

## Section 4.2 Implement

# Community Resource Directory

This tool supports care coordinators (CC) in identifying and utilizing a wide variety of community resources to help patients with healthcare-related needs. Developing and maintaining a community resource directory, as well as establishing working relationships and agreements, are essential components of a community-based care coordination (CCC) program.

**Time needed:** 15 hours to review tool, set up directory, and make initial contacts with 10 community resource representatives. **Maintenance:** 1 hour per month

**Suggested other tools:** Population Risk Stratification and Patient Cohort Identification; Community Resource Directory Template; Business Associate and Other Agreements; Patient CC Variance Reporting

## Table of Contents

How to Use .....	1
Community vs. Provider Resources.....	2
Potential Community Resources.....	2
Building the Community Directory .....	3
Agenda for Community Resource Meeting .....	5
Agreement Topics for Providing Community Resources.....	5

## How to Use

1. **Distinguish** between community resources and provider resources as used in this Toolkit.
2. **Review** the recommended content and determine how to create and manage the directory.
3. **Review** the list of potential community resources:
  - a. Identify and add to the list of community resources those believed to be most needed for the cohort of patients requiring care coordination as a means to prioritize contacts.
  - b. Identify and add to the list of community resources those already known to/used by the CCC program. Confirm that there are formal or informal agreements in place, or identify the need for such an agreement.
  - c. Contact, by order of priority, community resource representatives to introduce the community-based care coordination program and the care coordinator, learn about the community resource, and compile initial information about the community resource.
4. **Use** the agenda outline to introduce the community-based care coordination program to community resources and obtain necessary information from them.

## Community vs. Provider Resources

For purposes of this Toolkit, “community resources” are distinguished from “provider resources” with respect to the nature of services each type of resource provides, the type of information available about the resources, and communications about expectations each party will have for the other.

- **Community resources** generally refer to social or community services that help patients manage their activities of daily living, such as transportation, personal care, nutrition, support groups, etc. Many community resources are provided by local governmental agencies or charitable organizations.
- **Provider resources** are those that have licensed professional providers and other clinicians who provide diagnostic and treatment services. These include hospitals, clinics, specialty physicians, mental health care providers, nursing homes, home health agencies, durable medical equipment suppliers, etc.

## Potential Community Resources

The table below provides a starting list of many of the most common community resources. Begin to identify those in the community that are most likely needed given the cohort of patients being served by the CCC program. Add lines if more than one organization provides the type of service described; split rows for specialized service organizations. (See *Community Resource Directory Template* for a fillable form.)

Type of Community Resource	Priority H-M-L	Name of Organization(s)
Adult day care services		
Aging services—local agency providing senior centers, transportation assistance, meal programs, information on in-home help, etc.		
Alcoholics Anonymous		
Alert services—personal response for emergency services, usually commercial		
Assisted living facilities		
Crisis line		
Exercise/physical activity services		
Food pantries		
Health education—organizations that provide classes for those living with specific health conditions, health or computer literacy, or guidance on using social media, PHRs, etc.		
Homeless shelters		
Homemaker services		
Nutrition services--like Meals on Wheels		
Pastoral care		
Parish nursing		
Personal care services—meal preparation, housekeeping, bathing and grooming, shopping, transfer assistance, etc.		
Public health services		

Respite care		
Social services (addressing psychosocial needs, human services, welfare, protective services, etc.)		
Support groups or services—includes applicable social media sites		
Tobacco cessation services		
Transportation services—for in-home patients, transport to/from physician offices/clinics, other		
Weight management services		
Other (specify)		

## Building the Community Directory

The following tasks ensure that a community directory is up-to-date and useful:

1. **Database development.** As community resource needs are identified, determine how information about them will be compiled, retained, and updated. Paper-based systems such as a Rolodex and file folders are adequate. Contact management software or contacts in MS Outlook allow sorting, note annotation, and attachment of electronically created/scanned documents. Some states, counties, or municipalities are starting to develop or use commercial products to provide an online directory of community resources. Many of these include the ability to schedule services directly online.
2. **Finding resources.** While some of the needed community resources will be well-known, others may be more challenging to identify.
  - a. *Start with what may already be known.* Nearly every hospital or clinic knows of some resources, potentially known to different departments. For example, receptionists may have a list of transportation services. The billing staff may be familiar with certain types of financial assistance programs. An emergency department or social worker will know how to contact the local public health department and social services agencies.
  - b. *Use government agencies, charities, and other resources to enhance the list.* Many of these resources will already have started networking with other community resources.
  - c. *Refer to a telephone business directory and surf the web.* This is especially useful to target resources within a geographical area and to identify social media sites and apps for support groups.
3. **Obtaining information.**
  - a. Community resources that are already known to an organization and are being used successfully may only need a call from the community-based care coordinator for introduction purposes, to explain the new care coordination services being provided, to validate information known about the organization, and to determine if a formal agreement exists (if not already known).

If there is hesitation concerning any of the information exchanged however, it may be best to arrange either another phone call or even an in-person visit. For example, if it is detected that the volume of patients in the cohort for care

coordination may overly stretch the available resources, or if there has been any history of capacity or other types of problems, it may be best to arrange for an in-person visit – explaining in advance what the agenda will be (see next section below).

- b. Community resources unknown to the organization should be contacted to determine the nature of services provided, and if applicable to arrange for, ideally, an in-person visit or a specific time that can be set aside for a follow-up call to allow both parties to get to know one another.
4. **Types of information.** In getting to know the community resources, information will need to be exchanged by both the care coordinator and the resource. The resource needs to understand what the community-based care coordination program is about and the program's expectations for the resource. The care coordinator needs to understand what services are available, the resource's capacity, and other types of information. Both will need to have an understanding of how communications will take place and what types of information can be shared.

The following is information that the care coordinator should include in the community resource directory:

- a. **Contact information**, including name of organization, name of contact person(s), telephone and fax numbers, street addresses, mailing addresses, email addresses, website URL, etc.
- b. **Nature of services provided**, including capacity to provide services, hours of operation, and any cost to patient and method of payment required.
- c. **Process to obtain services**, lead time to arrange for services, and other requirements that either the care coordinator must have available or for which the care coordinator can obtain assistance, such as managing payment mechanisms.
- d. **Data sharing expectations** should be documented. Patients in the CCC program are those who have not declined to share health information. It is best to determine up front what information the community resource needs to provide the services and limit information sharing accordingly. For example, a diabetic patient will obviously need a diabetic diet, but the transportation service may not need to know the patient is diabetic. Professional judgment should be applied in determining what information to share.
- e. **Expectations for follow up** should be documented. The care coordinator needs to know if the patient attended a class, a caregiver got respite care, etc. Depending on the nature of the services, the follow up may only need to be about provision of the service or a report may need to be filed of what transpired during the service provision.
- f. **Transparency about issues** that arise should be an expectation of both parties, and the care coordinator should document, either in the directory or on a variance reporting tool, any issues that need resolution and/or tracking. No issue is too minor. Many minor issues can lead to bigger issues. (See *Patient CC Variance Reporting*.)

## **Agenda for Community Resource Meeting**

Whether via a telephone call or in person, it is helpful to have an agenda for an initial meeting with a community resource to ensure that all important topics are addressed. It is desirable to follow up the call or meeting with a summary of what was discussed and/or a formal agreement outlining the same.

The following are suggested topics to cover:

1. Introductions
2. Purpose of communication
3. Description of the community-based care coordination program
4. Request for information about the community resource:
  - a. Services
  - b. Capacity
  - c. Process to engage
  - d. Payment mechanisms for services, if any
  - e. Information needed about the patient and how that will be exchanged
  - f. Expectations for responding to requests for services, follow up, and issues management
  - g. Introduction to formal agreement (see below)
5. Questions and concerns
6. Follow-up steps for after meeting

## **Agreement Topics for Providing Community Resources**

Despite the best of intentions by both the care coordinator and the community resource, there is always the potential for miscommunication or lack of understanding about the expectations for both parties in arranging for and providing services to patients in need. Many CCC programs are starting to document these expectations in a formal, written agreement. Should the CCC program decide to use such an agreement, the topics covered should include:

1. Role of care coordinator in:
  - a. Arranging for services
  - b. Assuring patient understanding of the purpose of the service, if there is any payment required, and how payment will be made
  - c. Providing any information about the patient in advance of the service provision
  - d. Following up on service provision
2. Role of community resource supplier with respect to:
  - a. Availability of services
  - b. Timely provision of services
  - c. Obtaining and protecting the privacy of health information needed about the patient

- d. Outcomes of service provision
- e. Providing follow up

The above information is not provided as legal advice. Any formal, written agreement should be reviewed by legal counsel prior to use.

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**For support using the toolkit**

Stratis Health • Health Information Technology Services

952-854-3306 • [info@stratishealth.org](mailto:info@stratishealth.org)

[www.stratishealth.org](http://www.stratishealth.org)

