Implementing a Primary Care Liaison Role at an Area Agency on Aging

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NORTHWEST GERIATRICS WORKFORCE ENHANCEMENT CENTER

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Credit

Developers: Melissa Ensey and Breanne Wise-Swanson from the Area Agency on Aging and Disabilities of Southwest Washington. Allison Boll and Phung Nguyen from Aging and Disability Services of Seattle-King County. Elizabeth Phelan, Barbara Cochrane, and Aimee Verrall from the Northwest Geriatrics Workforce Enhancement Center.

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GLOSSARY OF COMMONLY USED TERMS

AAA: Area Agency on Aging, a nonprofit organization to address needs of older people at the regional or local level.

Aging Services Network: A national network of federal, state, and local agencies that provide services to meet the needs of older Americans.

Engagement: Connections between a clinic and the AAA, with the clinic indicating interest and/or setting-up a referral process in which patient referrals are sent to the AAA for their community-based services.

GWEP: Geriatrics Workforce Enhancement Program, funded by the Health Resources and Services Administration of the U.S. Department of Health and Human Services.

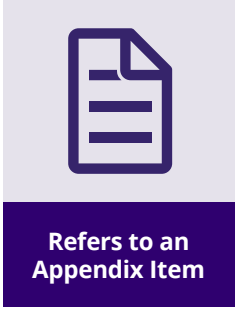
HIPAA: The Health Insurance Portability and Accountability Act of 1996, a federal statute designed to prevent unauthorized disclosure of an individual's protected health information.

PCL: Primary Care Liaison, an AAA employee who connects primary care practices with AAA resources.

Referral: A written or formal request from a clinical practice for AAA services on behalf of a patient or caregiver of the practice.

CALL-OUT IMAGES

An idea for practice



Refers to an Appendix Item

An example from practice

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WHY A PRIMARY CARE LIAISON?

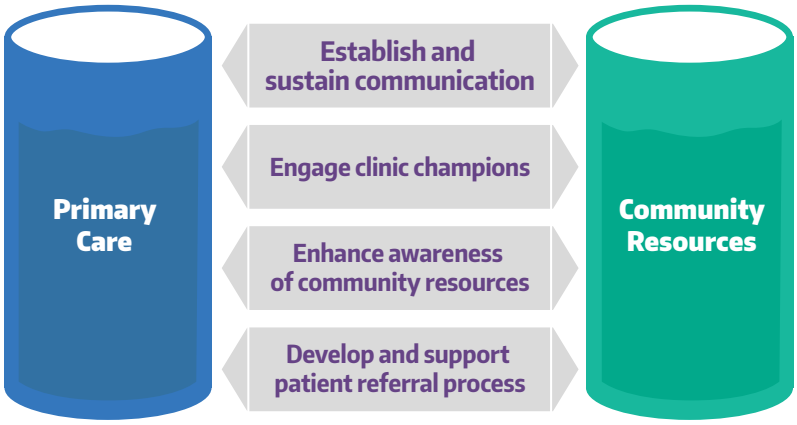
Older adults value their independence and want to age in place. Programs and services available through the Aging Services Network can help achieve this goal. However, primary care providers are often unfamiliar with these resources, and most older adults do not access them on their own. Older adults may thus miss important opportunities to use community resources to optimize their health, well-being, and daily life. Primary care clinics that do not connect older patients to helpful community resources may unintentionally increase pressure on informal (family) caregivers and increase the costs of formal long-term care.[1]

Experts recognize the need to integrate primary care and public health to optimize population health and lower costs.[2] As a publicly funded network, the Aging Services Network and Area Agencies on Aging (AAAs) work together to play a pivotal role in achieving this goal.

The Primary Care Liaison (PCL) role is a unique opportunity to bridge healthcare and AAAs, both of which have their own sets of norms, values, and focus areas. Healthcare focuses on providing outstanding, high-value care. AAAs focus on supporting older adults to age in place – balancing a high level of community services while seeking innovative ways to reach potential clients in a rapidly changing healthcare environment. The PCL role was created to connect primary care practices to community-based resources accessible through AAAs.

The PCL role was developed by the Northwest Geriatrics Workforce Enhancement Center (NW GWEC) as part of the mission of a 2015 Geriatrics Workforce Enhancement Program (GWEP) award. Over 45 funded GWEP centers across the nation support geriatrics education and training of primary care providers.[3]

Figure 1. How Primary Care Liaisons Build Clinical-Community Linkages



The purpose of this guide is to provide information to help an Area Agency on Aging add a Primary Care Liaison (PCL) – a role dedicated to primary care outreach for the purposes of connecting older adults, their families, and their care partners to evidence-based programs and resources in the community. The intended audiences for this guide include Area Agencies on Aging that seek to strengthen their collaboration with primary care practices in their catchment area, as well as individuals hired to fill the PCL role.

WHAT IS A PRIMARY CARE LIAISON?

A Primary Care Liaison (PCL) is an outreach and engagement specialist. Key elements of the PCL role include:

- **Outreach:** Identify and start conversations with members of the primary care community whose patients could benefit from access to community resources.
  - Make outbound outreach connections (emails, calls, in-person visits) to primary care clinics not yet engaged with the AAA.
  - Answer inbound emails and calls from engaged primary care clinics.
  - Cultivate relationships with local organizations that serve primary care providers.
- **Follow-up** with outreach visits that provide clinical staff with print or online materials to support patient and care partner education, empowerment, and self-care (e.g., informational brochures on AAA programs such as the Family Caregiver Support Program, the Information and Assistance phone line, medication management assistance, navigating moving from hospital to home program).
- **Facilitate patient referrals** from primary care to AAA / community resources.
- **Stay apprised** of current AAA programs, services, and resources by attending and participating in **AAA stakeholder meetings**.
- Gather information for accurate documentation of outreach and enter into a tracking database for use in **quality assurance** and program **evaluation**.

Figure 2. Primary Care Liaison Activities by Time Requirements

ASSESSING ORGANIZATIONAL READINESS TO IMPLEMENT THE PCL MODEL

Determine your organization's readiness for a PCL by asking the following questions:

- Do you have the support of your organization's leaders, such as funders and advisory board members?
- Can funding cover the salary for a PCL for at least 2-3 years?
- Is the organization's leadership committed to implement the PCL role with fidelity to the model?
- Do you have technical assistance to get started?
- Have you drafted evaluation and quality assurance plans?
- Do you have adequate budget and capacity to handle the potential increase in referrals to the AAA?
- Have you explored long-term financing strategies?

Consider using a published tool to assess organizational readiness, such as the ICTP (Implementation Capacity for Triple P) Adapted Organizational Readiness for Implementing Change measure.[4]

GETTING STARTED

Hiring a Primary Care Liaison

Once your organization is ready to add a PCL, recruiting will require creating a clear, detailed job description with a full set of qualifications and expectations for the position. A successful PCL is well equipped to translate and bridge gaps between healthcare systems and AAA. This role may be well suited for someone already employed at the AAA, which may mean a change of roles and duties, or it may be better suited for an individual outside the AAA who has other relevant experience, such as healthcare clinic management or community outreach and engagement.

Competencies needed for success as a PCL include:

- **Outstanding verbal and written communication skills (messaging)**
  - Proficiency with developing presentations and public speaking
  - Ability to adapt communication style to suit different audiences while maintaining professionalism

- **Outstanding interpersonal skills (rapport and connections)**
  - Ability to develop rapport and establish professional working relationships
  - Ability to interact effectively with diverse individuals and groups

- **Experience with outreach and engagement**
  - Ability to tailor information to multiple audiences that may have varying priorities
  - Understanding of race, social justice, and equity principles with an ability to apply this knowledge in daily interactions

- **In-depth knowledge of the AAA and Aging Services Network**
  - Awareness of particular needs of older adults in the AAA's catchment area
  - Strong understanding of organizations in the AAA's catchment area

See Appendix 1 for a sample PCL job description.

Laying the Groundwork for Success

A critical initial step is for AAA staff and the PCL to audit the AAA's current resources that relate to the PCL role (see text and figure, page 3). Staff and the PCL should thoroughly assess strengths and weaknesses internally within the AAA and externally in the community and AAA network for achieving the PCL tasks.

Inventory and Catalog AAA Resources

The PCL should start by creating an inventory of existing AAA resources that will be useful for PCL work, noting needs and areas for improvement. Ask internal staff and external stakeholders about resources such as existing relationships, contact information, and marketing materials.

Then, create a catalog of 1) clinical contacts including names and contact information of healthcare leaders already partnering with the AAA, 2) established and pilot clinical programs in the community, and 3) information about the AAA's participation in healthcare-oriented collaboratives. This information can be leveraged to brainstorm for outreach efforts, gain introductions, and collect feedback for evaluation.

Take note of existing outreach and collaboration efforts among healthcare providers, community partners, and stakeholders. The PCL can reference these relationships to help clinical partners see where and how the PCL fits into the overall community.

Tailor Outreach to the Needs of the Clinical Setting

Understanding who a clinic serves is a first step in establishing a fruitful connection. Plan an outreach approach that is based on awareness of a clinic's time constraints and the needs of its patient base. PCLs should review these points as part of initial contact with a clinic.

The PCL and community partners likely have shared goals (such as improving the health and well-being of older adults and adults living with disabilities). The PCL should consider what resources the PCL and AAA have that help achieve these goals. This consideration will be an ongoing component of PCL work to be revisited regularly with stakeholders and partners as relationships and priorities evolve.

Some AAAs use a decentralized, aging services network that contracts with multiple agencies to deliver programs and services to clinics and clients. These contracted agencies may also be working with healthcare partners to enhance the level of services for their mutual patients and clients. Clinicians and clinic staff may not understand this decentralized, network approach and why they are contacted by two seemingly similar agencies. The PCL should be ready to answer questions and explain how PCLs and the AAA differ from contracted agencies.

Understand Marketing the AAA

PCLs must have an overall understanding of the AAA's existing marketing and outreach materials. These may include brochures, websites, social media accounts and email marketing and promotional products. The AAA may have key messages that it uses to create awareness of its services and programs. These materials will likely be useful for outreach by PCLs but need to be tailored to specific audiences. The AAA's marketing and outreach staff may be able to consult, provide strategic advice, and give insights into alignment with other initiatives.

Consult with the AAA marketing and outreach staff about developing a section on the AAA website describing the AAA's involvement in local healthcare systems. This web section can also promote the Primary Care Liaison as a single contact for clinical partners (See Appendix 2).

Developing an Outreach Plan

Outreach is one of the most important functions of the PCL role. In this section, we outline an approach for connecting strategically with primary care practices in the AAA's catchment area to organize outreach and maximize efforts.

Prioritize Practices

To help with outreach, including presenting clear messages to clinical practices, start by reviewing your AAA's strategic goals. Identify the priority populations of the AAA.

Make an initial inventory of primary care practices within the geographic catchment area of the AAA and determine which have patient populations that align with the AAA's goals and priorities. Find the clinical practices that provide services and support systems to those populations. AAAs address social determinants of health as part of their mission. Knowing which clinics serve which populations will provide many opportunities to work with clinics to reach underserved populations who could benefit from available AAA programs.

Reach out to established primary care contacts in the first few months of PCL work. This outreach can be an opportunity to practice your engagement approach, gain familiarity with clinical settings, and receive feedback from trusted partners.

Target Engagement

Understanding the infrastructure of primary care practices that you are targeting for engagement can help define and tailor communication opportunities. This work may include:

- Creating a database of known contacts and geriatrics specialists
- Identifying the clinic staff members who make referrals, and
- Outlining the clinic's workflow for referrals to outside organizations, affiliated fellowship and residency programs, and care coordination programs.

Search the AAA's referral database for providers who have not connected with a PCL. AAA staff can also connect providers to the PCL. Most providers who have not had PCL outreach but know about their local AAA know very little about the full scope of services that an AAA offers or how the AAA can help their patients. It is easy to schedule outreaches with these providers as they've already identified that they want to use the AAA as a resource. These people often become clinic champions.

Identify Resources and Opportunities

Identify available, accessible resources within the AAA and the community to share with clinical contacts. Does the AAA have new or underutilized programs or services that have capacity to serve more people or that healthcare providers rarely access on behalf of their patients? Does the AAA or the community have resources that seem of high relevance to clinics that they could let patients and/or their family care partners know about?

Create two-sentence descriptions of each program or resource. One option is to create a reference document or guide for contacts that highlights and describes available AAA and community programs. This document may also include contact information for programs and if relevant the specific population sub-group and languages served (e.g., Asian Counseling and Referral Service – serves Asian Americans and Pacific Islanders; staff fluent in most Asian languages).

For resources that do not have a single phone or email (as does an Aging and Disability Resource Center), create a simple, one-page referral guide about the resource for primary care clinics.

Aim to balance presenting quality resources with not overwhelming recipients with too much information. Finding this balance is vital to successful PCL outreach. Clearly and concisely identifying resources for a clinic further conveys the value of the PCL role for clinic staff — they have a specific need, and the AAA has a resource to meet that need. The PCL should be a 'steward of all resources' in the area, not just the services provided by the AAA.

Figure 3. Five Core Services Provided by Area Agencies on Aging

Create a standard packet of resources to share with every clinical site. Packets can be made in advance, with other resources added based on the needs of clinical staff and patient populations. Pre-made packets will help with efficiency and tracking data on what information is shared.

Developing a Referral Protocol

Establishing (or revitalizing) a referral protocol — a way for primary care clinics to refer a patient or caregiver to the AAA's services — is a major PCL goal. To establish or revitalize a referral process, the PCL should start by understanding whether and, if so, how clinics are currently connecting their patients to the AAA. It is important for the PCL to schedule time to speak with stakeholders at the AAA who are responsible for intake, typically the Aging & Disability Resource Center or Information & Assistance department. Intake teams will likely be aware of clinics that are already utilizing the AAA. Some clinics may be providing the AAA's contact information to patients and instructing them to call the AAA themselves, some clinic staff may be calling or emailing the AAA on behalf of the patient, while others may be faxing over requests for services. The PCL should work with intake teams at their AAA to understand what is going well with the current referral process and if there are any barriers. For example, emails or voice messages from patients and providers often do not contain all of the information necessary to help intake teams successfully reach a patient, handwritten referrals can be difficult to read, or providers may be requesting services that are not provided by the AAA. Once the PCL understands the barriers experienced by the intake team, the PCL can work to develop a standardized referral process which will ultimately improve the quality of referrals. The PCL should continue to check in with the intake team periodically to see if barriers in the referral process persist and work to provide teach-back to clinic teams if there are knowledge gaps in the referral process.

Example of PCL teach-back in-action: We had a clinic social worker who would consistently refer patients for a "dementia assessment" which is not something we do. These referrals would frustrate our intake team because they were not really sure what services to connect these patients to. *"I was able to take this feedback and circle back to the social worker to explain what we could/couldn't do to support someone with dementia".* The quality of the referrals we received from that social worker improved after that conversation.

Implementing a Referral Protocol

Primary care clinics use a variety of modes for communication, such as phone calls, email, or fax. A PCL must understand a clinic's preferred/typical communication mode and integrate that option into the referral protocol. For example, one agency developed a referral form that primary care clinics faxed to their AAA **(see Appendix 3).**

When the referral protocol is ready, the PCL can begin using it, for example including it in the standard packet of resources and briefly reviewing it when meeting with primary care clinic contacts.

After a referral is made, clinic staff may directly contact the PCL to ask about its status. Document these contacts and address issues they raise. Keep track of the outcome of each referral to identify areas for improving the process. To ensure accountability, ask these questions: How will information about a referral outcome be accessed? With whom will feedback be shared to ensure service quality?

Consider using a general email address for referrals and inquiries instead of an individual's email. This will ensure consistency if the PCL is on leave or in case of staff turnover.

Anticipate an Increase in Referrals

Successful outreach and relationship-building will likely result in increased referrals to an AAA. As referrals increase, the PCL must be able to answer questions about the AAA's referral processes and troubleshoot and resolve any issues that arise. For example, if a clinic does not get a call back from the AAA's resource center (information and assistance) in the anticipated time frame (72 hours), they may contact the PCL.

The PCL should interact with key program staff at their AAA and contracted partners that may be affected by increased referrals, data tracking, and/or evaluation. The PCL should also share the nature of these referrals with AAA staff, as well as the referring clinic's knowledge of existing community resources. AAA staff who process referrals are important sources of information for the PCL when following up with clinics and providing feedback on the resolution of their referrals. The information can also guide clinics on how to make more effective referrals in the future. A quarterly audit of all referrals from an individual provider may identify trends and opportunities for further education for that provider and other clinic staff.

An increase in the number of people seeking access to AAA services will require ongoing training of AAA staff who receive and manage referrals, including eligibility determination. This training will ensure that all clinic stakeholders, including primary care providers and their teams, receive consistent information and access to the services relevant for a given patient whenever they contact the AAA.

The PCL analyzed how many referrals were sent in that listed a family caregiver. The PCL was able to determine that only about 5% of the referrals actually made it on to a program, which is much lower than we would like to see. This tells us that there is opportunity to improve the quality of the conversation that is happening between intake staff and the patient. As a result, our agency developed a monthly training series for our intake staff that specifically focused on engaging family caregivers and understanding the menu of services available for family caregivers.

Consulting on Client Cases

The PCL may be contacted directly by clinical partners seeking guidance or technical assistance about specific cases and situations. The PCL is not expected to be an expert on every issue. However, the PCL should work collaboratively with internal and external partners to coordinate information sharing and follow up. The PCL should suggest possible channels for resolution if issues arise.

Learn about HIPAA (Health Insurance Portability and Accountability Act) requirements in advance, to ensure compliance during the process and avoid problems when exchanging patient information. Knowledge of HIPAA will make working with healthcare partners around specific patient issues easier.

For referral forms completed at a clinic, consider working with clinic partners to add a paragraph for patient signature so patients can authorize release of their information to the AAA. This will add trust in the process and ensure HIPAA compliance.

INITIATING AND SUSTAINING CONNECTIONS WITH PRIMARY CARE

Outreach visits are a major component of the PCL's work. To transfer information between clinics and the community, the PCL must be familiar with existing resources and understand the needs of healthcare partners in real time. PCLs must tailor outreach conversations and presentations to individual contacts and visits.

Initiating Contact and Scheduling an Outreach Visit

The PCL can use different ways to initially contact a clinic or clinic network, depending on its size. Contact may start with a phone call to a clinic manager or email to an existing contact. Other methods include connecting through mutual colleagues or at conferences or other outreach events. Some clinic networks have an outreach or marketing specialist who engages with community partners, but some clinics may not have this type of staff.

If an initial phone call to a clinic is answered by a receptionist or other administrative staff, the PCL should ask to speak with a clinic manager. There may be situations where a receptionist or clinic manager will be unsure where to direct the PCL. In this scenario, a viable next step would be to ask if there is a social worker, patient navigator or other staff member who makes referrals or coordinates care in the community. Follow up via both phone and email when initially contacting a practice.

Use an email campaign to reach out to existing contacts to announce your partnership with an academic institution and the PCL's availability to meet in person.

See Appendix 4 for an example script of an initial contact conversation.

The AAA and PCL should establish a minimum and maximum number of attempts to contact potential partners, based on resources and priorities. In our experience, three attempts are ideal and yield the highest response rates. If a clinic is not interested, the PCL should note that and re-attempt outreach later. For all outreach efforts, document each date of attempted contact, means of connection (e.g., phone call, email, or in-person), and whether contact was made.

Upon reaching a practice, PCLs should introduce themselves, explain the reason for the contact, and offer an in-person visit to the practice to share information about available resources. A challenge at this stage might be distinguishing AAA programs from commercial services. An effective strategy might be establishing the trustworthiness and providing details of available resources (such as: Are services free? Are they publicly available? What is the program's reach?). Mention a well-known resource offered by the PCL's AAA (for example, Meals on Wheels – a well-established, valued program) or programs that meet a common need, such as transportation. Note whether or not substantial numbers of patients served by the clinic are also clients of their AAA. The option to co-brand with an academic partner, if applicable and needed, may lend credibility to the PCL program and leverage the partnership with a university or other academic institution.

See Appendix 5 for an example of an outreach campaign that co-branded an AAA with an academic partner.

The PCL will likely not be invited immediately to meet with primary care providers or an entire clinical team. Establishing ongoing communication will take time, during which the PCL can demonstrate their knowledge, efficiency, and reliability as a liaison.

Understanding Types of Outreach Visits

The duration and content of an outreach visit will vary depending on the audience, the PCL relationship, and the needs of the clinic or provider. Face-to-face meetings at the clinic are preferred whenever possible.

One-on-One Meetings

One-on-one meetings often take place between the PCL and a clinic manager and/or clinic social worker. These meetings are an opportunity for the PCL to explain their role and for clinics to assess the PCL's usefulness and can lay the groundwork for clinic staff to advocate for the PCL to attend an upcoming huddle or team meeting.

A one-on-one visit can also be effective when a relationship already exists between the AAA and a clinic. PCLs might meet with existing contacts to introduce themselves and their role, explore opportunities for a deeper connection, introduce new or updated resources available since an earlier visit, and identify next steps for collaboration. Next steps might include being invited to a team meeting or establishing regular check-ins or a referral process. Plan for a maximum meeting time of 30 minutes unless otherwise requested by the contact.

Team Meeting or Huddle

When arranging a date and time for an outreach visit with a clinic, the PCL should ask about a standing team meeting that they might attend. Team visits may be more convenient for clinic staff and allow the PCL to meet and give information to many team members at once.
For a team visit, the PCL needs to adapt to a different format than a one-on-one meeting and be prepared to answer questions on a variety of topics. Team meetings and huddles vary in duration, so the amount of time allotted to the PCL should be clearly identified – expect anywhere from 5 to 15 minutes.

The PCL should confirm details of the meeting with their contact before attending, including expectations for information to be shared, the number of people who will attend, specific programs or topics to address, or whether to provide a formal presentation (e.g., PowerPoint slides).

Drop-In and Drop-Off Visits

In general, PCLs should avoid common "sales" strategies such as drop-in visits. However, these visits can be productive if the PCL has not successfully reached the clinic via phone or other methods and believes the attempt would be worthwhile. Prepare a folder with the PCL's business card and basic program materials (such as an explanation of the PCL role, materials that the clinic staff might find helpful, and a flyer as shown in **Appendix 6**). Upon arrival, the PCL should give a brief introduction to the receptionist and say that they are dropping off a packet of resources and/or updated referral forms for the clinic social worker or navigator. Be prepared —the receptionist may offer to call the social worker and see if they're available for a brief chat!

Visits with Health Profession Trainees

Depending on the location, PCLs may have opportunities for outreach to training programs (such as for medical residents, nurse practitioners, or other health professions) or as part of regular teaching conferences (e.g., grand rounds). These situations provide an opportunity for health profession students to learn about Aging Services Network resources early in their training. This type of outreach will likely be pre-arranged, and the PCL may be asked to address a particular topic or subject (e.g., care transitions, resources for patients with dementia, or family caregivers). Be sure to have enough handouts for all attendees and leave time for questions.

Virtual Visits

Although face-to-face outreach visits are considered standard, virtual outreach might be necessary or even preferred. Virtual outreach is through videoconference or conference calls in which the PCL delivers a presentation or exchanges electronic information using telecommunication technologies.

Some virtual outreach tips include:

- **Familiarize yourself with virtual platforms.** Be flexible and use the online meeting platform suggested by the care team. If the care team uses a videoconferencing platform that is unfamiliar, ask for a quick trial log-in with the meeting organizer or technical support. Log into the meeting early to ensure your video, audio and screenshare functions are working.

- **Provide visual content.** To help establish rapport, present information to the care team on a webcam-enabled device, even if the care team does not have their webcams enabled. Use the platform's screensharing feature to give a slideshow presentation. Screensharing allows everyone to see your desktop and active documents you may share. For a conference phone call, send materials to the care team before starting so they can follow along.

- **Prepare a back-up plan for technical issues.** Prepare for technical problems during virtual outreach. For example, to address potential internet issues, download or print a copy of your presentation that you can access without the internet.

- **Anticipate screensharing errors.** Before the virtual outreach visit, email your slideshow presentation to your primary contact person(s). Let them know your contact phone number in case they need to call you in real time. Give them enough time to open your document and screenshare it for you if that has been the agreed-upon plan. If you will be screensharing, close unneeded documents so that you do not accidentally share personal or confidential information.

- **Troubleshoot audio issues.** Keep a phone, dial-in number, and meeting identification number ready in case you experience trouble with the audio system on your device.

Understanding Important Elements of an Outreach Visit

The PCL typically begins a visit with introductions, explaining the purpose of the visit, and providing high-level information about the AAA and its resources. This discussion could be followed by inquiries from the PCL about issues commonly faced by team members at patient visits. The PCL should offer tailored, detailed information about programs to address these specific issues (see "Preparing for Common Outreach Scenarios" below). If clinic staff are already aware and have successfully used community resources, the PCL should reinforce and encourage this positive practice.

Referrals

The PCL should end a visit by explaining how clinic staff can make referrals to their AAA and what patients can expect. Specifically describe how to make a good referral, and why it is important for providers to make a referral on a patient's behalf instead of having the patient self-refer. Ask how the clinic routinely finds out about community programs and resources that are used or needed by patients (such as a question on a clinic intake form, or routine screening practices). This information could help to guide which resources the PCL describes. For example, if all patients are screened for risk of falls or have conversations about remaining active and mobile as a part of Medicare Annual Wellness visits, provide resources that address fall risk (e.g., fall-prevention exercise classes). This approach supports the clinic's existing practices and tailors resources to the needs of the clinic's patients. PCLs should also offer their services as a 'liaison' and fortify the relationship with the clinic by offering ongoing support to address any questions that may arise regarding the referral process.

Placing a referral to the AAA on behalf of a patient will not only legitimize the AAA and its services as a credible resource but also maximize the likelihood that the patient will end up being connected to relevant services.

Written Materials

The PCL should leave written materials such as handouts and pamphlets about resources discussed in the meeting, as well as their contact information. The PCL might ask if they can place patient brochures in the waiting area.

Preparing for Common Outreach Scenarios

Scenario 1: Tailor Outreach Visit to Focus on a Specific Program or Resource. A PCL may be invited to a meeting of clinic providers and/or staff to speak about a particular program or resource offered by the AAA. Tailor the visit to focus on the requested issue but also take a few minutes to introduce the AAA more broadly. A practice might not be familiar with other services the AAA offers. This information could prime the clinic team for an ongoing relationship through expanded connections. If the PCL's AAA does not address a specific topic identified by the clinic, facilitate a connection to a more appropriate organization or individual in the community or offer to investigate and follow up.

Bringing a member of the AAA team to outreach meetings can be valuable. Examples are a case manager who frequently works with a clinic's patients or AAA staff who process referrals. Firsthand stories about shared patients enhance the information provided by PCLs and support them in deepening relationships between people who already connect frequently.

Scenario 2: Tailor Outreach Visit to the Clinic Staff's Role. Another scenario is for the PCL to tailor resources to an individual's role within the clinic, to broaden the number of staff members who take responsibility for enhancing a patient's connection to resources. Clinical staff may believe that someone else should discuss topics such as transportation or access to healthy food with a patient, but these assumptions can lead to patients falling through the cracks. Explain that, depending on clinic policies, a referral to the AAA can be from anyone at the clinic and does not have to come from a specific person in a particular role.

For example, some clinical staff may think that a referral to the AAA goes through a patient's insurance, requires pre-authorization, and must be sent by the clinic's social work team. Explicitly calling out differences between a referral to the Aging Services Network and other more familiar referrals may help clinical team members see that connecting a patient to a resource is within their scope.

Post-Meeting Follow-up

Following up after visits with a clinic will build and maintain relationships. Follow-up may include thanking team members for their time, providing resources requested by the team or shared during the meeting, recapping future engagement plans (e.g., regularly attending a meeting), and inviting the team to connect with the PCL in the future.

Include a thank you card with any materials mailed after an initial on-site visit.

Addressing Common Outreach Challenges

No Response to Outreach – Deciding When to Move on

On occasion, clinics or clinical managers may not respond to PCL attempts to engage. If this happens, strategies include:

- Attempt to engage with a different member of the interdisciplinary team. This could include calling the clinic and asking to speak with a patient navigator, social worker, or care coordinator.
- Use a different outreach format. Check the clinic's website for alternative methods of contact. Some clinics have an option to submit a web or email inquiry, which could result in a different individual receiving the contact and returning the inquiry.
- Network among contacts to find mutual connections with the clinic or staff to make an email introduction.
- Try contacting the clinic at another time, such as after 6 months or later using a PCL's best judgment. Put a reminder on the PCL tracking sheet and/or calendar.

Moving On: At times, despite the PCL's best attempts to connect with a clinic, phone calls or emails will not be returned. The PCL should discuss these situations with their supervisor, and if the supervisor concurs, the PCL should suspend further attempts to contact the unresponsive clinic and focus on other clinics. A final phone call, email or fax could be sent to the clinic to document the attempts to reach out and encourage them to contact the PCL with questions. The PCL might consider attempting contact with an unresponsive clinic in the future if new programs or services become available.

No Existing Clinic Contact

Engaging with a clinic is easiest if the AAA has a previously established working relationship with someone at the clinic. However, the unique role of the PCL presents opportunities for new connections. One strategy in this situation is to provide examples of recognizable programs that clinic personnel are likely to be familiar with, such as a home-delivered meal program, that the AAA oversees. Programs sponsored by the AAA that meet a specific, common need of many patients such as transportation to clinic appointments is another strategy. The PCL could also provide information on the number of patients served by the clinic who are also clients of their AAA. If this number is small, increasing the number of patients who access AAA services could become a shared goal.

Staff Turnover

Turnover in clinic staff can be a particular challenge. When you become aware that a key contact at a clinic is leaving their position, ask for an introduction to the replacement (if identified), or to an interim contact. Staffing changes are opportunities to deepen relationships with other staff at the clinic while establishing a new relationship with the contact's replacement. Many staff members connect with patients who may benefit from the AAA's services, so the PCL should continue looking for opportunities to familiarize themselves with new primary care staff and inform them on ways to connect with the AAA. Also bear in mind that the staff member who leaves a given clinic may contact you in the future if they assume a role within a different practice. So turnover may ultimately result in expanded clinical connections.

Combating "Sales" Tactics

AAAs adding a PCL may not be aware of the number of product representatives that regularly market to healthcare clinics. Pharmaceutical sales are a common example of companies that frequently offer swag or free lunches to clinic teams. The PCL must distinguish their services by noting that they are not-for-profit and offer free or low-cost public resources. This clarification can be made by sharing the ways that programs are funded (e.g., federally), describing the structure of AAA resources nationally, and highlighting the PCL's connection with an academic partner if such a connection exists.

Reinforcing the PCL's 'liaison' role will also distinguish this program from other sales-driven relationships. The PCL does not direct clinics toward particular products or services but expands their understanding and use of broader community-based resources in their area through individualized consultation. More important than polished talking points or a presentation is for the PCL to listen to the issues experienced by the clinical team and identify opportunities to meet their needs with resources and processes that enable patients to successfully access those resources.

Following Up After an Outreach Visit

The amount of follow-up and the frequency of return visits is often dictated by practice routines and previous visits. For some practices, follow-up might include weekly discussion of referrals and their outcomes. Other follow-up communications can focus on new services or programs offered through the AAA or other organizational partnerships. If materials are not left during the initial visit, the PCL could mail them to the clinic or drop them off after the visit as a simple form of follow-up.

The feedback loop created through clinical-community partnerships fostered by the PCL can create mutually beneficial relationships that influence clinic and AAA practices. Healthcare providers who make referrals to organizations outside the clinical environment often do not know what happens to these referrals or how their patients engage with the resources. The AAA and PCL can provide information to clinics about the resources that are most often used by their patients. This feedback can reinforce ways to discuss resources and make referrals. For example, if referrals from a particular provider have a high level of use by that provider's patients, discussing with the clinic how that provider talks with patients about the role of community-based resources in their overall care may help other providers find effective ways to introduce a program or service. Information from clinical staff about services their patients need that aren't currently available could inform the AAA's future programmatic decisions.

Example of PCL outreach in-action: A PCL was contacted by a clinic about a 55-year-old patient who needed to apply for Social Security Disability Insurance and medical benefits. A senior center near the clinic had an AAA advocate, so the PCL provided information about the AAA advocate and local resources and connected the clinic with the advocate. The clinic helped the patient schedule a senior center visit to meet with the AAA advocate, which also connected the patient with their neighborhood senior center. The solution created by the PCL was tailored to the clinic, providing an available and geographically accessible resource.

Connecting with Primary Care Outside the Clinic

Participating in community groups and healthcare-focused collaborative meetings helps PCLs because these meetings offer numerous possibilities to make new connections with potential partners. The meetings are an opportunity for PCLs to introduce themselves to healthcare professionals, explain their bridging role between AAAs and healthcare, and share their unique position to assist busy healthcare providers at a time when they are more open or ready to receive this information. These meetings are also a chance to check in informally with existing partners. Examples of these meetings include interdisciplinary gatherings where community resources are shared with professionals, community-wide coalitions, health fairs or health promotion events, or meetings focused on a particular diagnosis such as dementia or Parkinson's disease.

Example of PCL outreach in-action: A PCL contacted a clinic that shared many mutual patients with the AAA. After the initial meeting, the PCL invited two clinic care coordinators to a local coalition meeting on healthcare needs of underserved populations. The care coordinators' attendance strengthened the clinic's connection to the PCL and increased clinic awareness of local resources.

Sustaining Established Relationships

In addition to establishing contact with primary care practices and building significant connections, a major aspect of the PCL role is maintaining and growing long-term relationships. Regular and meaningful communication with primary care staff is essential to solidifying new connections and must continue even after referrals are received.

After a relationship is established with a practice and referrals to the AAA are a part of clinic workflow, relationship management often revolves around shared patients. Once the PCL has demonstrated value in helping clinic staff with questions or staffing challenging cases, many providers return to the PCL for ongoing support. As the relationship deepens, the PCL and clinic may connect on other topics. For example, hearing about trends clinics are seeing or what resources are missing may guide a AAA's strategic planning. The PCL can work with clinics on opportunities for creating formalized partnerships with the AAA or introducing clinics to other groups that would benefit the clinic. These routine interactions will continue to fortify the bridge the PCL provides between clinics and communities.

Examples of PCL partnerships in-action:

1. *"During an outreach presentation it became clear that there was misunderstanding of what Adult Protective Services (APS) does. I was able to provide a brief explanation, but then facilitated an introduction to APS. APS was able to provide an outreach presentation to the clinic the following month."*
2. *"Providers were unsure of how to expedite referrals for long term care for hospice patients, leading to long wait times for caregiving. I was able to work with the State agency responsible for processing long term care applications, learned how to expedite the process, and taught that process to the clinic social work team."*

Building solid, scalable habits and protocols to foster and maintain relationships past initial connections will keep practices engaged and satisfied long term and grow referrals. As connections and champions in primary care practices leave, the PCL should continue to stay in contact and bridge gaps even during staff turnover. Set up calendar reminders based on the practice's date of last contact and initiate emails or phone calls at set intervals (e.g., every 3 to 6 months) to check in, assess new needs from the practice, and offer relevant resources. PCLs find it worthwhile to send helpful, seasonally relevant resource lists developed within the AAA to their entire contact list a few times per year. For example, holiday food box information or extreme weather shelters are appreciated by clinics. The PCL can work with clinics on opportunities for creating formalized partnerships with the AAA or introducing clinics to other groups that would benefit the clinic. These routine interactions will continue to fortify the bridge the PCL provides between clinics and communities.

CONDUCTING QUALITY ASSURANCE

What is a Quality Assurance Plan and Why is it Important?

A quality assurance plan is critical to ensuring that the PCL role is implemented as intended. Quality assurance is defined as an ongoing system for describing, measuring, and evaluating program delivery to ensure that effective, high-quality services are delivered and program goals are met. A quality assurance plan guides internal monitoring and management and provides documentation to funders and other stakeholders about progress toward goals and mechanisms in place to assure quality programming. A quality assurance plan is an important part of the PCL's credibility with stakeholders and funders and helps build the case for a PCL as a worthwhile, high-value investment.

What are the Key Elements of a Quality Assurance Plan?

A quality assurance plan includes:

- **Planning.** Setting measurable objectives and establishing mechanisms to monitor whether the objectives are being met.
- **Monitoring.** Collecting information from key stakeholders (e.g., AAA staff, clinicians in primary care practice, clients) to inform decision-making.
- **Evaluating.** Analyzing what is or is not working and problem-solving. Making changes as needed to improve overall performance and enhance stakeholder satisfaction.

Track details of all outreach efforts to ensure ongoing attention to clinics and delivery of all requested information/resources, connections established with all receptive primary care clinics in the AAA's catchment area, saturation, and a comprehensive picture of the scope and impact of the PCL's work. Tracking can be with a simple spreadsheet or a more robust system such as an online program.

As noted in the "follow-up" section of this guide, PCLs should establish timelines for ongoing follow-up. Will the PCL reach out to contacts individually? If so, with what frequency? Will large email campaigns be conducted on a recurrent basis to highlight new resources and opportunities for collaboration? If so, the PCL should share the opportunity to be a part of this email distribution list during outreach visits and regularly evaluate the list for accuracy.

Outreach tracking information will periodically need to be summarized into performance indicators. Examples of performance indicators include:

- Types of health systems being reached
- Disciplines most frequently reached
- Materials most frequently requested
- Needs most frequently identified

Tracking Information

We have found the following data elements are the most vital when tracking outreach efforts:

- Health system – This element ensures multiple clinics within a larger health system are contacted.
- Clinic – This is individual clinic information, which is especially important for clinics that are part of a larger health system.
- Clinic zip code or location identifier – This helps ensure outreach occurs across different areas of a city or community.
- Clinic contact information – This element is usually a phone number or email address for an individual at the clinic. A dedicated contact person can schedule follow-up meetings, provide information missing from a referral form received at the AAA, and serve other useful "connector" roles.
- Purpose of contact – An example is: Is it a huddle meeting vs. one-on-one with a clinic manager?
- Date of contact – This element documents contacts over time and can help trigger follow-up.
- Type of contact – This element indicates in-person or virtual meeting versus phone or email.
- Discipline – For example, social worker, clinic manager, or primary care provider.
- Number of individuals attended – This element is for visits where more than one person from a clinic meets with the PCL (either in person or virtually).
- Follow-up Actions – This could include any identified need (e.g., flyers to drop off or resources to address specific questions) or a need for future follow-up.

EVALUATING THE PCL ROLE

Why Evaluate?

Periodically assessing the PCL role and services and PCL program outcomes is essential for demonstrating their value. Evaluation provides useful information about the success of the role, program, and services. It is also crucial for determining when something is not working well and identifying what to change to improve the program. Evaluation results can demonstrate benefits to older adults, family members, and caregivers. The results may describe the level of satisfaction that health professionals have with the PCL role, help identify areas for improvement, and strengthen existing working relationships with healthcare organizations. Evaluation findings might attract new healthcare organizations for future outreach. Evaluation also provides important information to share with funding agencies and other partnering organizations to communicate the success of the PCL program, generate support for its continued funding, and inform an understanding of potential challenges associated with the role.

What Type of Evaluation?

- A **process** evaluation assesses whether the procedures for reaching the intended audiences are working.
- An **impact** evaluation measures changes in knowledge, attitudes, beliefs, and (possibly) behaviors in the intended audiences.
- An **outcom**e evaluation measures changes in behaviors, health outcomes (disability, quality of life, death), and (possibly) healthcare utilization in patients served by clinics that the PCL works with.

How to Evaluate?

Evaluation planning ideally begins before hiring the PCL so the AAA can collect information in advance, to provide a baseline for determining the impact of the PCL's outreach efforts. Before the PCL starts, decide what the evaluation targets will be. (Examples are number of outreach efforts, number of successful outreach efforts, new primary care sites engaged.) Deciding the targets ahead of time will promote gathering the evaluation information in a prospective, organized, efficient way. Careful planning and regular collection of evaluation information will position your agency to perform evaluations at regular intervals or as circumstances require.

The document Demonstrating Your Program's Worth provides detailed information about evaluation and includes guidance about hiring and working with an evaluation consultant.[5]

Employing a professional evaluator, at least to help with setting up an ongoing evaluation structure, will ensure that your agency collects the necessary information for regular, comprehensive evaluation of the PCL role. If your agency has an academic partner, ask if they can help with setting up and conducting evaluations.

When to Evaluate?

Process evaluation should begin as soon as the PCL role starts, so the structure of the evaluation (such as who, when and what information will be collected) should be in place before the PCL is hired. Do the evaluation periodically, ideally every 3 to 4 months during the PCL's first year. Evaluation can eventually shift to every 6 or 12 months and may be conducted to support a funding proposal.

Impact evaluation can begin once the PCL contacts the intended audience (e.g., healthcare professionals). This type of evaluation could be a brief, post-outreach feedback questionnaire. A more in-depth evaluation would measure what the audience knows, for example about AAA services, at baseline and after PCL contact, to measure changes in knowledge resulting from PCL interaction. Evaluation activities should not be a burden for clinics and healthcare professionals, so contact them as little as possible. An evaluation request is best sent immediately after a successful clinic contact and only once for each healthcare professional involved.

The PCL program is intended to be permanent. So conduct outcome evaluations in partnership with stakeholders (e.g., funding agencies, policymakers) and tailor the evaluation to focus on their outcomes of interest. Outcome evaluations should be infrequent, for example every 2, 3, or 5 years.

CONCLUSION

Implementation of the Primary Care Liaison (PCL) role offers "value-added" to the community-based Area Agency on Aging (AAA) and the healthcare community in its area. The PCL can serve as a simple and efficient single point of contact for overburdened healthcare providers and positively impact their ability to serve patients. The PCL can also enhance the AAA's ability to reach people who facilitate care for those patients, such as family caregivers, who might not otherwise be served.

The ability to build a sustainable model of collaboration is imperative to the success of the PCL role. Creating a network of clinical systems that see the AAA as a part of their interdisciplinary team will ensure patients are efficiently connected to resources and offer benefits that extend beyond the work of the PCL.

The service provided by the PCL expands a clinic's interdisciplinary team and enhances an AAA's understanding of its vital partners' needs. Thoughtful provision of resources, timely follow-up, and ongoing process improvement can create lasting changes that will ultimately impact patient outcomes.

REFERENCES

1. Etz RS, Cohen DJ, Woolf SH, Holtrop JS, Donahue KE, Isaacson NF, Stange KC, Ferrer RL, Olson AL. Bridging primary care practices and communities to promote healthy behaviors. Am J Prev Med. 2008 Nov;35(5 Suppl):S390-7. doi: 10.1016/j.amepre.2008.08.008. PMID: 18929986. Institute of Medicine. Collaboration Between Health Care and Public Health: Workshop Summary. (Wisemann T, ed.). Washington DC: The National Academies Press; 2016. doi:10.17226/21755.

2. Roundtable on Population Health Improvement; Board on Population Health and Public Health Practice; Institute of Medicine. Collaboration Between Health Care and Public Health: Workshop Summary. Washington (DC): National Academies Press (US); 2016 Feb 4. PMID: 27010056.

3. Boll AM, Ensey MR, Bennett KA, O'Leary MP, Wise-Swanson BM, Verrall AM, Vitiello MV, Cochrane BB, Phelan EA. A Feasibility Study of Primary Care Liaisons: Linking Older Adults to Community Resources. Am J Prev Med. 2021 Dec;61(6):e305-e312. doi: 10.1016/j.amepre.2021.05.034. Epub 2021 Sep 6. PMID: 34497030.

4. Shea CM, Jacobs SR, Esserman DA, Bruce K, Weiner BJ. Organizational readiness for implementing change: a psychometric assessment of a new measure. Implement Sci. 2014 Jan 10;9:7. doi: 10.1186/1748-5908-9-7. PMID: 24410955; PMCID: PMC3904699.

5. Thompson NJ, McClintock HO. Demonstrating Your Program's Worth: A Primer on Evaluation for Programs To Prevent Unintentional Injury. Atlanta: Centers for Disease Control and Prevention, National Center for Injury Prevention and Control, 1998.

APPENDICES

Appendix 1: Sample Primary Care Liaison Job Description

The Primary Care Liaison (PCL) promotes healthy aging by connecting the health system with community resources that support caregivers and older adults to age in place.

Job Responsibilities

- Conduct primary care clinic visits and consultation to promote outreach, networking, and sharing of information about aging services and supports (minimum _ clinic visits per month).
- Assist primary care providers and/or clinic staff to make referrals to the Area Agency on Aging (AAA).
- Explore opportunities for outreach to any location where people access healthcare services (e.g., community pharmacies) to share information about aging services and supports available through the AAA.
- Maintain accurate records of outreach efforts. Track clinic visits and assess future clinic engagement.
- Explore opportunities to reach underserved populations that could benefit from health promotion programs.
- Synthesize learnings from outreach activities for other AAA staff.
- Participate in case staffing and problem-solving with primary care clinic staff, AAA case managers, and other professionals.
- Work collaboratively with AAA staff, partner organization staff, and other AAAs doing similar work.
- Work with older adults, family members, and their caregivers to increase knowledge, skills, and confidence in managing their health conditions.
- Facilitate patient, family members, and/or caregiver enrollment into evidenced-based programs.

Qualifications

Education: BA/BS degree in Social Sciences, Human Services, Business, Public Administration, or a related field is required (or a combination of education, training and/or experience that provides an equivalent background required to perform the work).

Experience

One year of experience in human services administration, service delivery, community organizing, contract administration, or related experience.

Appendix 2: Sample Webpage Content

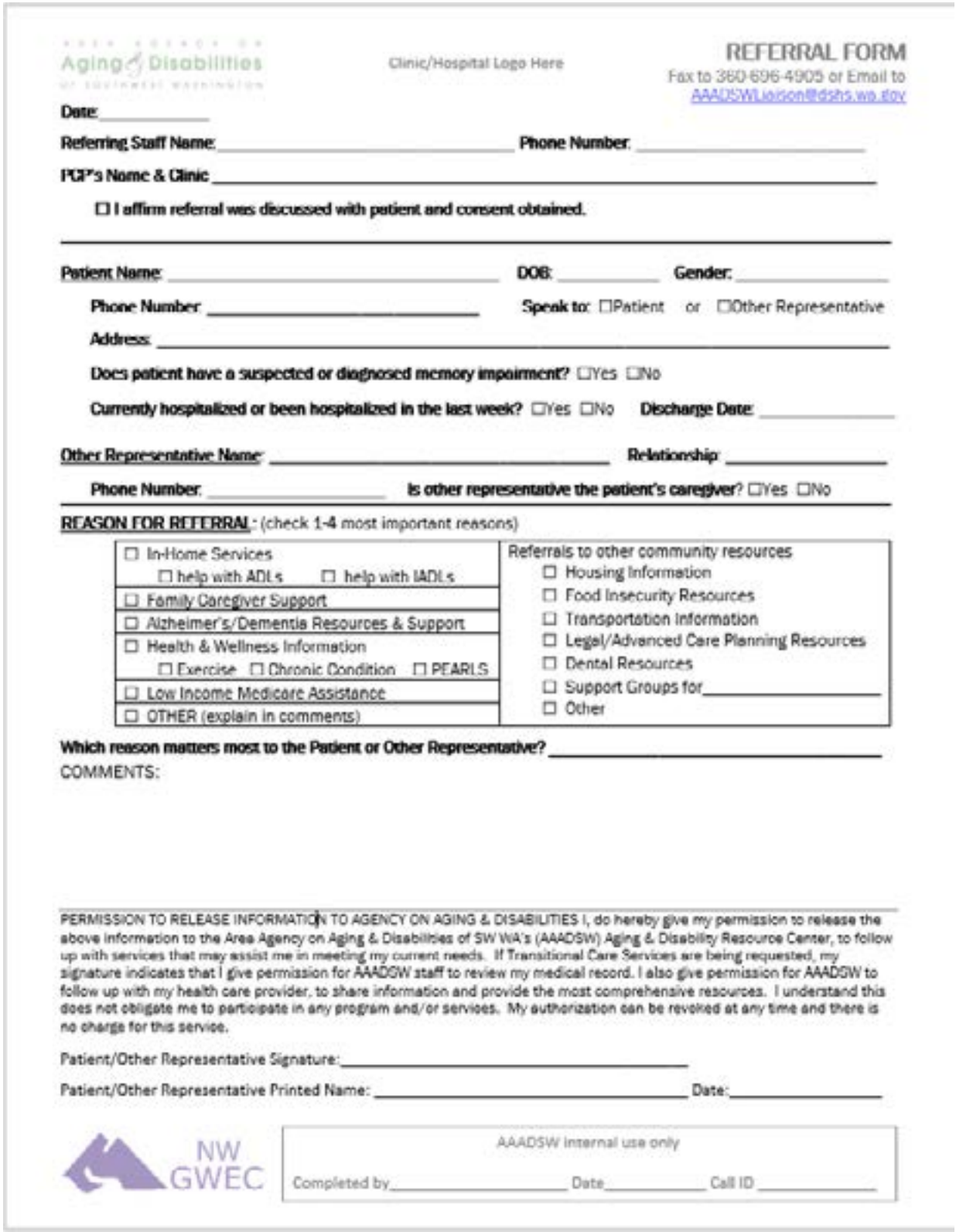
Healthcare Collaboration

[Agency Name], in collaboration with [partner(s)], aims to positively impact the healthcare system serving older patients and their families through targeted outreach and education.
A Primary Care Liaison is available to meet with primary care teams, discuss programs offered to patients in our community, and provide ongoing support to clinical and support staff.
Connect with our Primary Care Liaison [hyperlink email] to arrange a meeting or presentation with your clinical team.

Patient Resources

Healthcare providers can link patients and their families to services quickly and easily through [Aging and Disability Resource Center or AAA Point of Entry]. Direct referrals can be made via phone or secure email and an advocate will follow up with the patient. Connect with our Primary Care Liaison [hyperlink email] for more details.

Appendix 3: Sample Referral Form



Aging & Disabilities

Clinic/Hospital Logo Here

REFERRAL FORM

Fax to 360-696-4905 or Email to AAADSWLogon@dshs.wa.gov

Date: _____

Referring Staff Name: _____ **Phone Number:** _____

PCP's Name & Clinic _____

☐ **I affirm referral was discussed with patient and consent obtained.**

Patient Name: _____ **DOB:** _____ **Gender:** _____

Phone Number: _____ **Speak to:** ☐Patient or ☐Other Representative

Address: _____

Does patient have a suspected or diagnosed memory impairment? ☐Yes ☐No

Currently hospitalized or been hospitalized in the last week? ☐Yes ☐No **Discharge Date:** _____

Other Representative Name: _____ **Relationship:** _____

Phone Number: _____ **Is other representative the patient's caregiver?** ☐Yes ☐No

REASON FOR REFERRAL - (check 1-4 most important reasons)

☐ In-Home Services ☐ help with ADLs ☐ help with IADLs	Referrals to other community resources ☐ Housing Information ☐ Food Insecurity Resources ☐ Transportation Information ☐ Legal/Advanced Care Planning Resources ☐ Dental Resources ☐ Support Groups for_____ ☐ Other
☐ Family Caregiver Support	
☐ Alzheimer's/Dementia Resources & Support	
☐ Health & Wellness Information ☐ Exercise ☐ Chronic Condition ☐ PEARLS	
☐ Low Income Medicare Assistance	
☐ OTHER (explain in comments)	

Which reason matters most to the Patient or Other Representative? _____

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's (AAADSW) Aging & Disability Resource Center, to follow up with services that may assist me in meeting my current needs. If Transitional Care Services are being requested, my signature indicates that I give permission for AAADSW staff to review my medical record. 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/Other Representative Signature: _____

Patient/Other Representative Printed Name: _____ Date: _____

NW GWEC

AAADSW internal use only

Completed by_____ Date_____ Call ID _____

Appendix 4: Sample Script of an Initial Phone Contact

Option 1 - “Good afternoon, my name is ___, and I’m a primary care liaison at _____. We’re a public agency that provides services and resources for community-dwelling older adults, people with disabilities, and their caregivers. [I see that your clinic offers geriatric care medicine.] I would like to discuss how our programs can assist older patients managing [chronic conditions/needs at home.] [I’m wondering if staff might be interested in a brief meeting – social workers, navigators, RN care managers.] I imagine that the team might already be engaging with our network of services in some capacity, and I want to be sure that everyone has up-to-date information and support from us. Is there someone I could speak with about scheduling a meeting with interested staff?”

Appendix 5: Sample Email for an Outreach Campaign

Hi <contact's name>,

I'm <PCL's name>, and I'm a Primary Care Liaison at <AAA name [hyperlink to website]>. We are a public agency that provides social services and supports for older adults, adults with disabilities, and their caregivers. We offer five core service areas: nutrition, caregiver support, health and wellness, elder rights, and supportive services.

I'm reaching out to your primary care team to share information on aging and disability services for older patients. We aim to bridge the service gaps between the healthcare and social service systems in addressing the patient's health and social needs. As the Primary Care Liaison, I connect clinical teams with community resources and facilitate the referral process to local aging services network.

Is there someone I could speak with about the possibility of scheduling a brief meeting? Perhaps I could share with interested staff an overview of community aging and disability services during a team meeting. I understand you may already engage with our network of services in some capacity, and I want to be sure everyone has up-to-date information and support from us.

Warmly,
<PCL's Name>
<PCL's Signature with contact information>

Appendix 6: Sample Flyer Announcing the Primary Care Liaison