

## CARE RESOURCE COORDINATION:

### An Essential Pillar of an Effective and Equitable Pandemic Response

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## INTRODUCTION: CARE RESOURCE COORDINATION IS ESSENTIAL TO ACHIEVE EPIDEMIC CONTROL

Contact tracing is recognized as an essential pillar of infectious disease control, including for COVID-19. In contact tracing, case investigators (CIs) work with people newly diagnosed with COVID-19 to identify their recent contacts, as well as to advise on isolation procedures and duration.<sup>1</sup> Contact tracers (CTs) then notify these contacts and advise on seeking testing and on quarantine to avoid disease spread. Among other things, **contact tracing's efficacy in decreasing disease spread relies on the ability of diagnosed individuals ("cases") and their contacts to safely isolate and quarantine to avoid infecting others.** Unfortunately, not everyone can quarantine and isolate equally.

**Isolation and quarantine are burdensome to individuals and families, particularly those with limited resources.** Many individuals must take unpaid time off from their jobs—sometimes risking job loss and financial hardship—to isolate and quarantine. Further, contacts and cases may live in situations where safe isolation or quarantine is physically difficult or even impossible without assistance. For example, individuals may have limited food or cleaning supplies on hand, requiring them to leave their homes to go to food banks or stores. People may need medication refills, plans for child care or elder care, or support with communicating with their employers so they do not lose their jobs. Individuals in crowded homes may even require an alternate safe place to isolate to avoid infecting others, as may individuals with high-risk household members. Existing limitations in access to health services, such as lack of a primary care provider or support for mental illness, may also exacerbate these barriers to safe isolation and quarantine.

In part for these reasons, supports for safe isolation and quarantine have been recognized as an essential component of contact tracing by many leading public health groups (CDC,<sup>2</sup> ASTHO,<sup>3</sup> Resolve to Save Lives<sup>4</sup>), and modeling shows that adherence to public health measures such as isolation are critical to reducing the pandemic's impact.<sup>5</sup>

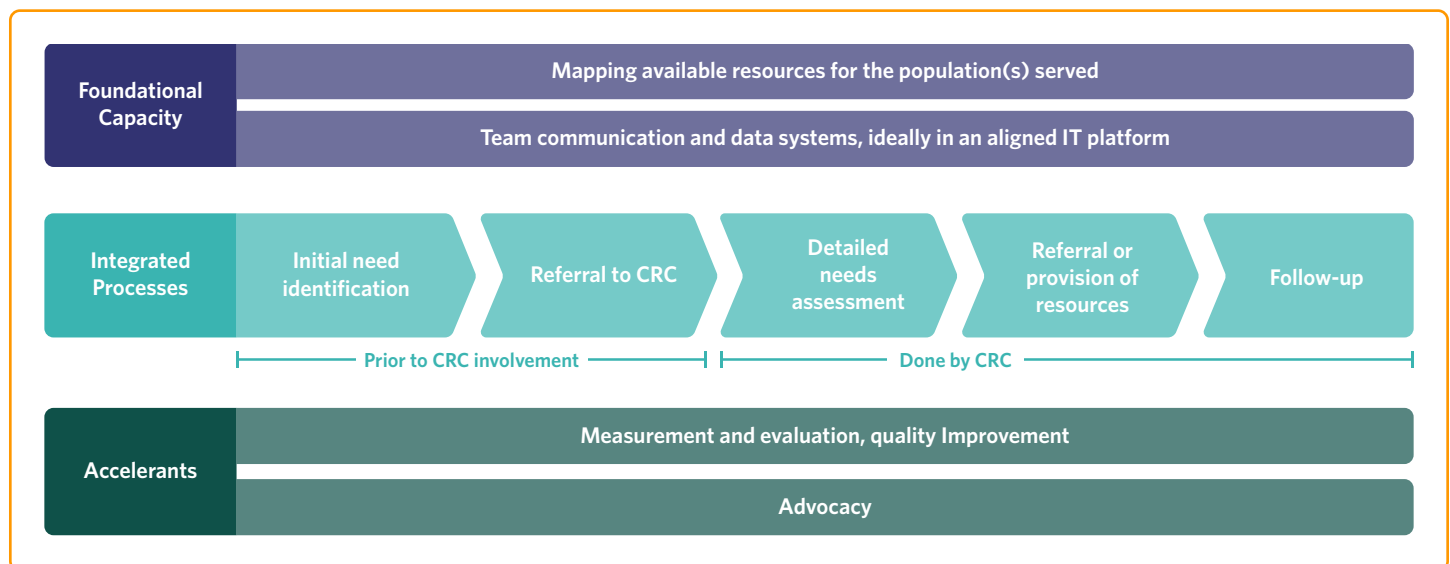
**In Massachusetts, data from the statewide contact tracing program shows that 15-20% of cases were referred for social need assistance.**<sup>6</sup> The most common need was food, with a wide range of other needs identified including assistance with housing, personal protective equipment (PPE), cleaning and other supplies, access to medical care, as well as concerns related to domestic violence, immigration status and employment.

**Care Resource Coordinators (CRCs) are individuals who facilitate identification of needs and the provision of social, material, and other supports that allow a COVID-19 case or contact to safely isolate or quarantine.** CRCs function as a bridge, connecting clients to service providers and community and government resources to ensure needs are met. The CRC role can have a variety of names in different contact tracing programs. It can be fulfilled by multiple cadres of workers: social workers, case managers, community health workers, community nurses, and others specifically trained in needs assessments and resource provision. Though there is variability in the exact structure, effective CRC programs share key commonalities.

## NINE COMPONENTS OF AN EFFECTIVE CARE RESOURCE COORDINATION PROGRAM

*An effective CRC program will include:*

1. Resources, either directly from the CRC program or available through connections to community-based organizations (CBOs), that are pre-identified and available to address the needs of cases or contacts
2. Team communication and data tracking systems, ideally integrated with the contact tracing program, preferably through an aligned information technology (IT) platform
3. A way for needs to be initially identified, either by the CT, CI, case or contact, or by a health service provider or community health worker
4. Mechanisms and protocols to refer cases or contacts in need of assistance to the CRC, including for the prioritization of the most urgent needs
5. Trained CRC staff who can build trust, perform detailed needs assessments, and evaluate available solutions for addressing needs
6. Adaptive systems to facilitate referrals between CRCs and CBOs or other resources in a culturally and geographically appropriate manner
7. Follow-up with cases and contacts to ensure needs are effectively met and that new needs do not arise
8. Defined systems to track outcomes and to monitor for unmet needs including a mechanism for identifying and responding to areas for improvement
9. Advocacy and policy efforts to improve the availability of social services and address common needs



**FIGURE 1: Components of an Effective Care Resource Coordination (CRC) Program**

CRC programs are built on foundations of existing or newly created community resources and facilitated by effective communication systems. Effective CRC programs systematically identify and refer cases to CRCs, who then connect individuals to resources and ensure needs are met. Monitoring, evaluation, and advocacy systems further strengthen CRC programs.

## ELEVEN KEY DESIGN QUESTIONS FOR A CRC PROGRAM

As policy-makers and program leaders consider how to integrate care resource coordination into their contact tracing programs and COVID-19 response, we have identified 11 critical questions that should be considered in the initial program design. These questions, and a range of possible answers, are discussed below. Final design choices will depend on the local context, contact tracing program structure, baseline social support infrastructure, and available human and budgetary resources.

### 1 Will existing staff be used or supplemented for a CRC function, or will new roles be created?

Many state and local public health departments have rapidly expanded their contact tracing programs during the COVID-19 pandemic, maintaining the capacity entirely within existing structures. Other jurisdictions have collaborated with or contracted with other groups to implement contact tracing, including non-governmental organizations, CBOs, and academic institutions. In both governmental and non-governmental structures, **existing staff** may have fulfilled a similar resource coordination function for clients prior to COVID-19. These can include community health workers, social workers, case managers, and resource managers. When this capacity already exists, organizations may choose to leverage existing staff to fulfill CRC program roles. Staff with some prior experience may be already familiar with existing community resources and approaches to resource coordination and thus require less training than creating a new workforce and may also be more rapidly deployable.

However, frequently there will be insufficient or no pre-existing staff. In these cases, CRC roles will need to be created and **new staff** hired, with appropriate resources devoted to their recruitment, training, and ongoing supervision. While this may seem like a significant effort, there are a variety of existing resources to help build these programs, including existing job descriptions and trainings that

can be easily modified. Furthermore, this crucial investment to create **a dedicated workforce allows targeted evaluation of the needs of COVID-19 positive individuals and their contacts.** It facilitates identification of emerging cross-cutting social support issues and promotes ongoing monitoring of an individual's support needs during the quarantine or isolation period. All of this facilitates adherence to public health recommendations and reduces the spread of COVID-19. These benefits are difficult to achieve without a dedicated CRC role. Indeed, if COVID-19 affected individuals are simply instructed to call a general external resource connector line (such as 211) without personal assistance, there can be significant barriers to accessing supports in a timely fashion.

**Regardless of the staffing model, it is essential that CRC staff be culturally and linguistically diverse and familiar with (and ideally drawn from) the communities they will serve.** This diversity is essential for CRCs to form trusting connections with the cases and contacts, to develop longitudinal relationships with community structures and resources, and to ensure needs are reported and addressed.

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*Every COVID response should deploy dedicated culturally and linguistically diverse CRC staff to support safe isolation and quarantine.*

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## 2 Where should CRC staff be hired and report?

Staff filling a CRC role can be seated within a number of different organizations and/or report to different branches of a government or organization. The decisions on where CRC staff should fit within a COVID-19 response will influence the referral pathways between CTs/CIs and CRCs, which are essential to the success of any program. Each option has potential advantages and disadvantages (outlined in Table 1).

In general, having staff dedicated to the CRC work and closely linked to contact tracing systems is recommended, regardless of where those staff sit in the organizational structure of the response.

*Best practice involves hiring dedicated CRC staff who are integrated with or closely linked to contact tracing.*

**TABLE 1**

CRC Staff Placement	Advantages	Disadvantages
<b>Within the contact tracing system:</b> CRCs are hired under the same umbrella as CTs and CIs	<ul style="list-style-type: none"> <li>Facilitates coordination and referral between CTs and CRCs</li> <li>Enables easier navigation of confidentiality and privacy, as all individuals are within one organization</li> <li>Improves communication between CTs and CRCs because a single information technology system can facilitate monitoring and evaluation; allowing real time communication and analysis of referral timing, patterns, and outcomes relative to contact tracing activities</li> <li>Ensures CRCs are specifically trained on needs for COVID-19 isolation and quarantine</li> <li>Allows CRCs to perform some contact tracing functions during isolation/quarantine (e.g. symptom checks)</li> </ul>	<ul style="list-style-type: none"> <li>Involves <i>de novo</i> workforce and/or resource list creation</li> <li>Requires close coordination with external partners to avoid duplicating efforts</li> </ul>
<b>Within a local CBO:</b> CTs/CIs refer outside of the contact tracing structure to a CRC at a contracted local CBO	<ul style="list-style-type: none"> <li>Capitalizes on existing trust between CBOs and the community</li> <li>Uses existing CBO service delivery networks and existing relationships with other organizations to facilitate referrals</li> <li>Capitalizes on existing CRC-like roles in CBOs</li> <li>Strengthens CBOs and promotes long-term integration of social support needs into future programming</li> <li>Increases operating budgets of some CBOs as a result of COVID-19 related funds and may therefore expand services, while others may need to adapt their workforces to changed regulations and activities due to COVID-19</li> <li>Facilitates connections to health care systems</li> </ul>	<ul style="list-style-type: none"> <li>Complicates coordination and CT efforts, as CRCs and CTs/CIs function in different systems</li> <li>Increases complexity and expense because of multiple data systems</li> <li>Increases difficulty in adjusting the CRC implementation approach as contact tracing volumes/needs change</li> <li>Expands CRC scope of activities outside of responding to contact tracing referrals, which could decrease CRC availability</li> <li>Affects information flow due to differing confidentiality and privacy laws by state</li> <li>Requires a shared understanding of goals and objectives between Departments of Public Health (DPH) and CBOs</li> </ul>

<p><b>Within another government organization:</b> For example, hiring community health workers within an office of rural health or hiring CRCs within another branch of a DPH</p>	<ul style="list-style-type: none"> <li>Facilitates sustainability if CRC functions overlap with other existing programs</li> <li>Capitalizes on existing networks/roles</li> </ul>	<ul style="list-style-type: none"> <li>Complicates coordination, as CRCs, CTs, and CIs function in different systems</li> <li>Reduces interoperability and real-time communications because of different data systems across multiple stakeholders</li> <li>Increases difficulty of adjusting the CRC implementation approach as contact tracing volumes/needs change</li> <li>Expands CRC activity scope outside of responding to contact tracing referrals, which could decrease CRC availability</li> <li>Affects information flow due to differing confidentiality and privacy laws by state</li> </ul>
<p><b>No dedicated staff:</b> Patients are connected to resources on an ad hoc basis or through existing external resource connectors such as dialing 211, a nationwide service that connects callers to health and human service organizations</p>	<ul style="list-style-type: none"> <li>Lessens upfront investment</li> </ul>	<ul style="list-style-type: none"> <li>Complicates referral pathways, forcing patients to call on their own, which can be difficult for those with low health literacy or agency, yet these individuals are often the most in need of services</li> <li>Makes it harder to specifically screen for and ensure that COVID-19 related isolation and quarantine needs are met</li> <li>Increases challenges for closed loop communication and follow-up, limiting ongoing M&amp;E and tracking of resource needs</li> <li>Lowers efficacy given above barriers</li> </ul>



In Immokalee, Florida, Health Promoters from a local health center provide care resource coordination in addition to patient education and advocacy for COVID-19 cases, contacts, and the community. Lissa Rinvil, Healthcare Network COVID-19 community health worker, from left, Zoe Bois, Healthcare Network COVID-19 medical assistant, Maria Plata, Lead Health Promoter for Southwest Florida with Healthcare Network, and Caroline Murtagh, Project Manager, Partners In Health, U.S. Public Health Accompaniment Unit, prepare COVID-19 education materials at the Marion E. Ferther Clinic that will be distributed at a family health fair in Immokalee, FL on Friday, Dec. 4, 2020. *Photo by Scott McIntyre for Partners In Health*



### 3 When will COVID-19 cases and contacts be screened for social needs?

**Screening for social needs should be done early and often.** Ideally, COVID-19 cases would isolate as soon as they develop symptoms or, if asymptomatic, as soon as they receive a positive test result, and contacts would quarantine as soon as they are notified of their exposure.

Screening for social support needs **at the time of testing** may facilitate isolation of symptomatic patients pending test results. This may be particularly useful in high-risk, socioeconomically, and racially- or ethnically-disenfranchised communities, or in settings where test results are very delayed. Screenings at the time of testing may also offer an opportunity to connect more individuals with both short- and long-term services, regardless of whether their tests return as positive or negative. Furthermore, early screening may facilitate rapid enrollment with state benefits programs, allowing some of these to be in place within the isolation and quarantine period.

Screening for social support needs **by CIs and CTs** during initial conversations with COVID-19 positive individuals and their contacts allows early identification of needs and links their identification to counseling about isolation or quarantine. Further, offering social supports during the contact tracing conversation may facilitate trust and make individuals more

receptive to CT efforts. In addition to screening at the time of the initial interaction, repeat screening during follow-up, even if brief, allows new needs to be addressed. In fact, experience suggests this may be a common occurrence, likely for three reasons: 1) new needs that arise, 2) trust develops with the contact tracing program, allowing individuals to ask for more support, or 3) individuals realize that needs exist after reflecting on the initial phone call, which is also often lengthy for epidemiological purposes. Finally, contact tracing awareness education (e.g., “Answer the Call” campaigns) can highlight the ways CTs can connect individuals to resources and may help improve pick up rates.

When possible, programs may choose a hybrid approach by screening for social determinants of health both at the time of testing and as part of contact tracing interactions. If the CRC program itself is unable to fulfill these dual functions, the program can work with local medical providers and testing organizations to explore other ways in which social supports can be offered at the time of testing.

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*Screening for social support should be done early and often. We recommend screening should start at testing sites and support should be offered throughout quarantine and isolation at regular intervals.*

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### 4 How will cases or contacts who need support be identified?

**It is important to use a standardized approach to assessing support needs.** If screening is part of a contact tracing program, needs assessments should be incorporated into any scripts. Screening can be done using a broad question (“Do you need help to isolate?”) or through specific needs assessment scripts that ask a series of questions about the patient’s living situation, available food, medication and supplies in the home, and questions to ensure caregiver roles are covered and high-risk scenarios identified. The CDC has a checklist of questions that can be adapted for a CT/CI needs assessment.<sup>7</sup> Broad screens are more open-ended and conversational but require the case or contact to extrapolate what they need for isolation. As a result, they may miss specific needs that are not immediately apparent. This could be exacerbated by the volume of questions and information in the initial phone calls that are also required for epidemiological information, collection of contacts, etc. To avoid this pitfall, combination approaches can be used.

Regardless of the approach, **CTs/CIs must be trained on the requirements for isolation, common social needs, and any specific needs assessment scripts. CTs/CIs must know how to refer patients to a CRC or equivalent for social support, must understand the range of supports that can be provided, and must be able to prioritize urgent referrals.** CTs/CIs should communicate to clients what to expect for CRC follow up and, if applicable, seek any needed consents for information sharing.

In addition to referrals from CTs/CIs to CRCs, programs should consider how they will receive external referrals for support needs. Cases, contacts, or communities in need of support can be identified through health care providers, community leaders, or others, in addition to through contact tracing programs.

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*Use scripted needs assessments to ensure all needs are identified; Train CIs/CTs in detail on needs assessments, prioritization and referrals to CRCs.*

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## 5 What needs will a CRC program address?

**CRC programs will need to address immediate material needs for cases and contacts to stay safely isolated at home for up to two weeks.** Experience to date suggests that these needs commonly include food; cleaning supplies; PPE; access to medications; rent and utility assistance; and assistance with obtaining COVID-19 testing, medical care or mental health care. In addition, cases and contacts may face intimate partner violence or have concerns relating to child or elder care, loss of employment, immigration status, or ongoing legal situations for which they may need assistance.

**As CRC programs develop and strengthen over time, they offer an opportunity to not only address immediate needs but also to help individuals connect to and access longer term support programs**

including ongoing food benefits, health insurance, and/or ongoing housing support.

Importantly, in addition to addressing a broad scope of needs, programs must ensure that short-term services are provided in a timely manner to meet immediate needs and prevent breaks in isolation or quarantine. For example, if a person in isolation requires food within two days, the delivery must occur by this time to avoid a break in isolation to go shopping. This dimension of timeliness should be considered when designing the components below.

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*Strong CRC programs rapidly address both immediate material and safety needs while connecting individuals to long-term social supports.*

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## 6 After a need is identified, how is the person referred to a CRC?

Once a CI or CT identifies a need and an individual agrees to a CRC referral, information about those needs must be passed to the CRC to facilitate service referrals. This process is easiest when the CRC, CT, and CI operate within one workforce, and ideally, one information system (see Table 1 above). **The referral between the CT/CI and the CRC should include contact information, a description of the need, and the urgency of the need.** Communication must be secure and comply with all local and national privacy regulations and must be timely to allow rapid follow-up. Standard operating procedures for CTs, CIs and CRCs reduce the risk of lost referrals or delayed follow-up. Ideally, the referral system between CT/CIs and CRCs

will include closed loop communication so that the CRC notifies the CT/CI when the appropriate service organization receives the referral and again when the need has been met, in addition to key progress along the way. With this closed-loop communication, CT/CI teams feel more invested in safe isolation supports and are likely to refer more often and with higher quality. In addition, when CT/CI teams check in with people during isolation and quarantine, they will be able to answer questions about the status of prior referrals.

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*Referrals should be detailed, secure, and timely to facilitate CRC follow up.*

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## 7 What trainings and protocols will a CRC require?

Since CRCs can come from a variety of backgrounds, baseline assessments of CRC skills can help focus training programs. In general, CRCs should be trained in the overall contact tracing process and on the characteristics of COVID-19, including isolation and quarantine needs, so that they understand the context in which they are operating. **CRCs must be able to make detailed evaluations on any area of need the program addresses**, typically including food; housing; intimate partner violence; access to supplies, testing, medical care, mental health care, and substance use treatment programs.

CRCs must be able to **determine both the scope and urgency of the need**. For example, household size is an important consideration when determining how long food will last. Trainings should cover how to make an assessment in these areas, and the available scope of long- and short-term resources. We recommend that programs develop a list of “core competencies” for their CRCs and use this to prioritize individual trainings. In addition to topic-specific trainings, this list should

include the skills required to form a trusting bond with a client, such as active listening, cultural competency, and psychological first aid.

In addition to training CRCs, programs should ensure that CIs, CTs, and other contact tracing stakeholders are trained on the CRC role and the scope of resources a CRC can provide. Trainings should include the mechanics of how to refer cases to a CRC, as well as guidance on how to discuss a pending referral and subsequent planned outreach with a case or contact. This helps them to best represent the program to cases and contacts, identify needs that may not be immediately apparent, accurately set expectations, and communicate critical contextual information with the referral to the CRC.

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*CRCs should be trained on a program's contact tracing systems, needs assessments and referral pathways, and on the soft skills required to form a trusting bond with COVID-19 cases and contacts.*

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## 8 How will the resource lists be generated, maintained and updated?

CRCs must connect individuals to programs and organizations capable of meeting their needs. To do this, they must understand and navigate the breadth of resources available and the requirements of different programs and organizations, across different contexts and geography. Depending on the structure of the CRC program and the background of each individual CRC, familiarity with the range of resources available in each jurisdiction at the start of any program may vary among CRCs. Further, available resources, and the ability of a given resource to meet COVID-19 isolation needs (for example, a food pantry that can deliver food), may change with time. For these reasons, **it is important to have an accurate, updated, and specific resource list available to CRCs that is dynamically adjusted over time**.

Options for generating resource databases include:

- A. Utilize and/or modify **pre-existing platforms** that collate resource lists: programs such as NowPow, Aunt Bertha, or 211 offer ways to collate existing resource lists. Customizability varies between platforms, as does cost. An overview of these

platforms is available from the Social Interventions Research and Evaluation Network.<sup>8</sup>

- B. Build off **existing organizational resource lists**: organizations, including local boards of health, may have existing resource lists that can be expanded and modified. This is particularly true for organizations that are already skilled at helping community members navigate resources. Examples may include local CBOs, local social work organizations, and/or case managers at federally qualified health centers.
- C. **Home grown databases**: at the start of a program, databases of resources can be crowdsourced by the resource coordination staff. This will be most successful when CRCs already have deep local knowledge of their target area.

To facilitate usability and optimize the success of referrals, any **resource lists should be organized geographically and thematically and include information about eligibility criteria for each resource**. Indexing taxonomies<sup>9</sup> can facilitate this organization.



Resources should be vetted for their ability to work with patients or contacts on isolation. For example, can a food bank deliver goods? Can they deliver on weekends? Do they have a variety of culturally appropriate foods? Finally, resource lists should be evaluated for the range of needs they meet, the ability to meet short- and long-term needs, and their geographic coverage. When gaps are identified, they should be communicated to departments of health and other state or local leadership to find solutions, including implementing public programs or tendering requests for proposals to fill service delivery shortcomings.

Regardless of how they are generated, resource lists require continuous maintenance. Follow up with clients after each referral will help identify whether individual organizations successfully meet constituent needs. In addition, CRC programs should pursue open lines of communication, if not formal relationships, with larger CBOs to ensure that the program's referrals are appropriate and remain welcome.

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*Programs should have geographically and thematically organized resource lists that are vetted and continuously updated.*

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## 9 What are best practices for referrals from a CRC for services?

To increase the likelihood of a successful referral, CRCs and clients must have a shared understanding of the need and potential solutions. With the individual's agreement, **CRCs should ideally make a warm handoff to the service organization**, meaning to directly contact the organization on the individual's behalf to facilitate connection to services. Warm handoffs can be done via three-way calls, electronic systems, or phone, email, or fax. **Direct communication** between the CRC and the organization **is more likely to be successful than providing a phone number and asking clients to call on their own**, which may be difficult for those with insufficient phone balance, low health literacy, language barriers, or limited agency. Finally, **CRCs should follow up with the client after the referral to**

**ensure the need was successfully met.** Progress and outcomes should be routinely documented and shared with the contact tracing teams. If a CRC has difficulty addressing a need, there should be clear escalation pathways which can range from involving a supervisor or local board of health to seeking peer mentorship for troubleshooting.

All communications with any service agency should comply with all relevant privacy laws and regulations.

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*Direct contact (warm referrals) between a CRC and a service organization increases the likelihood of successfully meeting case or contact needs.*

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Care Resource Coordinator Michelle Baum speaks every day with people in Massachusetts who have tested positive for COVID-19 or are at high risk for infection. A key part of her job is connecting people with social resources in their community, so they can safely isolate and reduce spread of the disease. *Photo courtesy of Michelle Baum*

## 10 What metrics can track the success of a CRC program?

The ultimate goal of a CRC program is to provide individuals the resources and supports needed to safely isolate and quarantine. However, successful isolation and quarantine is a metric that most programs will find elusive to measure, and which is also influenced by multiple other factors. Therefore, programs will likely track intermediate measures to follow their success over time to inform program improvement, ensure populations in need are reached, and to share experience with key partners at the community and state levels. In general, **metrics document the volume and types of need, the success in meeting that need, and the timeliness with which it was addressed. To ensure equity, metrics should be disaggregated by race, income level, age, gender, and geography.** Metrics on timeliness and successful completion of

needs should also be disaggregated by type of need to help identify resource gaps. Metrics should be considered in light of individuals served as well as households, as some referrals may apply to household needs. Example metrics are shown in Table 2.

Finally, programs can consider mixed evaluation methods that combine quantitative and qualitative data, including patient stories and/or interviews, to measure success.

*Metrics document the volume and types of need, the success in meeting that need, and the timeliness with which it was addressed. To ensure equity, metrics should be disaggregated by race, income level, age, gender, and geography.*

**TABLE 2**

Evaluation Goal	Example metrics	Comments
<b>Measure the scope of need</b>	# or % of cases/contacts needing resource support # or % needing support by support type # or % reporting inability to self-isolate/quarantine	These should be tracked cumulatively as well as longitudinally to assess changes over time (e.g., daily, weekly, monthly)
<b>Successful completion of needs</b>	% of individuals* successfully referred to a resource % of individuals* where need was ultimately met # of agencies tried to meet need	This could be analyzed on an individual basis (e.g., % of people where all needs were met) or on a need basis (% of identified needs where solution was found) Can also divide into short- and long-term needs.
<b>Timeliness</b>	Time between referral to CRC and reaching individual Time between CRC referral and successful referral to resource Time between CRC referral and completion of need	Ideally, programs would also consider timeliness of referral to CRC
<b>Program Operations</b>	Active cases being followed per CRC Patient outreach calls per CRC Average length of call per CRC	Calls between CRCs and patients may take significant time to fully assess and meet a need Different needs take different amounts of time to address. It is not recommended to analyze these metrics on an individual level, but to consider them on a group level to track overall workforce

\*of individuals referred to the CRC

## 11 How can CRC programs link to advocacy efforts?

**CRC programs can play important roles in local, state, and national advocacy.** CRC programs can identify community needs and gaps in resources, then can use this information to advocate for additional funding to reduce inequities. Further, CRC experience, resource lists, and needs analyses can be used by statewide programs, local advocacy efforts, and other stakeholders working to support vulnerable communities. CRCs can collaborate with local taskforces, boards of health, state agencies, and lawmakers to advocate for addressing social conditions that influence disease hot spots and transmission. CRC programs can clearly identify situations (such as evictions) that need to be addressed by external parties, which can both help individuals and raise awareness of systemic problems. **Such advocacy will reduce inequity, improve the health of the population, and help stop the spread of COVID-19.**

Within an individual contact tracing program, CRCs can be important advocates for approaches that best serve all populations, including racial and ethnic minorities, immigrant communities, non-English speakers, deaf and hard of hearing people, people with disabilities, and people of different sexual orientation and gender identity and expression. CRCs can guide programs to be more equitable and effective by offering training for CI/CTs and developing protocols and guides for best practice.

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*CRC programs can play important roles in local, state, and national advocacy. Such advocacy will reduce inequity, improve the health of the population, and help stop the spread of COVID-19.*

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## CONCLUSION

Using these 11 questions as a framework, **organizations can design effective CRC programs** that meet patient needs and ensure safe isolation and quarantine of COVID-19 cases and contacts, **which are essential to containing the spread of COVID-19.** Programs can and will evolve with time to add additional assessments, services, and monitoring frameworks. CRCs may take on additional roles in the response including advocacy; response planning within hotspots and/or within communities that are disproportionately affected by COVID-19; and coordination or liaison functions between CBOs, government agencies, and communities. Future work will need to examine best practices and considerations in these areas as well, but these analyses should not delay the implementation of high-quality CRC programming to address immediate needs.

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