Toolkit

Building Healthier Communities: Leveraging COVID-19 Vaccination to Address Social Determinants of Health

Updated March 23, 2021

OVERVIEW

As states progress through COVID-19 vaccination phases, millions of people will interact with the public health system, some of them for the first time in years. This is a critical opportunity to build trust between public health departments and communities and to address the social determinants of health (SDOH). SDOH are commonly understood as "…the conditions in which people are born, grow, live, work, and age as well as the complex, interrelated social structures and economic systems that shape these conditions." (CDC, 2019).[1] Inequities in SDOH, including insecure housing or food access, are linked to disparities in health outcomes. The COVID-19 pandemic, which has profoundly affected the lives of the poor, underscores the importance of addressing SDOH to achieve health equity. In the US, Black, Latinx, and Native American communities experience high burdens from COVID-19, with severe health and economic outcomes.[2]

Throughout the pandemic, Resource Coordination Programs have helped confirmed COVID-positive individuals (cases) and their contacts access the supports they need to safely isolate or quarantine,[3] critical actions to prevent disease spread. Resource coordination can be done by a Care Resource Coordinator (CRC), Community Health Worker (CHW), Social Worker, or another trained staff member. Here, for simplicity, we refer to this role as a CRC.

Now with vaccination, we have an opportunity to build upon lessons learned and expand resource coordination to address SDOH by meeting long-term needs for social and financial support, building healthier communities, and ultimately, reducing systemic inequities. This toolkit outlines ways we can leverage the vaccination programs to A) screen for social needs, B) screen for health care access, and C) connect individuals with relevant supports. It offers guidance both for existing CRC programs, as well as for sites seeking to create CRC capacity.

SOCIAL NEEDS: Social supports screening and referral at the point of vaccination

Screening for social determinants of health: When, how, by whom?

SDOH screening can be done while patients are waiting for vaccination or after vaccination during the observation period after the dose. In addition, these same procedures can be adapted to screen patients virtually at the time of registration for a vaccine appointment. If done prior to an appointment, transportation assistance to the appointment should be offered. For all screening, provide translation services to facilitate equitable access to services. For screening done at the vaccination encounter:

Screen while patients are waiting for vaccination: Ask SDOH screening questions (see Appendix A) at the time of check-in. Or, if the line is long, have trained staff move through the line to ask screening questions, provided social distancing or other measures allow for adequate privacy. Though a detailed screen can be done in under 10 questions, if length is a concern, a short 1-2 question screen can be used. Patients who screen positive should be referred to a resource coordinator.

Screen in the 15-minute observation period after vaccine dose: A trained staff member can move between patients after their vaccine dose to ask screening questions and refer patients in need to a CRC. For mRNA vaccines, this can be paired with second dose scheduling and transportation arrangements, if needed.

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[1] Centers for Disease Control and Prevention. (2019). *NCHHSTP Social Determinants of Health*. https://www.cdc.gov/nchhstp/socialdeterminants/index.html

[2] Centers for Disease Control and Prevention. (2020). *COVID-19 Racial and Ethnic Health Disparities*. https://www.cdc.gov/coronavirus/2019-ncov/community/health-equity/racial-ethnic-disparities/index.html

[3] Kerkhoff AD, Sachdev D, Mizany S, Rojas S, Gandhi M, Peng J, et al. (2020) *Evaluation of a novel community-based COVID-19 'Test-to-Care' model for low-income populations.* PLoS ONE 15(10): e0239400. https://doi.org/10.1371/journal. pone.0239400

Screenings can be done by a variety of personnel, including registration staff, clinical assistants, trained volunteers, and dedicated screeners. Screeners should be trained on screening scripts (Appendix A), active listening, cultural competency, and non-judgmental questioning techniques. Active screening (using specific screening questions asked verbally) is recommended and is most likely to successfully meet patient needs. If active screening is impossible, distribute flyers with lists of available resources or ways for patients to reach resource coordinators.

Referral to CRCs: what to do when a need is identified

Individuals who indicate a need should be referred to a resource coordinator. As described above, this role can be filled by a CRC, CHW, Social Worker, or trained staff member. Here, we refer to this role as a CRC. Individuals can be referred to either remote CRCs (off-site) or to those on-site.

Referring to a remote CRC: A CRC off-site will contact and work with the individual after the vaccination encounter. To refer, site staff should explain the referral process to patient and seek consent to refer:

- When a patient screens positive (i.e. in need of social supports), the screener should set expectations about next steps. The patient should know that they will be referred to a CRC, when they can expect a call, and what help the CRC can or cannot provide.
- Screening scripts should be adapted to include any necessary consents for the screener to share contact information and patient needs with the CRC program; this consent should be documented.
- Screeners must verify the best contact number and time to reach the patient, along with any other necessary information.
- Secure information sharing is critical (**box right**).

FACILITATE SECURE REFERRAL AND INFORMATION-SHARING

Secure referral systems should be used to share information with the CRC program on a regular interval, ideally in real time.

Examples of referral systems include:

- Database and survey programs: RedCap, Excel/smartsheets, Online forms
- CRM platforms such as those used for contact tracing: SalesForce, CommCare
- Dedicated resource linking software that can refer patients to contracted organizations with CRC capacity: NowPow, Unite Us, Aunt Bertha, etc
- If needed, referrals can be made by email, fax or paper forms, though these methods limit tracking and are less systematic. For these reasons, these methods are recommended as a last resort.

Referral systems should comply with all relevant privacy and legal regulations. Systems should include an option for urgent referrals, for example, when a family faces imminent eviction.

Even with remote referral, always provide a way for patients to reach out to CRCs. An incoming call number can help patients without a stable phone number or who have difficulty receiving incoming calls due to disabilities or work or family obligations. This reduces the risk someone will be lost to follow-up.

Linking to an in-person CRC in real time (CRC at vaccine site): CRCs can work with individuals at vaccine sites at one of two times.

1) If wait times are prolonged, CRCs can support patients waiting to receive the vaccine. For example, at first come, first served vaccine sites it may be possible for individuals to speak with a CRC while maintaining their place in line.
2) Alternatively, individuals can speak with a CRC after vaccination. To set this up, designate a desk or area for the CRCs. When individuals screen positive, direct them to go to that area to speak with a CRC after vaccination.

Programs implementing real-time CRC linkages should:

- Explain the CRC availability and the process to any patients with identified needs. If patients need to move to a different physical space, they should be given clear instructions on when and where to go.
- Ensure any physical waiting space for CRC services is large enough to allow for social distancing.

- Ensure privacy so that patients do not disclose confidential information in a crowded area.
- Provide translation services to facilitate equitable access to services.

Real-time, in-person CRC programs should simultaneously offer remote or follow-up services. Not all individuals will be able to stay longer at a vaccination site to meet with a CRC in real time.

FACILITATING ON-SITE CONNECTIONS TO COMMUNITY ORGANIZATIONS

In addition to resource coordination programs, having community-based organization (CBO) representatives on-site can facilitate linkages to services. This promotes the vaccine site as a collaborative, community network of support, and it may be faster than referral to CRCs if the CBO can directly deliver the needed services. This approach is particularly useful if a small number of CBOs provide most local resources, and/or if a CBO is used as a location for a pop-up vaccine site.

CBOs at vaccine sites should be targeted to anticipated needs: for example, vaccine sites at shelters may partner with CBOs specializing in housing and support for individuals experiencing homelessness.

The logistics of this approach (in relation to timing around vaccination and setup of consultation areas) are similar to those for in-person CRC linkages above.

Linkage to resources after referral to CRCs:

In order for CRCs to effectively link clients to care and services, programs must equip CRCs with:

1) **Lists of available resources** organized by geography and support area, which specify eligibility criteria and scope of support (Appendix B).

   These can be generated by:

   - Expanding existing resource lists, such as those from local health centers, social work organizations, and/or departments of public health.
   - Utilizing programs that collate and organize resource lists, such as NowPow, Aunt Bertha, or Unite Us.

2) **Mechanisms to update and maintain resource lists:** For key resources, maintain open channels of communication between the CRC program and the resource organization about the status of funds for certain programs, referral volume, eligibility/application criteria, and resource details. Resource availability may fluctuate over time depending on funding and demand.
3) **Defined processes for referral from a CRC to a CBO,** ideally using a warm referral, or direct contact between the CRC and the CBO. Programs should record referrals made for tracking and follow up. Some referral software can do this automatically. CRCs should designate cases for special follow up if patients are particularly vulnerable or have complex needs.
4) **Mechanisms to facilitate benefits applications,** such as for SNAP, WIC, or Medicaid. Many states have enrollment counsellors or community partners who can help individuals apply - CRCs can connect eligible individuals to these services. Referrals to health care and health insurance are discussed in further detail in the toolkit.

REAL-TIME SUPPORT: offering resources directly at vaccine sites

In areas with high rates of food insecurity or high resource needs, resources provided at the time of vaccination can help reach vulnerable populations. These should be coupled with information about long-term support and other resources. Common resource needs amenable to delivery at vaccine sites include:

- **Food**: Facilitate partnerships with local organizations and food pantries to distribute premade food boxes. This approach has been successfully used at testing and vaccine sites. Couple this with flyers about local food pantries and on how to apply for long-term food assistance.
- **PPE and cleaning supplies**: Facilitate distribution of face masks and hand sanitizer to help reduce the spread of COVID-19. Couple this with important education that, even after vaccination, everyone must continue to regularly wash hands, wear masks properly, and follow all social distancing protocols.

For any resource, it is important that the resources are clearly available to all, independent of decision to be vaccinated. This avoids the possibility or perception of coercion.

HEALTH CARE SERVICES: Screening and referrals at point of vaccination

Screening for primary health care and health insurance: Screening for primary health care access and health insurance can be easily incorporated into SDOH screens described above (for scripts, see Appendix A). Systems for tracking and referrals can also be similar. Additional considerations include:

a) Prior to screening, always clearly explain that vaccination is free regardless of insurance status or access to health care.

b) Screening can be integrated into the registration process, especially if insurance information is collected.

c) As with SDOH screening, active screening is preferred and most effective.

Referrals for primary health care and health insurance: Referrals for health care and health insurance can also be easily incorporated into the systems described above for referrals to social services.

a) Considerations for referral to health care:
   i. Maintain lists of nearby federally qualified health centers (FQHCs) for patient referrals patients. Contact each health center to: (1) verify they are accepting new patients, (2) understand the time frame for new patient visits, (3) discuss ways to streamline referrals and minimize barriers to patients making initial appointments, and (4) discuss any restrictions on insurance types and/or sliding scale payment options for self-pay for uninsured individuals.
   ii. Have information available in multiple languages about free or reduced payment options to encourage individuals to access affordable care even without insurance. Undocumented individuals or those who do not qualify for public insurance programs may be able to be seen via sliding scale payment mechanisms, which often include a free care option depending on income.
   ii. In addition to FQHCs, contact hospitals and large practice groups, particularly safety net hospitals. Verify the same information as above.

b) Considerations for health insurance referrals:
   i. Many states have enrollment counselors or specialists who can help navigate the complex enrollment process. Seek partnerships with these individuals or understand how to refer to them.

SUPPORTING RESOURCE CONNECTIONS AFTER VACCINATION

After the vaccination encounter, resource coordinators should continue to support patients. Follow-up outreach takes two forms: first, an initial encounter if there was no in-person resource coordination available at the vaccination site, and second, follow-up after the initial CRC encounter. In addition, programs can staff incoming call lines.

 **For initial resource coordination after vaccination**	For programs without CRCs at vaccination sites, CRCs will need to conduct both initial and follow up outreach after the vaccination. Initial outreach should be within 24 hours of receiving referral to the CRC program. Programs should have a method to 'flag' urgent cases for rapid outreach, and CRCs should be trained to recognize and rapidly address these cases. • At the start of any call, CRCs should introduce themselves, explain the connection to patient's recent vaccination referral, and set a tone to build trust and rapport with the patient. • CRCs should perform a detailed SDOH screen (if not already done/documented) and discuss the patient's needs in greater detail. Referral from a CRC to an organization or long-term service can mirror the methods described above.
 **Follow up resource coordination, which should occur after all CRC referrals**	Experience to date shows that not all resource referrals will be successful. For example, a patient may be referred to a program that they are not eligible for, or a program that has run out of resources to provide. For these reasons, ***follow up is critical*** to meet patient needs. • If an initial referral was not successful, CRCs should explore the reasons why. Sometimes, CRCs can contact the organization with the patient to navigate questions of eligibility. Other times, referral to a different organization may be needed. • When possible, programs should designate reserve funding to meet needs not served by existing organizations. Ideally, CRCs will follow up with all patients with an initial resource referral to ensure the need was met, within 24-48 hours after resource referral. If caseloads prevent this, follow up should be prioritized for: 1) individuals identified as particularly vulnerable at the time of initial assessment and 2) individuals with complex resource needs or needs that are known to be difficult to meet.
 **Incoming call lines for follow-up**	To address follow-up needs, design ways for patients to contact resource coordinators, ensuring multiple channels for contact to accommodate cultural, technological, or privacy considerations. • Provide resource coordinator contact information in the form of phone numbers, emails, on-line forms, or consistent "office hours" at accessible locations.
 **Track progress**	Implement simple tools and work-flows to ensure timely processing of documented needs, planned follow-up, and specific support/resource delivery. Examples of tools used by existing resource coordination programs include CRM software such as Salesforce, as well as home grown solutions such as smart sheets. Document all communication between CRCs and clients so that others following up on the case can quickly understand the relevant context.

MONITORING, EVALUATION, AND QUALITY IMPROVEMENT FOR RESOURCE COORDINATION

Programs are most responsive when they understand what needs people face and what barriers exist to meeting these needs. Programs should regularly assess and review feedback from communities and program data to highlight emerging or changing needs and improve the efficiency of matching resources to need. Data that identifies needs and resource gaps should be shared with government and private partners on a regular basis, to advocate for resources and programs to address these gaps. As a minimum, programs should:

a) Analyze number and types of needs by geography and demographics

b) Analyze percent of unfulfilled needs by need type, geography, and demographics

c) Solicit qualitative feedback from resource coordinators on difficult cases and other program details.

CONCLUSION

The COVID-19 vaccination rollout, reaching millions, is an incredible opportunity to not only respond to the acute COVID-19 crisis, but to build healthier communities and to strengthen our social safety net as well as our public health systems in the long term. Vaccination presents a chance to reach historically marginalized and at-risk communities, offer meaningful connections to social supports, and facilitate access to the healthcare system. The Care Resource Coordination opportunities described here are well positioned to bridge gaps and connect people to services. Implementing these alongside vaccination efforts is not only possible, but essential, to address the needs and inequities COVID-19 has laid bare.

APPENDIX A: SCREENING SCRIPTS

Health Related Needs Screening

(Adapted from North Carolina Social Determinants of Health Screening[4] and American Academy of Family Physicians Social Needs Screening Tool[5])

We want to help you and your family with all aspects of your health. Not having enough food or reliable transportation or a safe place to live can make it hard to be healthy. We are asking everyone a few questions about their needs. If you need assistance, we will refer you to someone who can try and find community resources to help. You can still receive your free vaccination today no matter how you answer these questions.

	Refer for resource coordination		
Food			
1. Within the past 12 months, did you worry that your food would run out before you got money to buy more?	Often	Sometimes	Never
2. Within the past 12 months, did the food you bought just not last and you didn't have money to get more?	Often	Sometimes	Never
3. Are you currently worried about not having enough money to buy food for you or your family?	Yes		No
Housing/ Utilities			
4. Are you worried or concerned that in the next two months you may not have stable housing, or that you may need to stay outside, in a car, in a tent, in an overnight shelter, or temporarily in someone else's home (i.e. couch-surfing)?	Yes		No
5. Think about the place you live. Do you have problems with any of the following?			
Bug infestation	Yes		No
Mold	Yes		No
Lead paint or pipes	Yes		No
Inadequate heat	Yes		No
Oven or stove not working	Yes		No
No or not working smoke detectors	Yes		No
Water leaks	Yes		No
6. In the past 12 months has the electric, gas, oil, or water company shut off or threatened to shut off services in your home?	Yes		No
Transportation			
7. Within the past 12 months, has a lack of transportation kept you from medical appointments or from doing things needed for daily living?	Yes		No
Interpersonal Safety			
8. Do you feel physically or emotionally unsafe where you currently live?	Yes		No
Immediate Need			
9. Are any of your needs urgent? For example, you don't have food for tonight, you don't have a place to sleep tonight, you are afraid you will get hurt if you go home today.	Yes		No
10. Would you like help with any of these needs?	Yes		No

[4] North Carolina Department of Health and Human Services. (2020) *Screening Questions*. https://www.ncdhhs.gov/about/department-initiatives/healthy-opportunities/screening-questions

[5] American Academy of Family Physicians. (2018) *Social Needs Screening Tool*. https://www.aafp.org/dam/AAFP/documents/patient_care/everyone_project/hops19-physician-form-sdoh.pdf

Abbreviated Health Related Needs Screening

We want to help you and your family with all aspects of your health. Not having enough food or reliable transportation or a safe place to live can make it hard to be healthy. We are asking everyone a few questions about their needs to try and help. You can still receive your free vaccination today no matter how you answer these questions

	Refer for resource coordination	
1. Are you worried about not having enough food to eat or enough money to buy food for you or your family?	Yes	No
2. Are you worried that in the next two months you may not have stable housing or that utilities in your home may be shut off because of inability to pay?	Yes	No
3. Would you like to speak to a resource coordinator for help with food, housing, utility payments, medical care, or any other needs?	Yes	No

Health insurance and health care access screen

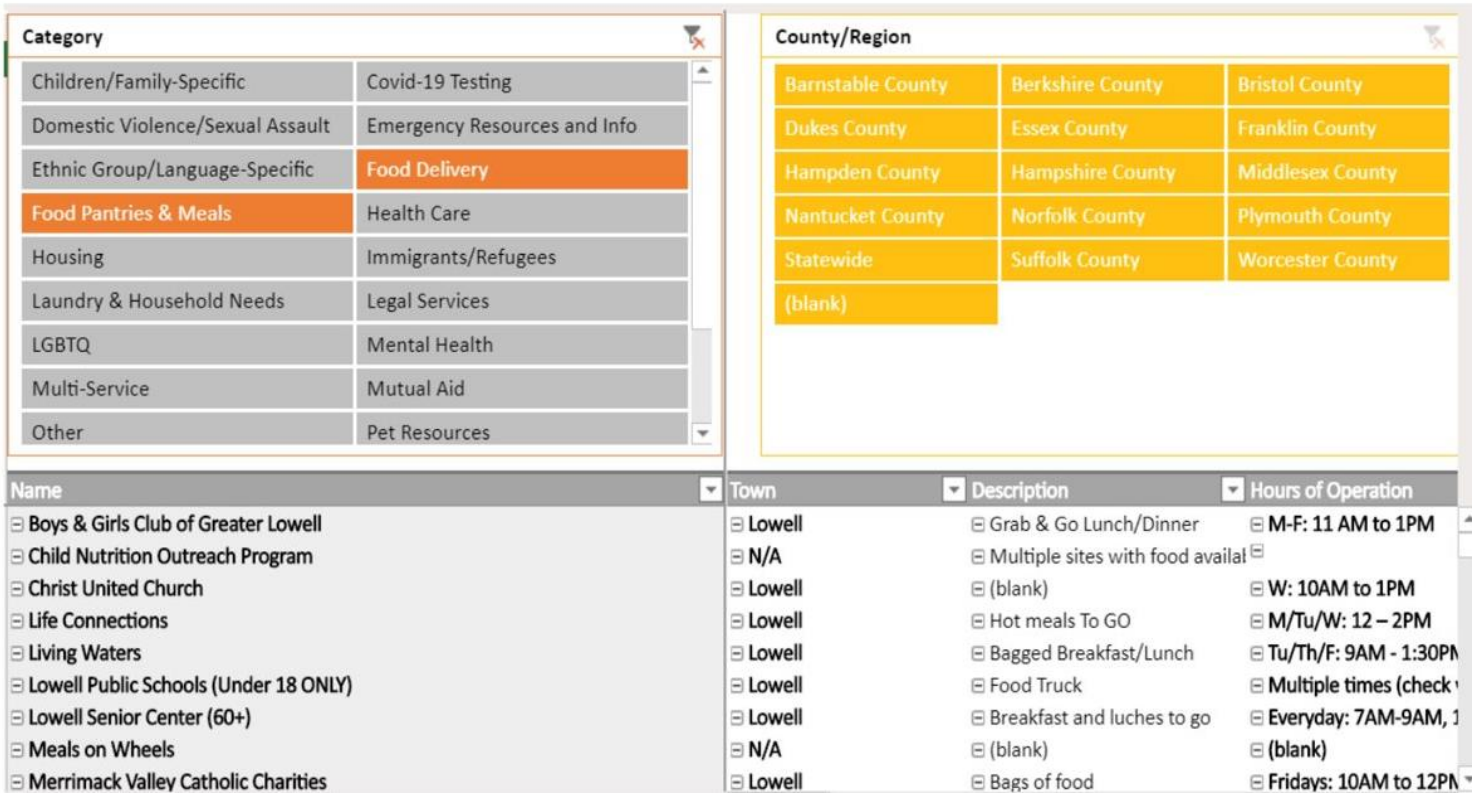
You do not need health insurance or a primary care doctor to receive your free vaccination today. However, if you do not have health insurance or a primary care doctor, we can help you speak with someone about what if any programs you might be eligible for.

1. Do you currently have health insurance?
2. Do you have a primary care doctor or clinic that you see for routine medical care, such as annual physical exams or minor illnesses?

If an individual answers no to either question, refer for connection to services or care

APPENDIX B: RESOURCE LISTS

Example of an excel-based Resource Bank from the Massachusetts Community Tracing Collaborative (CTC)[6], organized and sortable by category of service, county/region, name of service provider, hours of operation, and language (not shown).



Category		County/Region		
Children/Family-Specific	Covid-19 Testing	Barnstable County	Berkshire County	Bristol County
Domestic Violence/Sexual Assault	Emergency Resources and Info	Dukes County	Essex County	Franklin County
Ethnic Group/Language-Specific	Food Delivery	Hampden County	Hampshire County	Middlesex County
Food Pantries & Meals	Health Care	Nantucket County	Norfolk County	Plymouth County
Housing	Immigrants/Refugees	Statewide	Suffolk County	Worcester County
Laundry & Household Needs	Legal Services	(blank)		
LGBTQ	Mental Health			
Multi-Service	Mutual Aid			
Other	Pet Resources			

Name	Town	Description	Hours of Operation
Boys & Girls Club of Greater Lowell	Lowell	Grab & Go Lunch/Dinner	M-F: 11 AM to 1PM
Child Nutrition Outreach Program	N/A	Multiple sites with food availal	
Christ United Church	Lowell	(blank)	W: 10AM to 1PM
Life Connections	Lowell	Hot meals To GO	M/Tu/W: 12 – 2PM
Living Waters	Lowell	Bagged Breakfast/Lunch	Tu/Th/F: 9AM - 1:30PM
Lowell Public Schools (Under 18 ONLY)	Lowell	Food Truck	Multiple times (check
Lowell Senior Center (60+)	Lowell	Breakfast and luches to go	Everyday: 7AM-9AM, 1
Meals on Wheels	N/A	(blank)	(blank)
Merrimack Valley Catholic Charities	Lowell	Bags of food	Fridays: 10AM to 12PM

[6] COVID-19 Community Tracing Collaborative Resources. (2020) https://www.mass.gov/covid-19-community-tracing-collaborative-resources

Example of a Resource List compiled by the Pima County Health Department. Note that resources listed may not be up-to-date, but illustrate a low-barrier approach to compiling a comprehensive set of social support services for CRC programs.

COMMUNITY RESOURCES - TUCSON

COMMUNITY WIDE CRISIS LINE – 520-622-6000

1-800-796-6762 - TTY/TDD – 1-888-248-5998

CRISIS TEXT LINE: Text "home" to 741741

Contents

COMMUNITY RESOURCES - TUCSON

CRISIS SUPPORT

CRISIS/SUICIDE/BEHAVIORAL HEALTH HOTLINES

- Community-Wide Crisis Line – 520-622-6000 1-800-796-6762 – TTY/TDD – 1-888-248-5998
- National Suicide Prevention Lifeline (24 hours) 1-800-273-TALK (8255)
- Mobile Acute Counseling Team – 520-622-6000
- Red Nacional de Prevención del Suicidio (24 hrs Español), 1-888-628-9454
- CODAC- (520) 327-4505 Health, wellness, and recovery. Call for nearest location.
- CPSA – Community Partnership Inc. – 1-800-796-6762 TTY/TDD– 1-888-248-5998 Behavioral Health services
- Teen Lifeline – 1-800-248-TEEN(8336) Open 24 hrs for crisis support, Peer Counselors on M-Su 3PM-9PM
- Trevor Lifeline (LGBTQ youth) 24 hrs 1-866-4-UTREVOR – 1-866-488-7386
- Southern Arizona Aids Foundation (LGBTQQIA Youth & Adults) -24 hr Crisis Line: (800) 553-9387

DOMESTIC VIOLENCE

Anyone in immediate danger or who knows someone in immediate danger should call 911

- Emerge Center Against Domestic Abuse -(888) 428-0101; (520) 795-4266 24-hr Bilingual Crisis Line and Shelter
- National Domestic Violence Hotline- 1-800-799-SAFE (7233)
- Pima County Attorney's Office- (520) 740-5525 – Victim Services Division M-F 8-5
- Orders of Protection- (520)740-3210
- Rape, Abuse & Incest National Network- 1-800-656-HOPE, 1-800-656-4673
- Su Voz Vale (Your Voice Counts) Southern Arizona Center Against Sexual Assault -24 hr crisis line (520) 327-7273 or (800) 400-1001 Bilingual program providing free services to victims of sexual violence and their families.
- Administration of Resources and Choices (ARC)- Crisis Line (520) 339-2801 non-emergency (520) 623-3341 Provides emergency shelter for adults aged 55+ living in abusive situations.
- Project SafePlace - Jewish Family and Childrens Services –(520) 795-0300
- Las Familias-(520) 327-7122 victims of childhood sexual abuse
- DES Adult Protective Services – 1-877-SOS-ADULT (1-877-767-2385) Report abuse, neglect, and exploitation of vulnerable or incapacitated adults
- Southern Arizona Aids Foundation (LGBTQQIA Youth & Adults) -24 hr Crisis Line: (520) 624-0348 (800) 553-9387

BASIC LIFE NEEDS

AFFORDABLE HOUSING

- CRAIG'S LIST – www.craigslist.org Perhaps the best do-it-yourself way to find affordable housing.
- TMM Family Services, Inc.- 1550 N. Country Club Road (520) 322-9557 Affordable apartments on rental housing campuses located in Tucson, Marana, Willcox, Douglas, and Thatcher
- Primavera – 882-5383 x 136 Homeownership classes and down payment assistance programs.
- Our Family Services (CommonUnity) – (520) 323-1708 x242 Housing & support for pregnant & single mothers 18-21
- Pima County Housing Center (El Banco) – 801 W Congress Street (520) 724-2460. Programs on home ownership, foreclosure, Section 8, and other housing programs. Also visit www.pima.gov for more information
- Pima Council on Aging (PCOA) – (520)790-7262 Helpline Information on low cost housing, medical assistance, and elder rights. For Adults 55+
- Chicanos Por La Causa – (520)882-0018 Housing & counseling for singles and families.
- Tucson Public Housing Program- 310 N Commerce Park Loop (520) 791-4742
  Family Housing Resources- 1700 E Fort Lowell Rd Ste 101 (520) 318-0993 Low-income apartments and homeownership programs.
- City of South Tucson Housing Authority – 1601 S. 6th Ave (520) 792-2424 Low-rent housing in South Tucson

SHELTER/TRANSITIONAL HOUSING

- Primavera – **Men's Shelter**-200 E Benson Highway (520) 623-4300; **Family Shelter**-(520) 882-5383 Call for location
- Our Family Services-New Beginnings – (520)323-1708 x410 Emergency shelter for homeless families, couples and singles
- Salvation Army Hospitality House - 1002 N Main Ave (520) 622-5411 Emergency shelter and transitional housing for homeless men, women, and families. TB test required.
- Gospel Rescue Mission-Men's Shelter - 312 W 28th Street (520) 740-1501 x7215