

## Section 4.1 Implement

# Provider Resource Directory

This tool supports care coordinators (CC) in identifying and utilizing different types of providers to help patients with their health care needs. Developing and maintaining a provider 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 key provider representatives. **Maintenance:** 1 hour per month

**Suggested other tools:** Provider Resource Directory Template; Community Resource Directory (and template); Business Associate and Other Agreements; CCC Fact Sheet for Providers

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## How to Use

1. **Review** the *Community Resource Directory* tool to distinguish between community resources and provider resources as used in this Toolkit.
2. **Review** the recommended directory content and determine how to create and manage the directory.
3. **Consider** the list of potential providers with whom care may be coordinated:
  - a. Identify and add to the list of providers 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 providers 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.
  - c. Contact, in order of priority, provider representatives to introduce CCC program and CC, learn about the provider, and compile initial information about the provider.
4. **Use** the agenda outline to introduce the CCC program to providers and obtain necessary information for the directory.

## Potential Providers for Care Coordination

The following table provides a list of the general types of providers for whom the care coordinator should have contact information.

**To use:** Begin to identify those who are most likely needed given the cohort of patients being served by the CCC program, including the primary care providers (PCPs) for these patients. Add lines if more than one provider organization provides the type of care described; split rows for specialized providers.

Type of Community Resource	Priority H-M-L	Name of Organization(s)
Primary care provider		
Hospital		
Emergency department		
Skilled nursing facility		
Home health agency		
Specialty provider—critical (e.g., cardiologist, oncologist)		
Specialty provider—non-critical (e.g., podiatrist, ophthalmologist)		
Hospice/palliative care		
Dietician		
Pharmacist		
Physical therapist		
Respiratory therapist		
Home parenteral service provider		
Durable medical equipment provider		
Rehabilitation provider		
Occupational therapist		
Music therapist		
Local public health nurse		
Social worker		
Mental Health (psychiatrist, psychologist)		
Holistic medicine provider		
Chiropractor		
Herbalist		

Acupuncturist		
Massage therapist		
Personal trainer		
Naturopath		
Other (specify)		
Other (specify)		

See *Provider Resource Directory Template* for a fillable form.

## Building the Provider Directory

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

1. **Database development.** As providers with whom care must be coordinated 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 contact lists in MS Outlook allow sorting, note annotation, and attachment of electronically created/scanned documents.
2. **Finding providers.** “Provider” is a term that is often considered narrowly in context to refer only to physicians and physician extenders (e.g., nurse practitioners, physician assistants, nurse midwives). However, in the broadest sense, “provider” is any person or entity, usually with licensing requirements, that provides and gets paid for providing care to patients, generally through an insurance mechanism. Hence providers broadly include hospitals, clinics, nursing homes, durable medical equipment providers, and many others. Each provider will be impacted directly or indirectly by the care coordination program.

While many physicians on the medical staff of the local hospital or clinic and other providers may be well-known to the nursing department of the hospital or clinic, other providers may be more challenging to identify.

- a. Start with providers already known
  - b. Ask known providers to identify other providers to whom they refer patients
  - c. Refer to a telephone directory and surf the web – this is especially useful to target provider resources within a geographical area
3. **Obtaining information.**
    - a. Providers who have been introduced to the care coordination program may include those active on the hospital or clinic medical staff who have attended a CCC program introduction or launch meeting. Providers in some settings may have become a part of an ACO structure. Keep in mind that care coordination can represent a significant culture change for providers,

especially for physicians, so it is best to plan a more formal meeting for all providers with the potential exception of those with whom the care coordinator is already working.

- b. Providers needing information about the care coordination program should be contacted to arrange for, ideally, an in-person visit. For primary care providers and specialty physicians it is very important that this meeting be held directly with them – potentially early in the morning or around the lunch hour.
4. **Types of information.** In introducing the care coordination program and obtaining provider agreement to work with the program, briefing materials should be distributed, such as provided in the *CCC Fact Sheet for Providers* included at the end of this tool and as a stand-alone document (handout) in this Toolkit. Additional reference material on the benefits of care coordination can be helpful as many physicians seek strong evidence of effectiveness before adopting new processes.

During the meeting with providers, expectations for both parties should be discussed, and information about the provider needs to be obtained for inclusion in the provider directory. The latter may be obtained through a telephone call or other separate conversation with an office manager prior to or after the in-person meeting if necessary.

The following is information that the CCC program should include in the provider resource directory:

- a. **Contact information**, including name of the organization, name of contact person(s), office telephone and fax numbers, street addresses, mailing addresses, email addresses, website URL, etc. Include dedicated telephone numbers/email addresses for specific providers as applicable.
- b. **Nature of services provided**, including capacity to provide services, hours of operation/open access, and reimbursement restrictions (e.g., do not accept certain insurers).
- c. **Data sharing expectations** should be documented. Patients in the CCC program include those who have not declined to share health information and providers should be assured that data sharing has been accepted by the patient. It may be helpful to provide information about the CCC program guidelines.
- d. **Technical requirements and ability to share data**, such as via secure email, portal to electronic health record (EHR), a health information exchange organization, or via other mechanisms.
- e. **Expectations for follow up**. Depending on the nature of the services, the follow up may only be about the provision of services or a report on what transpired during the service provision.

## **Agenda for Provider Meeting**

An agenda helps ensure all important topics are addressed during the meeting with a provider. It is desirable to follow up with a summary of what was discussed and/or with a formal agreement outlining the same.

The following are suggested topics to cover:

1. Introductions
2. Purpose of meeting
3. Description of the CCC program and the role of the care coordinator
4. Request for information about the provider
  - a. Services
  - b. Capacity
  - c. Process to engage care coordination services for a patient
  - d. Information the provider needs about the patient and how that will be exchanged
  - e. Expectations for responding to requests for services, technical requirements, documentation, follow up with notices and reports, transparency and issues management
5. Transparency about patient issues that may arise that require resolution and/or tracking
6. Questions and concerns
7. Follow-up steps for after meeting

See *CCC Fact Sheet for Providers* in this Toolkit for a stand-alone document that can be reproduced and provided as a meeting handout or leave-behind.

## **Community-Based Care Coordination (CCC) Fact Sheet**

### **Ten Facts Providers Need to Know about Community-based Care Coordination:**

1. There is no cost to you or your patients for care coordination.
2. Care coordinators do not interfere with your patient care and are not a replacement for their own provider.
3. Care coordinators are nurse practitioners, physician assistants, or other qualified individuals who will follow the care plans established by the patient's provider.
4. Care coordinators identify and work with patients with multiple chronic conditions and who are at high risk for readmission and/or frequent use of the emergency department.
5. Community-based care coordination is provided to all providers and social service resources for patients identified.
6. Care coordinators have frequent contact with patients to check on diverse needs relating to the quality of their health, care needs, and lifestyle issues.
7. Care coordinators find ways to “connect the dots” for patients with multiple providers and community resource needs.

#### Care coordinators:

- a. Help patients prepare for visits with providers
  - b. Ensure providers share information about patients in transitions of care
  - c. Proactively manage patient care needs, such as obtaining transportation and nutrition support
  - d. Monitor reminder systems for patients, such as taking medications, keeping scheduled appointments, obtaining applicable preventive care services, etc.
  - e. Provide patients and their family/caregivers health education and supplemental discharge instructions
  - f. Aid in medication reconciliation in transitions of care
  - g. Monitor physiological and psychological signs for needed interventions
  - h. Help patients or their family members/caregivers maintain a personal health record
8. Care coordination empowers patients and their family/caregivers to be engaged as part of the Patient Care Team and to participate in shared decision making.
  9. The goal of community-based care coordination is to improve the quality, cost, and experience of care for patients, and to develop lasting self-management skills.
  10. Community-based care coordination is an important way to help providers succeed under advanced payment models, such as shared savings arrangements with an insurer.

## Additional Resources

The following is a list of additional information about care coordination and its impact on value-based purchasing that may be useful to reference when engaging providers.

- House Committees on Energy & Commerce and Ways & Means and the Senate Committee on Finance Staff (Feb. 6, 2014) Repealing and Replacing the SGR. Available at: <https://energycommerce.house.gov/press-release/committee-leaders-applaud-bipartisan-bicameral-agreement-repeal-and-replace-sgr>
- Goedert, J. (Jan. 31, 2014) CMS: Medicare & Medicaid ACOs are Saving Money, Health Data Management. Available at: [http://www.healthdatamanagement.com/news/cms-medicare-medicaid-acos-are-saving-money-47194-1.html?utm\\_campaign=daily-feb%203%202014&utm\\_medium=email&utm\\_source=newsletter](http://www.healthdatamanagement.com/news/cms-medicare-medicaid-acos-are-saving-money-47194-1.html?utm_campaign=daily-feb%203%202014&utm_medium=email&utm_source=newsletter)
- Burton, Rachel. (Sep. 13, 2012) Improving Care Transitions, Health Affairs, Vol. 33, No. 2. Available at: [http://www.healthaffairs.org/healthpolicybriefs/brief.php?brief\\_id=76](http://www.healthaffairs.org/healthpolicybriefs/brief.php?brief_id=76)
- Peikes, D. et al. (Feb. 11, 2009) Effects of Care Coordination on Hospitalization, Quality of Care, and Health Care Expenditures Among Medicare Beneficiaries: 15 Randomized Trials. JAMA, Vol. 301, No. 6, 603-618. Available at: <http://jama.jamanetwork.com/article.aspx?articleid=183370>
- Slide presentation on the above research. Available at: [http://www.mathematica-mpr.com/publications/pdfs/health/award\\_peikes\\_brown\\_chen\\_AH\\_2010.pdf](http://www.mathematica-mpr.com/publications/pdfs/health/award_peikes_brown_chen_AH_2010.pdf)
- Coleman, E.A. and M. V. Williams. (Sep/Oct 2007) Executing High-Quality Care Transitions: A Call to Do It Right. Journal of Hospital Medicine, Vol. 2, No. 5, 287-290. Available at: <http://www.caretransitions.org/documents/Executing%20high%20quality%20-%20JHM.pdf>
- Coleman, E.A. et. al. (Nov. 2004) Preparing Patients and Caregivers to Participate in Care Delivered Across Settings: The Care Transitions Intervention. JAGS, Vol. 52, No. 11. Available at: <http://www.caretransitions.org/documents/preparing%20patients%20-%20jags.pdf>

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