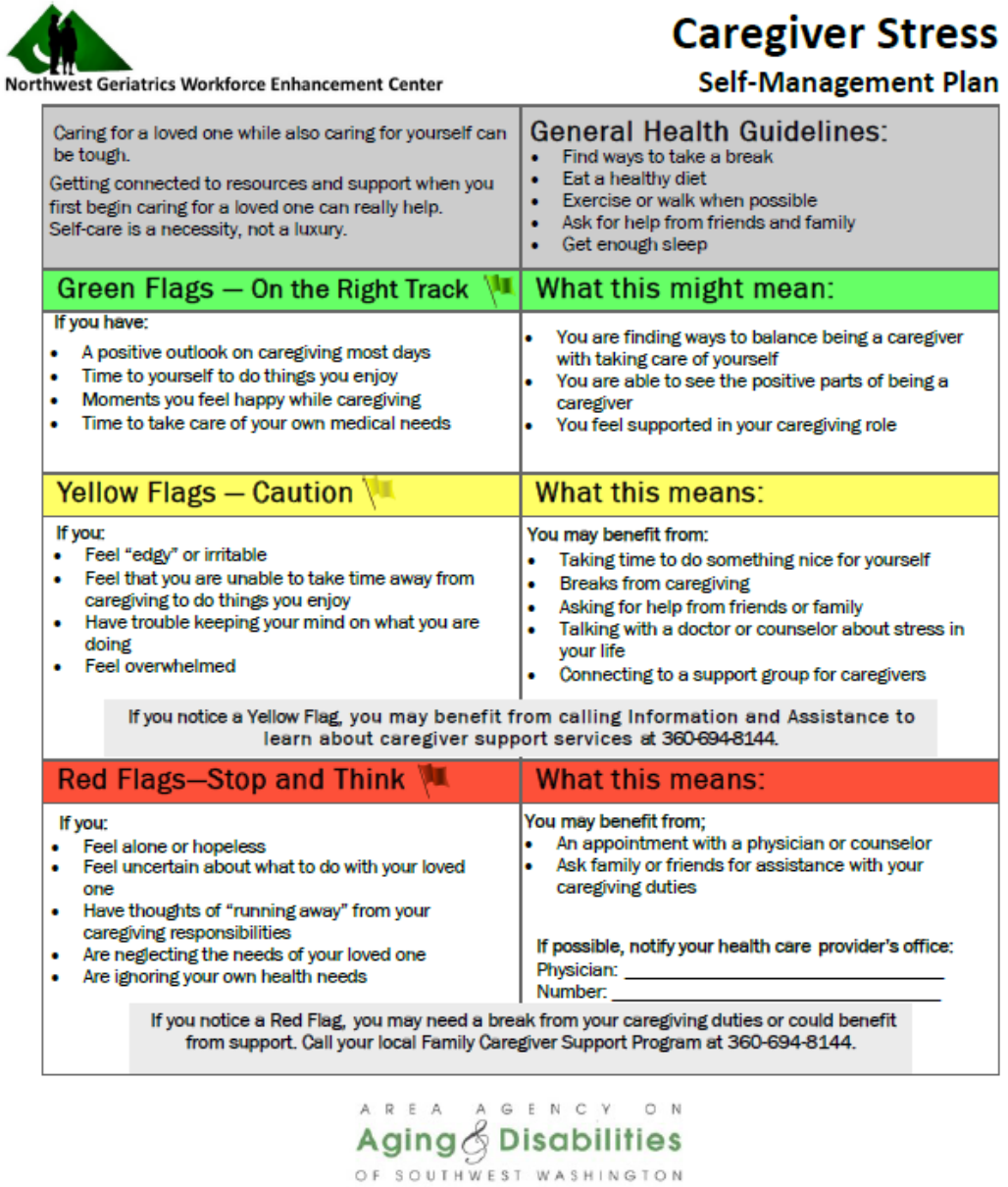
SERVICES TO SUPPORT HEALTH & WELLNESS

- **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.wa.gov
Cowlitz & Wahkiakum Counties: 360-577-4929 or iakelso@dshs.wa.gov

Caregiver Stress Self-Management Plan



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Caregiver Stress
Self-Management Plan

Caring for a loved one while also caring for yourself can be tough.

Getting connected to resources and support when you first begin caring for a loved one can really help. Self-care is a necessity, not a luxury.

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

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

Yellow Flags — Caution	What this means:
If you: • Feel "edgy" or irritable • Feel that you are unable to take time away from caregiving to do things you enjoy • Have trouble keeping your mind on what you are doing • Feel overwhelmed	You may benefit from: • Taking time to do something nice for yourself • Breaks from caregiving • Asking for help from friends or family • Talking with a doctor or counselor about stress in your life • Connecting to a support group for caregivers

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	What this means:
If you: • Feel alone or hopeless • Feel uncertain about what to do with your loved one • Have thoughts of "running away" from your caregiving responsibilities • Are neglecting the needs of your loved one • Are ignoring your own health needs	You may benefit from; • An appointment with a physician or counselor • Ask family or friends for assistance with your caregiving duties If possible, notify your health care provider's office: Physician: _____ Number: _____

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.

AREA AGENCY ON Aging & Disabilities OF SOUTHWEST WASHINGTON

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

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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

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Questions?

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Resources

- Porterfield DS et al. Linkages between clinical practices and community organizations for prevention. Am J Prev Med 2012;42(6S2): S163-171. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3478082/
- ETZ RS, Cohen DJ, Woolf SH, et al. Bridging primary care practices and communities to promote healthy behaviors. AM J Prev Med. 2008;35 (suppl 5): S390-S397. https://www.ncbi.nlm.nih.gov/pubmed/18929986

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Contact us

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