COVID-19 Case Investigations

Tools for LBOHs

November 9, 2021

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Bureau of Infectious Disease and Laboratory Sciences
MA Department of Public Health
Updates for today, Tuesday, 11/9/2021

- **CTC Care Resource Coordination Presentation**
  - Fynn Crooks, Manager of Training
  - Anne Moller is the Assistant Director of the Care Resource Coordination (CRC) Program for the Massachusetts Community Tracing Collaborative (CTC).
  - Odessa Holt manages the Care Resource Coordination Program for the Massachusetts Community Contact Tracing Collaborative (CTC).

- **CTC Timeline for Closure**
  - Last Day to send cases is 11/30
  - CTC officially ends on 12/31
    - Salesforce database will be retired and no longer used – relevant case/contact tracing data will be brought back to MAVEN
  - Reminder to check your Immediate, Routine & Pending Case Report Form Workflows *(something other than COVID)*
  - LBOH Immediate Workflow – COVID-19 events only – please check your workflow **TODAY** and clear out the workflow
Timeline for CTC Closure

- The last day to send cases to the CTC is **Tuesday, November 30**.
- Your Local Health Liaison (LHL) will be available through **Thursday, December 30**.
- The CTC will close **Friday, December 31**.

<table>
<thead>
<tr>
<th>November</th>
<th>December</th>
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<td><strong>12/27</strong></td>
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**Today**
- **11/30** Last day to send cases to CTC
- **12/30** End of LHL support
- **12/31** CTC closes
Check your Immediate, Routine & Pending Workflows

- Reminder to check your Immediate, Routine, Pending Case Report Form Workflows
  - LBOH Notification for Immediate Disease
  - LBOH Notification for Routine disease (737 cases sitting in this workflow today)
  - LBOH Case Report Forms (CRF) are pending (930 cases)
Immediate Notification workflow (COVID-19 Only)

- **UPDATE:** COVID-19 Immediate Notification Workflow - 1,250 events in this workflow this morning
  - This will allow proper notification of all new COVID-19 events for your jurisdiction. *(Confirmed and Probable Cases)*
  - Please review all events/cases in this workflow and complete your **Step 1 - LBOH Notification to “Yes”** to clear out this workflow.
  - If you are retaining ownership then complete **Step 2** (Investigation Started) & **Step 3** (LBOH Investigator (name, lboh, phone number))
  - When you are done then complete **Step 4** (Case Report Form Complete)
  - You can complete **Step 5** if you want – if not then leave blank
COVID Contact Tracing Trainings

- While you are onboarding you can have your volunteers/new staff take the updated Contact Tracing Trainings that are not dependent on having MAVEN access.

  - Intro to COVID-19 Investigations Part 1 Basics, Oct 5 - 2021 Presentation
  
  - Intro to COVID-19 Investigations Part 2 Labs and Case Investigation, October 12 - 2021 Presentation
Care Resource Coordination
Care Resource Coordination Introduction

• Care resource coordination includes assessing for resource and support needs, responding to safety concerns, and supporting vulnerable populations.

• It's important to be familiar with key resource partners and resource gaps, and to collaborate with community agencies.

• Identifying needed resources is an integral part of outbreak investigation and local health response to COVID-19, and can be applied to a range of other health conditions.
Care Resource Coordination Promotes Health Equity

• Disparities in health outcomes are exacerbated by the fragmented social support landscape in the United States
• A local safety net supports community members' short-term and long-term resource needs and contributes to future stability
• Connections to community resources lessen the burden of COVID-19 on already vulnerable individuals and families
CRC Workflow

**Identify need**

- Needs assessment through interview—type of assistance determined and the priority level of the need (e.g. does the individual have enough food to isolate for 24 hours? For 2–3 days?)

**Match with appropriate resources**

- Consider referral urgency, geographic location, and cultural considerations
- Connect the individual directly with the resource (warm hand-over) or provide resource information to the individual

**Follow-up**

- Follow-up with both parties to confirm resource coordination
- Provide a contact phone number for the individual to call back with additional resource needs or questions
Flexible Model

Resource coordination is flexible, and communities can use different models for assessment and resource connection based on staffing:

- Communities with dedicated resource coordinator roles may create a standard assessment to review with cases/contacts
- Contact tracers/case investigators, public health nurses, community health workers could incorporate some assessment questions into their script to screen for resource needs
- Resource needs may be introduced by case/contact during contact tracing or outbreak investigation
## Common Resource Needs

- Food
- Financial concerns
- Medication delivery
- Housing
- Access to Care
- Legal assistance
- Personal Protective Equipment
- Mental health & substance abuse support
- Transportation
## Resource Coordination: Access to Care

<table>
<thead>
<tr>
<th>Easy</th>
<th>Medium</th>
<th>Hard</th>
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<tbody>
<tr>
<td>Individual has MassHealth but has never had a primary care physician.</td>
<td>Person has a health condition that puts them at risk for serious symptoms. They believe they cannot access preventative care, because they are not eligible for health insurance. Lives in a community with a health center.</td>
<td>Case just got COVID results and is in distress. Reports they are diabetic and are out of their medication and supplies. Health insurance has lapsed. Their PCP left the health center and they do not know how to get their prescription refilled.</td>
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</tbody>
</table>

- **✓** Offer options, case could call the number on the back of their card to connect to their assigned PCP, they could reach out to a Community Health Center or other local provider
- **✓** Follow up to confirm

- **✓** Warm handover to community health center patient financial advocate
- **✓** Ask patient financial advocate to connect individual to registration to make an appointment
- **✓** Follow up to confirm individual was able to make an appointment

- **✓** Provide support, ask for consent to call the health center to advocate
- **✓** 3-way call to health center
- **✓** Connect with patient financial assistant to re-enroll in health insurance
- **✓** Identify a prescribing doctor who can refill prescriptions
- **✓** Confirm medications and supplies can be delivered
Resource Coordination: Housing

<table>
<thead>
<tr>
<th>Easy</th>
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<tbody>
<tr>
<td>Individual lives in a crowded apartment with a relative who is immunocompromised and cannot isolate.</td>
<td>Family is two months behind on rent and unable to pay this month due to lost wages from being ill.</td>
<td>Eviction in process, individual must leave their apartment and cannot enter a shelter due to isolation/quarantine.</td>
</tr>
<tr>
<td>✓ Warm handover to intake line for Isolation and Recovery Hotel.</td>
<td>✓ Refer to website or agency to apply for the Emergency Rental Assistance Program.</td>
<td>✓ With consent from case, advocate with landlord for them to complete isolation before eviction.</td>
</tr>
<tr>
<td></td>
<td>✓ If they need application assistance, refer to FRC or CAA</td>
<td>✓ Refer to legal aid to confirm eviction is legal and provide additional support.</td>
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<tr>
<td></td>
<td>✓ Advise household to inform landlord</td>
<td>✓ Refer to Isolation and Recovery Hotel</td>
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Resource Coordination: Food

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<td>Food for a household with no dietary restrictions in a city with an established food pathway and reliable 24-hour delivery turnaround.</td>
<td>Household specifically asking for milk for a toddler, and mentions they also need diapers. The food pantry has limited, shelf-stable items.</td>
<td>Household has one day of food left, limited financial means and no social supports. Rural town has a small food pantry that does not have a delivery service in place.</td>
</tr>
<tr>
<td>✓ Problem-solve with case: is there someone who can shop for them? Do they have SNAP and could order for delivery? ✓ Complete referral via phone, email, or form. ✓ Follow up to confirm household received food</td>
<td>✓ Problem-solve with case: is there someone who can shop for them? Do they have SNAP and could order for delivery? ✓ Could a Family Resource Center, church, or volunteer group help? ✓ Purchase with emergency funds</td>
<td>✓ Problem-solve with case: is there someone who can shop for them? Do they have SNAP and could order for delivery? ✓ Could a Family Resource Center, church, or volunteer group help? ✓ Is there a food pantry they can access that offers no-contact pickup? ✓ Purchase with emergency funds.</td>
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Plan for Urgent Resource Needs

Lessons Learned from the CRC Emergency Fund

• Unrestricted fund from Partners In Health, separate from CTC contracted funds
• Last resort for urgent situations where resource partner cannot deliver
  • Weekends and holidays
• Common needs: food, diapers, formula
• Order using delivery apps
• Average cost of emergency fund order: $51.40
Anticipate Complex Social Situations

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<th>Topics</th>
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<td>Safety Concerns</td>
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<td>Communication Barriers</td>
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<td>Disability</td>
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<td>Intimate Partner or Domestic Violence /Sexual Assault</td>
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<tr>
<td>Shelter/Unhoused</td>
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<td>Ineligible for Resources</td>
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<td>Loss of Home Care</td>
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Detailed Assessment for Common Resource Needs

• Over the next 2–3 weeks, how do you plan to get food and groceries? Can someone bring you food or can you have it delivered? Will you have reliable access to food for you and your family during isolation/quarantine?

• Do you have the medications you'll need over the next 2–3 weeks? Do you anticipate any difficulties with delivery of medications in the next few weeks?

• Do you feel you are safely able to isolate at home?

• Do you have a Primary Care Provider you could contact for questions about symptoms?

• Are there any concerns about taking time off from work to isolate or quarantine?

• Do you have a way to get to a COVID testing site?

• How are you and your family coping during this time?
Assessment: Screening

If you can only ask one screening question:

"Let’s think forward about two weeks. Are there any concerns that come to mind when you think about getting through that time at home? "

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Strategies for Success in Serving Your Community

• Hiring multilingual staff and using interpreter services with training
  • Reimbursement for interpreter services available

• Specific knowledge of supporting marginalized populations
  • Recruit staff from within communities served
  • Trauma-Informed Care and Cultural Humility

• Close partnerships with community health centers and community organizations
  • Maintaining existing relationships: Community Resource Guides and Introductions
  • Building additional capacity

• Prioritization of health equity and social justice as part of every public health response
  • Build resilience and long-term stability through interviews and resource coordination
Resource Available: Interpreter Services

Resources for Your Community:

• DPH is providing full reimbursements for interpretation services through June 2022. Three different vendors are available to choose from.

Specific Knowledge of Supporting Marginalized Populations

• **Trauma-Informed Care** realizes the widespread impact of trauma and understands potential paths for recovery; recognizes the signs and symptoms of trauma in clients; and responds by fully integrating knowledge about trauma into policies, procedures, and practices, and seeks to actively resist re-traumatization. (SAMHSA)

• **Cultural Humility** may be defined as a process of being aware of how people's culture can impact their health behaviors and in turn using this awareness to cultivate sensitive approaches to care.
## Trauma-Informed Care & Cultural Humility in Practice

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<th>Accompaniment</th>
<th>Empowerment</th>
<th>Autonomy</th>
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| • Empathy and Compassion  
• Active Listening  
• Signal non-judgement  
• "We can work on this together." | • Provide information, resources, and tools to support people caring for themselves and their families  
• Set healthy boundaries | • The case/contact is the expert in their own life  
• Ask for Consent  
• Respond to the Priorities |
Efficient Local Resource Utilization

• Maintain and create relationships with regional external partners to facilitate partnership, collaboration, and long-term solutions
• Stay current on updates to resource availability and wait time
• Anticipate gaps in routine services or resources. Are there upcoming weekends and holidays that might create challenges for cases/contacts or support services?
• Do you have backup resources? Partnerships with additional organizations or adjoining communities can help build redundancy
• Advocate for resources that match the needs of your community, including culturally relevant food and other essential items like hygiene products, cleaning supplies, and diapers
Building Local Capacity

Questions for local resource partners:

- Do you offer delivery and/or no-contact pickup? What is the turnaround time for delivery?
- What is the best way to refer someone to you?
- Which languages are spoken by your staff? Do you use interpreter services?
- Do individuals have a choice of food pantry items? Do you provide culturally-specific food items?
- Are there ways in which you support specific communities?
Role Play

- Case is the mother of two daughters
- She works at a daycare and was called by a contact tracer as part of a cluster investigation
- The younger daughter attends the daycare and is also a positive case
- The older daughter goes to school, and is a contact
- Mom is vaccinated, the children are not
- Family recently moved from another part of the state, and have almost no social support in the area
- Mom is overwhelmed
Resources for Local Health

• Reimbursement for interpreter services

• Community Resource Guides will be available this month
  • Reach out to your Local Health Liaison for more information

• Upcoming MAVEN Webinar on Building Trust
In Summary

**Creating close connections with populations and communities**
- Anticipating challenges and knowing how to respond effectively. This is done through building advocacy and trust (essential for communities that are historically marginalized)

**Collaborations and partnerships with community organizations**
- Collaborating with these organizations strengthens the community's response, identifies gaps in resource coverage, and promotes cross-agency support where there is overlap – schedule monthly meetings to share knowledge
- Connecting individuals with social services addresses the short-term need for safe isolation and quarantine, plus supports long-term stability

**Supporting vulnerable populations**
- Assessment identifies barriers to quarantine and isolation, safety concerns, and urgent needs
- Identification of population-specific resources (elderly, disabled, people experiencing homelessness and/or financial distress, undocumented individuals, LGBTQIA+)
- Appropriate training with an emphasis on empathy
Thank you for your time!
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*Thanksgiving week* | *Winter holidays*
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