December 2020

# Care Resource Coordination:
# An essential part of an effective and equitable pandemic response

Partners In Health

# Context for these materials

The ideas presented in this deck reflect the latest public health thinking and scientific evidence as of December 2020. However, the COVID-19 landscape is changing dramatically daily, and so must our recommendations over time.

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# Overview

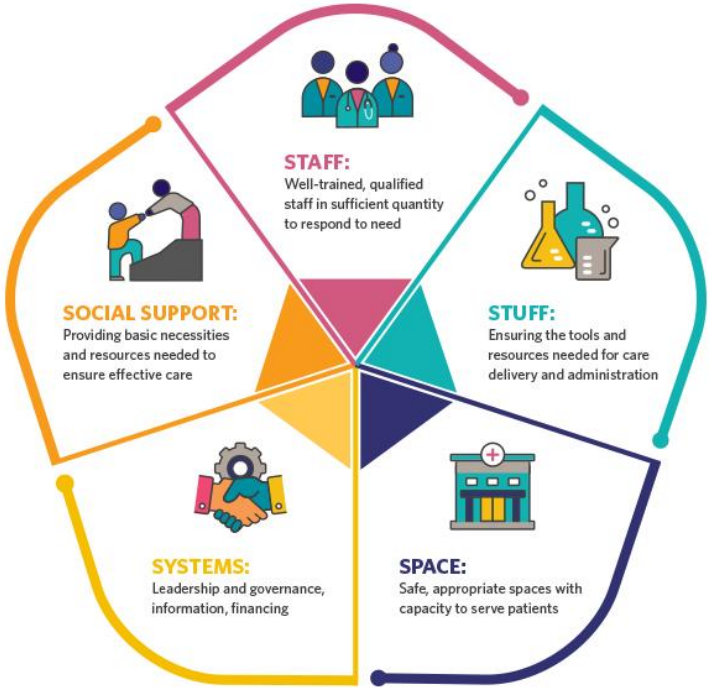
1. **Defining care resource coordination and why it matters**
2. **Components of care resource coordination**
3. **How to design an effective and equitable CRC program: eleven key design questions**

# Defining care resource coordination and why it matters

# Care resource coordination is the process of identifying the social supports needed to allow cases and contacts to safely isolate or quarantine

**Care resource coordination (CRC)** is the process of identifying the needs and providing the social, material, and other supports that allow a COVID-19 case or contact to safely isolate or quarantine. CRC can be fulfilled by social workers, case managers, community health workers, community nurses, and others specifically trained in needs assessments and resource provision.

- CRC is an **essential part of an integrated health system response to the pandemic** and **can be applied to a range of diseases** beyond COVID-19.
- **Social determinants of health and disparities** in health outcomes are exacerbated by the fragmented social support landscape in the United States. Public health measures and **CRC are a must have to address this problem.**
- For over three decades in our global work, PIH has championed integrated social support mechanisms as part of effective health system strengthening. PIH views health system strengthening as a mix of **5 fundamental ingredients: staff, stuff, space, systems, and social support.** Removing any one item would result in a weaker health system overall. Providing basic necessities and resources is essential to ensure effective care.




**PIH's "Five S's"**

# Care resource coordination is an essential part of any public health response to COVID-19

- Safe isolation and quarantine require resources. At a minimum, people **need enough food, medication, safe home environment with a separate bedroom (and ideally bathroom), cleaning supplies and personal protective equipment.** Without these, people are at risk of inadequately isolating**.**

- **Financial concerns due to risk of unemployment or lost income** mean they may not be able to purchase the resources required to isolate or quarantine safely.

- **Due to COVID-19, US households currently have higher rates of food insecurity and housing instability:**
  - In October 2020, a study estimated that **42% of children live in a household struggling to afford basics**
  - In September 2020, a study estimated **17% of adult renters lived in a household where they were not caught up on rent**

- **Modeling supports that adherence to public health measures, such as isolation, are critical to reducing the pandemic's impact.**

# **Case Study:** Massachusetts Community Tracing Collaborative

**Community Tracing Collaborative**

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According to the **Massachusetts statewide contact tracing program, 15-20% of cases were referred for social assistance**. Individuals and families, particularly those with limited resources, find it difficult to isolate and quarantine for the following reasons:

- Risk of job loss and financial hardship
- Crowded living arrangements
- Limited food or cleaning supplies
- Lack of child care or elder care
- Lack of a primary care provider or support for mental illness



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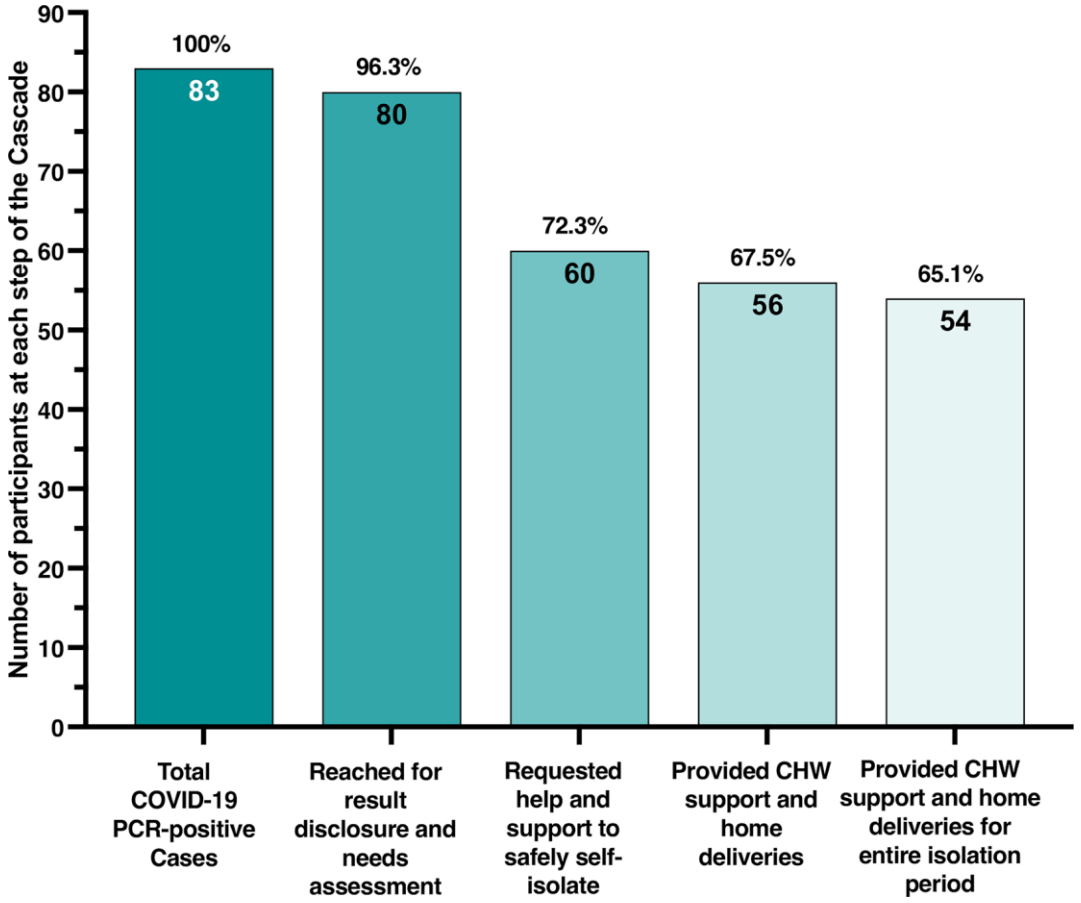
# **Case Study:** San Francisco "Test-to-Care" Model




The Test-to-Care model is a community-based approach designed to address barriers to isolation and quarantine for socioeconomically vulnerable Latinx individuals newly diagnosed with COVID-19. The model was part of a 3-week epidemiologic surveillance study in a primarily Latinx neighborhood in the Mission district of San Francisco, California.

Key components of the model include:

1. Provision of COVID-19-related education and information about available community resources
2. Home deliveries of groceries, personal protective equipment and cleaning supplies to facilitate safe isolation and quarantine
3. Clinical and social support and follow-up

According to the study, **more than 70% of COVID-19 patients needed support to safely self-isolate.**

Sources: https://journals.plos.org/plosone/article?id=10.1371/journal.pone.0239400

# **Case Study:** NYC Isolation Support

The NYC Health + Hospitals Community Care division set up the isolation hotel program in response to how much the pandemic was overwhelming inpatient units and emergency departments in the system's 11 hospitals.

"The hotel program operates on the premise that all suspected or confirmed COVID-19-positive individuals, individuals experiencing symptoms of COVID-19-like illness, or individuals vulnerable to COVID-19 **require physical, emotional, social, and family support to aid their recovery**.

**The aim of the isolation hotel program was to provide a safe and supportive environment for individuals…"**



Sources: https://www.liebertpub.com/doi/10.1089/HS.2020.0123

# Components of Care Resource Coordination

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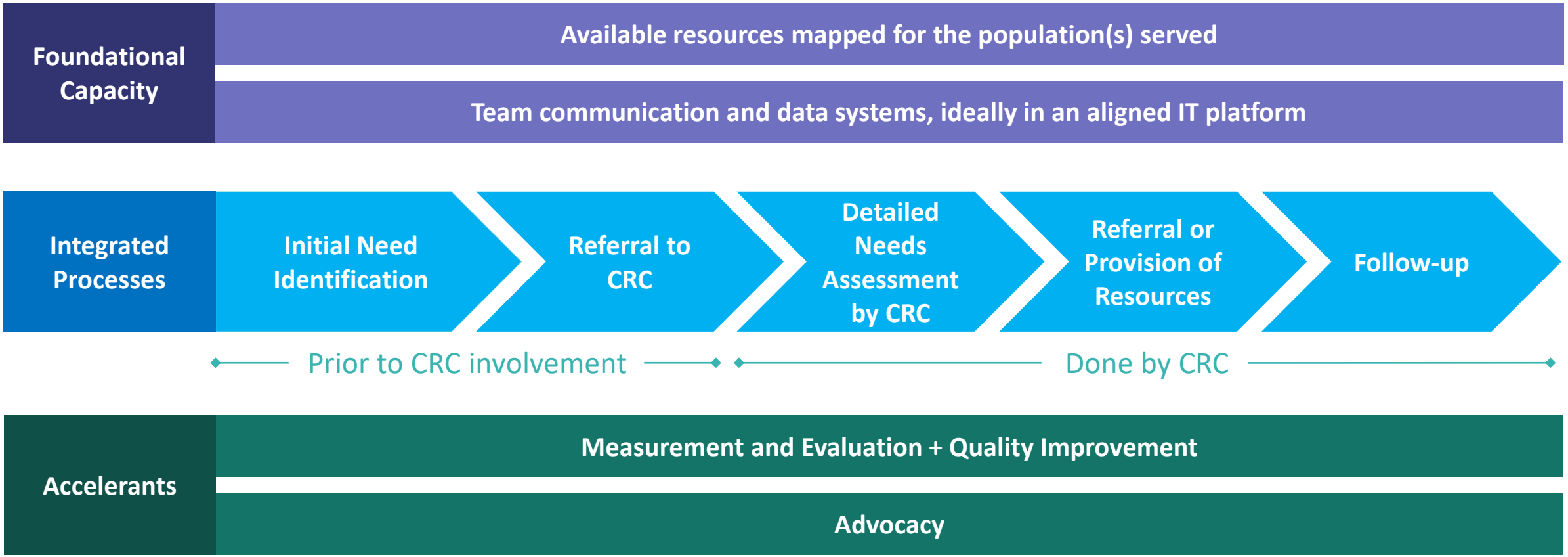


# Foundational Capacity

**Foundational Capacity**

**Available resources mapped for the population(s) served**

Pre-identify the available resources to address the needs of cases or contacts. Resources can come directly from the CRC program or through community-based organizations (CBOs).

**Team communication and data systems, ideally in an aligned IT platform**

Create tools to support team communications and data collection, sharing, and reporting. Platforms used for communication and data tracking should ideally be integrated with the contact tracing program.

# Integrated Processes

Develop a process for identifying needs, either by the Contact tracer, Case investigator, case or contact, or by a health service provider or community health worker.

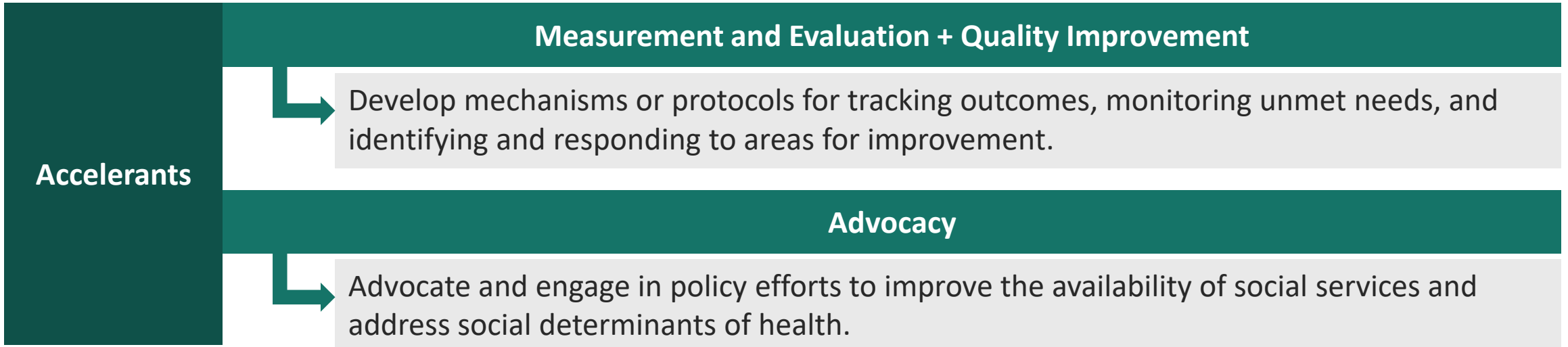
Develop mechanisms and protocols to refer cases or contacts in need of assistance to the CRC, including for the prioritization of the most urgent needs.

Train local CRC staff who can perform detailed needs assessments and can evaluate available solutions for addressing needs.

Adapt systems to facilitate referrals between CRCs and CBOs in a culturally and geographically appropriate manner.

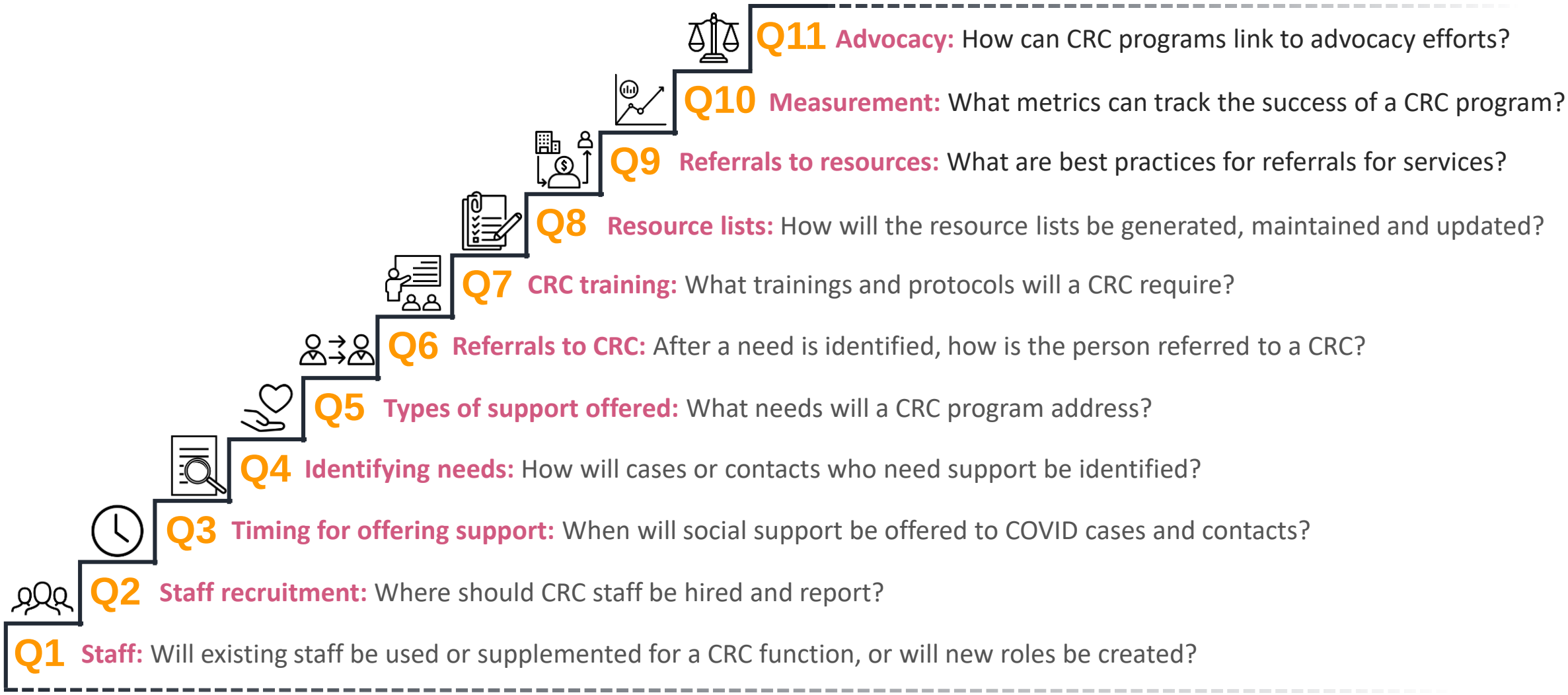
Follow-up with cases and contacts to ensure needs are effectively met and that new needs do not arise during their isolation period.

# Accelerants



# How to design an effective and equitable CRC program: eleven key design questions

# Eleven key design questions for a CRC program



**Q11 Advocacy:** How can CRC programs link to advocacy efforts?

**Q10 Measurement:** What metrics can track the success of a CRC program?

**Q9 Referrals to resources:** What are best practices for referrals for services?

**Q8 Resource lists:** How will the resource lists be generated, maintained and updated?

**Q7 CRC training:** What trainings and protocols will a CRC require?

**Q6 Referrals to CRC:** After a need is identified, how is the person referred to a CRC?

**Q5 Types of support offered:** What needs will a CRC program address?

**Q4 Identifying needs:** How will cases or contacts who need support be identified?

**Q3 Timing for offering support:** When will social support be offered to COVID cases and contacts?

**Q2 Staff recruitment:** Where should CRC staff be hired and report?

**Q1 Staff:** Will existing staff be used or supplemented for a CRC function, or will new roles be created?



**Each question will be addressed on subsequent slides.**

Q1

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

- Dedicated CRC staff **increase the likelihood** individuals will follow up on referrals and **receive necessary support.**
- The CRC function can be **incorporated into roles of existing staff** or be **implemented through new staff.**
- In either situation, CRC is most successful when **staff are culturally and linguistically diverse** with **strong ties to the local community.**

**Existing staff**

- Integrate CRC function into roles of existing staff such as community health workers, social workers, case managers, resource managers
- Existing staff are likely to require less training, will be rapidly deployable, and have stronger relationships with individuals and organizations

**New staff**

- Recruit, hire, train and supervise new CRC roles
- New staff will be beneficial if existing staff lack capacity or the necessary experience to meet CRC needs
- More in-depth resources (e.g., job descriptions, trainings) are available on the PIH Resource Library

Q2

# Where should CRC staff be hired and report?

- Where CRC staff are hired and report influences referral pathways, coordination, and data sharing between **Contact Tracers (CTs)**, **Case Investigators (CIs)** and **Care Resource Coordinators (CRCs).**
- Integration and close linkages with CT/CI ensures those who are required to isolate/quarantine receive necessary support.

| | Advantages | Disadvantages |
|---|---|---|
| **Within contact tracing system** | ▪ Simplifies coordination, data sharing, and monitoring/evaluation across CTs/CIs and CRC<br>▪ Prevents issues related to sharing of private/ confidential information across organizations | ▪ May require de novo workforce<br>▪ Requires close coordination with external partners to avoid duplicating efforts |
| **Within another governmental agency** | ▪ May identify synergies related to roles/ external partnerships with other agencies<br>▪ May facilitate sustainability if embedded in an established agency | ▪ Issues of interoperability between data systems and privacy/ confidentiality issues can complicate information sharing with CTs/CIs<br>▪ CRC goals, objectives, and priorities may differ from those of other agencies and CBOs |
| **Within a local community-based organization (CBO)** | ▪ Capitalizes on existing trust, relationships, and networks with individuals and community organizations | |

Q3

# When will social support be offered to COVID cases and contacts?

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

**Potential points for screening:**

## During testing

- Beneficial in high risk, socioeconomically or ethnically disenfranchised communities, or in settings where test results are very delayed
- Ensures support for individuals to isolate while waiting for test results
- Offers an opportunity to screen more individuals (even those who test negative) for social needs and connect them to both short- and long-term services

## During contact tracing

- May facilitate trust and make individuals more receptive to contact tracing efforts
- Once positive, individuals may provide more details on their social needs

Q4

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

Appropriate **identification and understanding of the needs** of cases or contacts starts with CTs/CIs and requires:

## 1 Training of CTs/CIs

- Contact tracers and case investigators must be trained to:
  - Obtain patient consent to collect and share information as needed
  - Use selected needs assessment tools
  - Assess requirements for isolation, common social needs, individual barriers/challenges accessing supports
  - Collect/record information using standard processes and platforms
  - Communicate with CRC including: how to refer individuals to CRC, range of supports provided by CRC, what to expect for CRC follow-up

## 2 Use of standard, scripted needs assessment tool

- **Scripted needs assessments** ensure all needs are identified and reported in a consistent manner across individual CRCs
- Needs assessment tools should:
  - **Start with broad questions** (e.g. “Do you need help to isolate?”) for a more conversational approach
  - Transition to **specific questions about the patient’s living situation and available food and supplies in the home**; CDC has a checklist of questions that can be adapted

Q5

# What needs will a CRC program address?

Strong CRC programs rapidly address both **immediate and long-term material, social, and emotional needs**

## Examples of immediate needs

- Food
- Cleaning supplies
- PPE
- Rent and utility assistance
- Medical needs such as medications, medical or mental health care, COVID-19 testing (for contacts)
- Additional concerns such as domestic violence, immigration status, child or elder care, loss of employment

## Examples of long-term needs

- Support negotiating leave from work
- Economic relief benefits (e.g., SNAP)
- Health insurance
- Housing support
- Ongoing legal situations

Q6

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

- Referrals to a CRC are **detailed, secure, and timely** to facilitate CRC follow up and facilitate appropriate resource connections.
- This process is **easiest when the CRC is integrated and linked to CT/CI functions** with a common information sharing platform.

**Example information included in referrals to a CRC**

- **Contact information**: name, birth date, phone number, email address, mailing address
- **Preferred mode of communication** (e.g., text, phone call, email)
- **Description of the needs**: standard formats (e.g., check-boxes, drop-down menus) enable data to be easily aggregated for reporting purposes, however free/open text must be available to describe unique nuances in individual situations
- **Urgency of need** (e.g., support required immediately, within the next 5-7 days, within the next month, ongoing)

**Additional characteristics of referral process**

- Secure and timely communication that complies with **local and national privacy regulations**
- **Closed loop communication** whereby the CRC notifies the CT/CI when appropriate service organization receives the referral and again when the need has been met

Q7

# What trainings and protocols will a CRC require?

- Since CRCs can come from a variety of backgrounds, training programs should focus on ensuring that **all CRCs have the baseline skills to provide consistent and comprehensive support to individuals.**
- Programs should develop a list of "**core competencies**" for their CRCs and use this to prioritize individual trainings.

| Example skills or core competencies included in trainings |
| --- |
| ▪ Understand COVID-19 testing, contact tracing, and isolation and quarantine requirements |
| ▪ Interpret assessments from testers or CT/CIs on individuals needs (e.g., food, housing, supplies, medical and behavioral health care) and provide additional detail on individual context and challenges where appropriate |
| ▪ Maintain updated resource lists (if part of role) |
| ▪ Build relationships with community resources and establish referral processes to critical resources |
| ▪ Develop skills required to form trust with clients, including active listening, cultural competency, and psychological first aid |

Q8

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

- CRC programs require a **database of local resources**, **organized geographically and thematically**, with **clear processes for vetting and updating** contact information.
- There are several options for generating this database depending on what is already available locally

**Existing platforms**

- Use existing platforms maintained by 211 or vendors (e.g., Aunt Bertha, NowPow)
- Access a platform overview here.*

**Local resource lists**

- Build off resource lists generated/maintained by local organizations such as boards of health, community-based organizations (CBOs), social work organizations, federally qualified health centers (FQHCs)

**Home-grown databases**

- Crowd-source resources at program inception leveraging local knowledge and relationships
- May require additional efforts to understand scope of services and capacity of local organizations

**Existing platforms may have costs associated*

Q9

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

- **Direct contact (warm referrals) between a CRC and a service organization increases the likelihood individuals follow through on referrals** and receive the necessary supports.

**Make a warm handoff**

- Conduct handoffs via three-way calls, electronic systems, or email to the service organization, directly contacting the organization on the individual's behalf to facilitate connection to services

**Follow up with the client**

- Follow up after the referral to ensure the need was successfully met

**Develop clear escalation pathways**

- Develop clear pathways which can range from involving a supervisor or local board of health to seeking peer mentorship for troubleshooting, if a CRC has difficulty addressing a need

Q10

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

Measurement and evaluation metrics document the **volume and types of need**, the **success in meeting that need**, and the **timeliness** with which it was addressed.

| Program Goal | Example metrics | Comments |
|---|---|---|
| **Measure the scope of need** | # or % of cases/contacts needing resource support<br># or % needing support by support type<br># or % reporting inability to self-isolate/quarantine | Track cumulatively and longitudinally to assess changes over time (e.g., daily, weekly, monthly) |
| **Successful completion of needs** | % of individuals successfully referred to a resource<br>% of individuals where need was ultimately met<br># of agencies tried to meet need | Analyze 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) |
| **Timeliness** | Time between:<br>▪ need identification and referral to CRC<br>▪ referral to CRC and reaching individual<br>▪ CRC referral and successful referral to resource<br>▪ CRC referral and completion of need | Disaggregate by type of need to identify resource gaps (e.g., lack of capacity results in longer timeframes to meet needs) |
| **Program Operations** | Active cases being followed per CRC<br>Patient outreach calls per CRC<br>Average length of call per CRC | Analyze by CRC to look for patterns given variations at individual level may be driven by the nature of individual needs |

- Metrics allow you to:
  - Follow success over time
  - Inform **program improvement**
  - Ensure populations in need are reached
  - **Share experience** with key partners at the community and state level
- Consider metrics relative to individuals, households, and populations served
- **To ensure equity, metrics should be disaggregated by race, income level, age, gender, and geography**

Q11

# How can CRC programs link to advocacy efforts?

- 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.**

**CRC programs can link to advocacy efforts by:**

- Identifying resource gaps and promote solutions
- Advocating for addressing social determinants of health that influence hot spots or uneven disease transmission
- Identifying situations requiring escalation to external parties (e.g. evictions)
- Raising awareness of systemic problems
- Promote:
  - Funding for resources
  - Methods for addressing geographic resource gaps or gaps in accessibility
  - Solutions for previously unidentified areas of need

Q11

# **Case Study:** Advocacy can Impact Social Support Resources

## Massachusetts Invests in Public Health and Social Support Services

The Massachusetts Senate Passed a FY21 budget of $46 billion that “aims to move the Commonwealth towards an equitable recovery by making critical investments in sectors impacted by COVID-19."

The budget includes provisions for:

- Early education
- Childcare
- Food security
- Housing supports
- Public health

***“With a second surge of COVID-19 upon us, we must do everything we can to shore up critical resources for those most in need so that we can begin to build towards an equitable recovery.”***

**- Senate President Karen E. Spilka (D-Ashland)**



*Source:* https://framinghamsource.com/index.php/2020/11/18/massachusetts-senate-passes-46-billion-budget/

# Conclusion

Using these questions as a framework, organizations can design **effective and equitable** CRC programs that **meet patient needs and ensure safe isolation and quarantine of COVID cases and contacts**, which are essential to containing the spread of COVID-19.

Programs can 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 disproportionally affected by COVID-19; and coordination or liaison functions between CBOs, government agencies, and communities.

# US Public Health Accompaniment Unit

For more information please contact LearningCollab@pih.org

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