Containing the Spread of COVID-19 through Contact Tracing

HCGC Webinar Series
Wednesday, July 22, 2020
During the Webinar

- Please **mute** your phone and/or computer to reduce background noise.
- This webinar is being recorded. The recording, slides, and supplemental materials will be posted on our website following the webinar.
- If you have a question please use the **chat feature** in Zoom or hold it until the Community Discussion at the end of the webinar.
Welcome to our Presenters

Webinar: Containing the spread of COVID-19 through Contact Tracing

Wednesday, July 22nd
10:00 AM - 12:00 PM

- Historical context
- Best practices
- Lessons learned
- Innovative models to reach vulnerable populations

Featured Presenters:

Alex Jones, MS, RN, CPH
Assistant Health Commissioner
Director of Prevention and Wellness
Franklin County Public Health

Jill Feldstein, MPH
Chief Operating Officer
Penn Center for Community Health Workers
University of Pennsylvania

John Welch, DNP, MS, CRNA
Executive Director
Massachusetts Community Tracing Collaborative
Partners In Health

www.hcgc.org/events
HCGC Overview

OUR MISSION

To improve the quality, delivery, and value of healthcare and the overall health for all people in the Columbus region.

OUR VISION

Optimal health for all people in the Columbus region.

WHAT WE DO

Using a collaborative process, we are:
- Fostering shared learning and communication,
- Collecting and sharing aggregate health data, and
- Scaling knowledge and innovation.
Health Disparities:
HCGC’s mission is designed to serve “all people.” However, we are acutely aware that total population measures can hide wide-ranging disparities among different portions of our community. HCGC is committed to seeking opportunities to close health disparity gaps.

Employers as Key Healthcare Stakeholders:
Employers play a special role in funding our current healthcare system. HCGC has experienced that the wide variety in the Central Ohio’s self-insured and fully insured employer market makes singular employer strategies impractical. HCGC seeks opportunities to address cost issues whenever possible.
HCGC Supporters

100% of our Board of Directors & Staff

Individual & Corporate Donations

Healthcare Collaborative of Greater Columbus
Healthcare Improvement with a Regional Focus

One of over 30 Regional Health Improvement Collaboratives (RHICs) across the country

HCGC is a non-profit organization with multi-stakeholder governance, fully supported by grants, sponsorships and project work.
Partners In Health (PIH) is a global non-profit, social justice organization striving to make health care a human right for all people, starting with those who need it most.

"The idea that some lives matter less is the root of all that is wrong with the world."

Dr. Paul Farmer
“Our mission is to provide a preferential option for the poor in health care. By establishing long-term relationships with sister organizations based in settings of poverty, Partners In Health strives to achieve two overarching goals: to bring the benefits of modern medical science to those most in need of them and to serve as an antidote to despair”
Founded in Cange
Haiti, 1983

University Hospital Mirebalais
Haiti, 2013
SOCIAL JUSTICE

A specific view of the world based on solidarity principles compels us to expose injustice that leads to poverty and sickness and to fight for the universal human right to health.

This is why we fight.

MEDICAL WORK

Our Work is medical in nature. We believe our expertise and research can be used to cure not only our patients but also the root causes of rising inequality.

This is how we do it.
Fundamentals of health systems strengthening

- **STAFF:** Well-trained, qualified staff in sufficient quantity to respond to need
- **SOCIAL SUPPORT:** Providing basic necessities and resources needed to ensure effective care
- **SYSTEMS:** Leadership and governance, information, financing
- **STUFF:** Ensuring the tools and resources needed for care delivery and administration
- **SPACE:** Safe, appropriate spaces with capacity to serve patients
Test
Increase access to testing and number of people tested so people with COVID-19 are aware of their diagnosis and can self-isolate

Trace
Trace all contacts of people with COVID-19 to ensure safe quarantine and testing for those who need it

Isolate
Put transmission to a stop through timeline and safe isolation and quarantine for people with COVID-19 and their contacts

Support
Identify vulnerability and address needs for social assistance so all people can safely isolate and quarantine
Contact Tracing: The Wuhan Experience

Significant lockdown alone

Contact tracing and Supported isolation
MA Community Tracing Collaborative

Governor’s Covid-19 Command Operations

General Contractor
- State-run insurance Exchange (ACA HIX)
- Quasi-public
- Consistent with Federal/State funding streams

Workforce Partner
- Partners In Health
  - Community Health Centers

Technology Partner
- Accenture
  - Call Center Platform

Digital Automation Partners
- TBD

State/Local Public Health Authorities

Timeline
- 7 days to establish
  - Mobilize General Contractor
  - Select key partner organizations
  - Begin hiring, onboarding, training
  - Select & configure CRM, integrate with digital apps
  - Integrate with State DB

- 6 days to operations launch
- 13 days total to go-live

State EPI Database
- system of record “MAVEN”
Breaking the Chains of Transmission

![Graph showing a significant increase in cases on April 12, labeled 2,615, and a peak in May 27 with 107,221 cases. The graph is attributed to Community Tracing Collaborative and Partners in Health.](image)
“The more they are suffering, the more natural their sufferings appear. Who wants to prevent the fishes in the sea from getting wet?”

Bertolt Brecht
Linking Contact Tracing to Care

- **Care Resource Coordinators:**
  - Speak 23 languages
  - Recruited from MA communities
  - Experienced professionals in social work, nursing, psychology, public health, and more
  - Geographically assigned
  - Work within local communities and in collaboration with local partners
  - Work to connect and communicate with health network as vulnerabilities are discovered
  - Geographic task forces across stakeholders to coordinate
CRC Team Structure

- **Resource Navigators**
  Supervise CRCs and support logistics, document lessons learned, lead local partnerships, and liaise with LBOH

- **Thematic Working Groups**
  Bring together content experts to develop protocols, train staff, and lead evidence-based and community-linked strategy in key topic areas

- **Geographic Task forces**
  Multi-sectoral groups to collectively identify barriers to safe isolation and implement joint strategies

**Immigration**  **Violence**  **Benefits**

**Brockton**  **Pending**

**Mental Health & Substance Use sub-committee**

**Communication**
- Weekly meetings
- Daily Bulletin
- Shared Documentation
- Case Review
- People’s Hero and Notes from the Field
- Daily Team Huddles

**Partners In Health**
Care Resource Coordination Workflow

1. Vulnerability identified during home assessment in initial case investigation / contact tracing

- Food
- Housing
- Medications
- Mobility / ADL
- Household Items
- Social connectedness
- PCP Referral
- Safety Concerns

2. Contact tracing team indicates type of assistance needed, priority level, and refers to care resource coordinator

3. CRC works to connect case or contact to resources

- Triage
- Gather more information
- Research
- Connect to LBOH
- Connect to services
- Document key milestones
- Follow up
- Warm handoffs
## Referrals by Type of Resource

<table>
<thead>
<tr>
<th>Type of Resource requested</th>
<th>Number of Referrals</th>
</tr>
</thead>
<tbody>
<tr>
<td>Food</td>
<td>285</td>
</tr>
<tr>
<td>Specific Household Items</td>
<td>147</td>
</tr>
<tr>
<td>Financial Assistance</td>
<td>98</td>
</tr>
<tr>
<td>Find a PCP</td>
<td>81</td>
</tr>
<tr>
<td>Connecting to Unemployment</td>
<td>72</td>
</tr>
<tr>
<td>Housing</td>
<td>71</td>
</tr>
<tr>
<td>Clinical Care</td>
<td>56</td>
</tr>
<tr>
<td>Medication</td>
<td>26</td>
</tr>
<tr>
<td>Request for Employer Note</td>
<td>20</td>
</tr>
<tr>
<td>Referral to Isolation</td>
<td>12</td>
</tr>
<tr>
<td>Other</td>
<td>9</td>
</tr>
<tr>
<td>Referral for Mental Health</td>
<td>8</td>
</tr>
<tr>
<td>Social Network Connections</td>
<td>8</td>
</tr>
<tr>
<td>Support for Chronic</td>
<td>8</td>
</tr>
<tr>
<td>Child Care/Elder Care</td>
<td>7</td>
</tr>
<tr>
<td>Lack of Mobility</td>
<td>6</td>
</tr>
<tr>
<td>Concern for Safety</td>
<td>3</td>
</tr>
</tbody>
</table>

*Partners In Health*
Referrals to CRCs: A Consistent Need
Leadership & Partnership in Massachusetts

JRI; Khalsa Aid; Nesterly; Shopping Angels; Family Van; CCBC; Community Servings; Harvard Medical School
CARE FOR THE HUMAN FIRST.
THEN TREAT THE DISEASE.
A national center of excellence for CHW research, implementation and dissemination

**RESEARCH**
- Formative: 1,500 patient interviews
- Evaluative: Three RCTs improved primary care access, quality, mental health, reduced hospitalization
- $2.47 saved for every $1 spent

**PATIENT CARE**
- More than 12,000 individuals served in Philadelphia

**DISSEMINATION**
- 50 member organizations in 20 states
THE PROBLEM(S)
Community Health Workers: Social First Responders in the COVID Pandemic

TEST, TRACE AND ISOLATE
Community Health Workers: Social First Responders in the COVID Pandemic

Deferred Preventive Care
HEALTH BEHAVIORS
ECONOMIC CHALLENGES
A PART OF THE SOLUTION
STRONG FUNDAMENTALS

- Hiring
- Training
- Supervision
- Duration & Case Loads
- Holistic Workflows
- Quality Control
- Standardized Playbooks
Community Health Workers: Social First Responders in the COVID Pandemic
WORKFLOW

1. Text/call patient
2. Explain checking in on them during COVID
3. Get to know them
4. Offer tailored resources
5. Consents
6. Offer cell phone and stay in touch for 2-4 weeks
7. Contact tracing
<table>
<thead>
<tr>
<th>VIRTUAL RESOURCES</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>COVID-19 CONTAINMENT</strong></td>
</tr>
<tr>
<td>Woman with recent fever and cough who is worried she may have COVID.</td>
</tr>
<tr>
<td>• Conduct/support contact tracing with local health dept</td>
</tr>
<tr>
<td>• Share COVID prevention strategies</td>
</tr>
<tr>
<td>• Create public service announcements</td>
</tr>
<tr>
<td>• 3-way calls with providers</td>
</tr>
<tr>
<td>• Arrange for pharmacy to deliver meds</td>
</tr>
<tr>
<td>• Arrange for delivery of medical equipment</td>
</tr>
<tr>
<td><strong>HEALTH BEHAVIOR CHANGE</strong></td>
</tr>
<tr>
<td>Man struggling to lose weight and quit smoking.</td>
</tr>
<tr>
<td>• Digital tracking computer programs/apps</td>
</tr>
<tr>
<td>• Online resources for at-home exercises</td>
</tr>
<tr>
<td>• Virtual exercise group</td>
</tr>
<tr>
<td><strong>RESOURCES FOR DAILY LIFE</strong></td>
</tr>
<tr>
<td>Single mother laid off and home with young children who are out of school</td>
</tr>
<tr>
<td>• 211 or online resource directories (e.g. Aunt Bertha)</td>
</tr>
<tr>
<td>• Arrange delivery of food, essential supplies</td>
</tr>
<tr>
<td>• Free education resources and activities to help with homeschooling</td>
</tr>
<tr>
<td>• Assist patients with filling out paperwork or applications for benefits, etc.</td>
</tr>
<tr>
<td><strong>HEALTH SYSTEM NAVIGATION</strong></td>
</tr>
<tr>
<td>Older man without internet or tele-health portal who needs dialysis</td>
</tr>
<tr>
<td>• 3-way phone call to providers to facilitate telephone visits</td>
</tr>
<tr>
<td>• Arrange essential services like dialysis</td>
</tr>
<tr>
<td><strong>PSYCHOSOCIAL SUPPORT</strong></td>
</tr>
<tr>
<td>Woman stuck at home with her abusive partner</td>
</tr>
<tr>
<td>• CHW to provide ongoing social support (e.g., weekly calls)</td>
</tr>
<tr>
<td>• Crisis hotlines for mental health or intimate partner violence</td>
</tr>
<tr>
<td>• Refer to SW for telephonic therapy</td>
</tr>
<tr>
<td>• Computer/apps for cognitive behavioral therapy</td>
</tr>
<tr>
<td><strong>COLLECTIVE ACTION</strong></td>
</tr>
<tr>
<td>Patient who is frustrated that in her neighborhood, trash hasn’t been picked up and that there isn’t enough information about COVID testing</td>
</tr>
<tr>
<td>• Voter registration info</td>
</tr>
<tr>
<td>• 311 for city service requests</td>
</tr>
<tr>
<td>• 211 for resources on block captain associations, clean-up</td>
</tr>
<tr>
<td>• Text COVID to 888-777 for updates from City</td>
</tr>
</tbody>
</table>
The COVID-19 Ground Game
Proven Community Health Worker Solutions for Public Health Challenges.

CHW.UPENN.EDU
THE FUTURE
Take Action.
IMPaCT is leading a national coalition to support sustainable CHW programs.
Thank you!

Jill Feldstein

jill.feldstein@pennmedicine.upenn.edu

chw.upenn.edu
FCPH COVID-19 Public Health Investigation Overview

HCGC: Containing the Spread of COVID-19 Through Contact Tracing

Alexandria (Alex) Jones, MS, RN, CPH
Assistant Health Commissioner & Director of Prevention & Wellness
COVID-19 Timeline

- **December 2019** - First cases identified in Wuhan City, Hubei Province, China in patients

- **January 21, 2020** – First case in the United States is a traveler returning from Wuhan City

- **March 9, 2020** – First case is reported in Ohio

- **March 12, 2020** - First case reported in FCPH jurisdiction

- **Present** – Widespread ongoing community spread in most countries around the world
Clinical Features of COVID-19

> Anyone can have mild to severe symptoms
  • Some people infected with COVID-19 will not develop symptoms
  • Older adults and people who have severe underlying medical conditions seem to be at higher risk for developing severe illness

> Symptoms may appear 2-14 days after exposure
  • Cough, sore throat, shortness of breath or difficulty breathing, fever, chills, muscle pain, new loss of taste or smell
  • Other less common symptoms include nausea, vomiting, or diarrhea

> Reinfecion after recovery?
  • The immune response to COVID-19 is not yet understood. Individuals with MERS-CoV infection are unlikely to be reinfected shortly after they recover, but it is not yet known whether similar immune protection will be observed for individuals with COVID-19
Transmission of COVID-19

> COVID-19 is primarily spread from person-to-person between people who are in close contact
  > Respiratory droplets produced when an infected person coughs, sneezes, or talks can land in the mouths, noses, or eyes of people who are nearby, or possibly be inhaled into the lungs

> Infected individuals may be capable of transmitting the virus 48 hours before their symptoms start

> Recent studies have suggested that COVID-19 may be spread by people who are not showing symptoms
## Confirmed vs. Probable Cases

<table>
<thead>
<tr>
<th>Laboratory</th>
<th>Clinical</th>
<th>Epidemiologic Link</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Confirmatory:</strong> Positive PCR test result</td>
<td>At least one: cough, shortness of breath, or difficulty breathing and no alternative more likely diagnosis</td>
<td>Close contact to a confirmed or probable case of COVID-19</td>
</tr>
<tr>
<td><strong>Presumptive:</strong> Positive antibody test result</td>
<td>At least two: fever (measured or subjective), chills, rigors, myalgia, headache, sore throat, new olfactory and taste disorder(s) and no alternative more likely diagnosis</td>
<td>Is a member of a risk cohort: healthcare worker, first responder, hospitalized patient, long-term care facility resident, or member of other congregate setting</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>&gt; Confirmed Case</th>
<th>&gt; Probable Case</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Confirmatory lab</td>
<td>• 1 Clinical AND 1 Epidemiologic Link</td>
</tr>
<tr>
<td></td>
<td>• Presumptive lab + 1 Clinical</td>
</tr>
<tr>
<td></td>
<td>• Presumptive lab + 1 Epidemiologic Link</td>
</tr>
</tbody>
</table>
# Social Distancing vs. Quarantine

<table>
<thead>
<tr>
<th>Social Distancing</th>
<th>Quarantine</th>
</tr>
</thead>
<tbody>
<tr>
<td>General practice recommended to limit close contact with others</td>
<td>Separates someone who may have been exposed to COVID-19 away from others</td>
</tr>
<tr>
<td>Maintain at least 6 feet from other people (about 2 arm’s length)</td>
<td>Stay home for 14 days from last exposure to COVID-19. No visitors</td>
</tr>
<tr>
<td>Avoid crowded places or mass gatherings</td>
<td>Frequently wash hands</td>
</tr>
<tr>
<td>Telework and online classes</td>
<td>Avoid sharing personal household items like dishes or towels</td>
</tr>
<tr>
<td>Virtual visits with friends and family</td>
<td>Self-monitor for symptoms of COVID-19</td>
</tr>
</tbody>
</table>

**EVERYONE**

**CONTACTS**
## Isolation vs. Quarantine

<table>
<thead>
<tr>
<th>Isolation</th>
<th>Quarantine</th>
</tr>
</thead>
<tbody>
<tr>
<td>&gt; Separates sick people from others</td>
<td>&gt; Separates someone who may have been exposed to COVID-19 away from others</td>
</tr>
<tr>
<td>&gt; Stay home at least 10 days from the start of symptoms. No visitors</td>
<td>&gt; Stay home for 14 days from last exposure to COVID-19. No visitors</td>
</tr>
<tr>
<td>&gt; Limit contact with household members by using your own room &amp; bathroom, if possible</td>
<td>&gt; Frequently wash hands</td>
</tr>
<tr>
<td>&gt; Avoid sharing personal household items like dishes or towels</td>
<td>&gt; Avoid sharing personal household items like dishes or towels</td>
</tr>
<tr>
<td>&gt; Clean and disinfect high-touch surfaces. Wash your hands frequently</td>
<td>&gt; Self-monitor for symptoms of COVID-19</td>
</tr>
</tbody>
</table>

### CASES

### CONTACTS
# Discontinuation of Isolation

## Symptomatic Case
- Can be released from isolation **11 days* after onset** of symptoms if:
  - At least 3 days have passed since resolution of fever **AND** respiratory symptoms began improving

## Asymptomatic Case
- Can be released from isolation **11 days* after specimen collection date** if no symptoms develop during isolation

*Use **14 day** isolation period for cases returning to congregate settings, who are hospitalized, or who are immunocompromised

<table>
<thead>
<tr>
<th>0 Onset or Collection Date</th>
<th>1 First Day of Isolation</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
</tr>
</thead>
<tbody>
<tr>
<td>7</td>
<td>8</td>
<td>9</td>
<td>10 Potential Last Day of Isolation</td>
<td>11 Release from Isolation</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
**Discontinuation of Quarantine**

> Contacts

- Can be released from quarantine **15 days after last exposure** to case if they do not develop symptoms
- Contacts who become cases are moved from quarantine to isolation

<table>
<thead>
<tr>
<th>Day of Last Exposure</th>
<th>First Day of Quarantine</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
</tr>
</thead>
<tbody>
<tr>
<td>7</td>
<td>8</td>
<td>9</td>
<td>10</td>
<td>11</td>
<td>12</td>
<td>13</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Last Day of Quarantine</th>
<th>Release from Quarantine</th>
</tr>
</thead>
<tbody>
<tr>
<td>14</td>
<td>15</td>
</tr>
</tbody>
</table>
Epidemiology Update for COVID-19 for
Franklin County Public Health, 2020
July 20, 2020, 10:00am

<table>
<thead>
<tr>
<th>COVID-19 Case Data*</th>
<th>3,700 (3,557 Confirmed, 143 Probable)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Cases</td>
<td>3,700</td>
</tr>
<tr>
<td>Age Range</td>
<td>&lt;1 – 102 years</td>
</tr>
<tr>
<td>Median Age</td>
<td>41 years</td>
</tr>
<tr>
<td>Gender</td>
<td>1,934 female 1,684 male</td>
</tr>
<tr>
<td>Hospitalized (overall)</td>
<td>310</td>
</tr>
<tr>
<td>ICU Admissions (overall)</td>
<td>87</td>
</tr>
<tr>
<td>Deaths***</td>
<td>115 (76 White, 30 Black, 3 Asian, 2 Hispanic, 4 Unknown)</td>
</tr>
<tr>
<td>Onset Date Range</td>
<td>01/15/2020 – 07/16/2020</td>
</tr>
<tr>
<td>Asymptomatic Cases</td>
<td>440</td>
</tr>
</tbody>
</table>

*Data are pulled from the Ohio Disease Reporting System and are subject to change as additional information is gathered. Some data may have a lag time based on completion of case finding at the time of this report. **Probable case counts added to the data as of 4/14/2020. ***Cause of death has not yet been determined.

Cases in Franklin County Public Health Jurisdiction Residing in Another County:

<table>
<thead>
<tr>
<th>County</th>
<th>Cases</th>
</tr>
</thead>
<tbody>
<tr>
<td>Franklin</td>
<td>3,177</td>
</tr>
<tr>
<td>Union</td>
<td>17</td>
</tr>
<tr>
<td>Fairfield</td>
<td>261</td>
</tr>
<tr>
<td>Delaware</td>
<td>74</td>
</tr>
<tr>
<td>Licking</td>
<td>164</td>
</tr>
</tbody>
</table>

https://covid-19.myfcph.org/
> As defined in Ohio law, FCPH provides service to all townships and villages in Franklin County.
> 14 cities in Franklin County also contract with FCPH to serve as their health department.

<table>
<thead>
<tr>
<th>City</th>
<th>Village</th>
<th>Township</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bexley</td>
<td>Brice</td>
<td>Blendon</td>
</tr>
<tr>
<td>Canal Winchester</td>
<td>Harrisburg</td>
<td>Brown</td>
</tr>
<tr>
<td>Dublin</td>
<td>Lockbourne</td>
<td>Clinton</td>
</tr>
<tr>
<td>Gahanna</td>
<td>Marble Cliff</td>
<td>Franklin</td>
</tr>
<tr>
<td>Grandview Heights</td>
<td>Minerva Park</td>
<td>Hamilton</td>
</tr>
<tr>
<td>Grove City</td>
<td>Obetz</td>
<td>Jackson</td>
</tr>
<tr>
<td>Groveport</td>
<td>Riverlea</td>
<td>Jefferson</td>
</tr>
<tr>
<td>Hilliard</td>
<td>Urbancrest</td>
<td>Madison</td>
</tr>
<tr>
<td>New Albany</td>
<td>Valleyview</td>
<td>Mifflin</td>
</tr>
<tr>
<td>Pickerington</td>
<td></td>
<td>Norwich</td>
</tr>
<tr>
<td>Reynoldsburg</td>
<td></td>
<td>Perry</td>
</tr>
<tr>
<td>Upper Arlington</td>
<td></td>
<td>Plain</td>
</tr>
<tr>
<td>Westerville</td>
<td></td>
<td>Pleasant</td>
</tr>
<tr>
<td>Whitehall</td>
<td></td>
<td>Prairie</td>
</tr>
<tr>
<td>Whitehall</td>
<td></td>
<td>Sharon</td>
</tr>
<tr>
<td>Worthington*</td>
<td></td>
<td>Truro</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Washington</td>
</tr>
</tbody>
</table>

* Provide plumbing services only
Jurisdiction

> FCPH provides service to 14 cities and all of the townships and villages in Franklin County
  - Columbus Public Health provides service to Columbus and Worthington

> FCPH also serves the portions of these cities that overlap with surrounding counties
  - Dublin into Delaware and Union Counties
  - New Albany into Licking County
  - Reynoldsburg into Fairfield and Licking Counties
  - Pickerington into Fairfield County
  - Westerville into Delaware County

> FCPH is responsible for cases, contacts and facilities that are located within our jurisdiction
  - Data collected on cases, contacts, or facilities outside our jurisdiction get transferred to the appropriate local health department
Jurisdiction

Franklin County Public Health

Columbus Public Health
Contact tracing for COVID-19 typically involves:

- Interviewing people with COVID-19 to identify everyone they had close contact with during the time they may have been infectious
- Notifying contacts of their potential exposure
- Referring contacts for testing if become symptomatic
- Monitoring contacts for signs and symptoms of COVID-19
- Connecting contacts with services they might need during the self-quarantine period
Positive results reported from labs, providers, or ODRS

Jurisdiction is confirmed and case is added to line list

Contacts identified & added to line lists

Case investigation team attempts to contact the case

Unable to contact after several attempts

Home attempt

Initial contact & interview complete

Case isolated if criteria for d/c of isolation are not met

Isolation order sent

Interview completed if probable

F/u for d/c of isolation

Disease containment team notifies employers, daycares, LTCFs, or other LHDs

Disease containment team works with facility to identify, notify, and quarantine additional contacts & prevent future spread

Contact investigation team notifies contact & provides quarantine guidance

Contact investigation team monitors contacts for symptoms

F/u for d/c of quarantine and self-monitoring

Case investigation team determines if contact now meets probable case definition

Contact investigation team notifies case investigation team if a contact develops symptoms
> Sense of urgency

- Public health is sometimes the first to notify people that they have tested positive or have been exposed to COVID-19
- Behavior change (staying home) is more likely when someone is contacted directly by public health and asked to stay home
- The sooner we speak with these individuals and ask them to stay at home, the sooner we can prevent further exposures by them
Incident Command Structure – IDER Operations

- Radha Sayer
  - IDER Ops Chief
  - Brooke Vaughan
    - Disease Containment Branch Chief
      - Susan Hamilton
        - Non-Healthcare Containment Lead
          - Terry Bugg
            - Non-Healthcare Containment
          - Mitali Dalwadi
            - Non-Healthcare Containment
          - Sue Figler
            - Non-Healthcare Containment
          - Angela Baca
            - Non-Healthcare Containment
          - Tabitha Palmer
            - Non-Healthcare Containment
        - Alyssa Grothaus
          - Healthcare Containment Lead
          - Mary Taylor
            - Healthcare Containment
          - Denise Tomn
            - Healthcare Containment
          - Paula Miesler
            - Healthcare Containment
        - Paula M/Brooke H
          - Facility Containment Leads
      - David Norris
        - Data Coordination Lead
        - Lawrence Ware
          - Data Coordinator
      - Kara Keller
        - Contact Investigation Lead
      - Alex Evans
        - Case Investigation Lead
      - Nikki Stout
        - Case Investigation Lead
      - Scott Brewer
        - Isolation Clearance Lead
        - Scott Brewer
          - Epi and Sur Branch Chief
          - Charlie B/Trevor R
            - Isolation Resident Service Lead
      - Jenn Kerr (PT)
        - Case Investigation
      - Melissa Xidas
        - Case Investigation
      - Naveen Gurephi
        - Case Investigation
      - Terek Beyene
        - Case Investigation
      - Gabi Boehm
        - Case Investigation
      - Mana Bonfiglio
        - Case Investigation
      - Anissa Bingman
        - Case Investigation
Confidentiality

> All personal information that we obtain from a case or contact is held in strict confidentiality.

> Some cases or contacts have questions on why we are trying to gather that information

  > ONLY used for the purpose of public health investigation and contact tracing so we can notify those who may have been exposed.

  > Trust is key!
> Trust during the case interview and contact tracing paramount
> Critical that workforce is reflective of communities we serve
> Social needs exacerbated in the COVID-19 pandemic
> Contracting with HCGC HUB to have CHWs provide public health investigation services
  • Assisting with providing wrap around services to some of our most vulnerable populations
Thank You!!

Questions?:

Alex Jones: alexjones@franklincountyohio.gov

https://covid-19.myfcph.org/
Social Determinants

Health Behaviors
30%

Social and Economic Factors
40%

Clinical Care
20%

Physical Environment
10%
Social Determinants

Healthcare Collaborative of Greater Columbus
How the HUB works in Central Ohio

**CARE COORDINATION IN CENTRAL OHIO**
Community Health Workers (CHWs) serve as partners, advocates, and coaches for their clients and work to identify health needs and risks. Each risk is then translated into a pathway—including unmet needs for transportation, housing, and more—and tracked through completion in an electronic database. CHWs are employed by medical clinics, social service agencies, and other organizations throughout the region. There are currently 12 Care Coordination Agencies (CCA's) employing over 30 CHWs participating the HUB:

- CelebrateOne
- Columbus Urban League
- Franklin County Public Health
- Heart of Ohio Family Health Centers
- PrimaryOne Health
- Physicians CareConnection
- The Breathing Association
- OhioHealth
- Urban Strategies
- Wellness First
- Ethiopian Tewahedo Social Services
- Union County Public Health

**HOW IT WORKS**

1. **Find:** CHWs enroll clients in the HUB. Healthcare providers and others refer clients to the HUB.

2. **Engage:** Once enrolled, clients complete a comprehensive assessment to identify health and social service needs (risks).

3. **Plan:** CHW works with their supervisor to develop a plan of care based on the identified risks. Each risk translates into a standardized Pathway.

4. **Problem Solve:** CHWs meet regularly with clients in their homes to build trusting relationships and offer support. Behavioral change is supported through the use of Learning Modules.

5. **Track:** HUB staff reviews data on a regular basis to ensure that clients receive a high quality and meaningful experience. The HUB works to reduce duplication of services and identify community gaps in resources.

6. **Pay:** HUBs bill Medicaid managed care plans and other funding partners for successfully completing Pathways. HUBs distribute payments to the organizations that employ CHWs. HUBs keep a small administrative fee.
A CERTIFIED NATIONAL MODEL

The Pathways HUB Model encompasses community network development guidance, incentives for community-based organization collaboration, client and family risk assessments, CHW training, Pathways risk-mitigation workflows to confirm that outcomes are achieved, as well as billing and common reporting and benchmarks. When combined, these tools help communities in their initiatives to improve health equity and measure success of those initiatives. With published evidence of both outcome improvement and cost savings, this approach and its national Certification is officially recognized by both payers and policy makers focused on pay for outcomes.

Certified Pathways Community HUB Model Endorsers
20 Core Pathways

- Adult Education
- Employment
- Health Insurance
- Housing
- Medical Home
- Medical Referral
- Medication Assessment
- Medication Management
- Smoking Cessation
- Social Service Referral
- Behavioral Health Referral
- Developmental Screening
- Developmental Referral
- Education
- Family Planning
- Immunization Screening
- Immunization Referral
- Lead Screening
- Pregnancy
- Postpartum
Central Ohio Pathways HUB: Current Data
*As of 7.20.2020

622 Active Clients
1,200 Total Clients Served
5,888 Pathways Completed

Care Coordination in the
#CentralOhioHUB

Healthcare Collaborative of Greater Columbus
Central Ohio Pathways HUB: Current Data

*As of 7.6.2020

Eligibility Category Makeup
• Adult – 1/3 of clients
• Maternal - 1/3 of clients
• Pregnant – 1/3 of clients

*Pediatric-new as of May 2020-Important amidst pandemic to ensure families are keeping up with pediatric vaccinations to avoid other communicable disease cases from spiking

89% of babies born to mothers in the Central Ohio Pathways HUB...

...are born at a healthy birth weight.

#CentralOhioHUB
#CollaborateColumbus

Healthcare Collaborative of Greater Columbus
Care Coordination in the COVID-19 Pandemic

Early April:

- HUB community health workers are providing updated COVID-19 education, tools, and care coordination to their clients to address health disparities in Central Ohio

February: 219 Client Check-ins
March: 278 Client Check-ins

As of March 1:
343 Pathways Opened
325 Pathways Completed

- Exponential increase in education pathways regarding proper handwashing and social distancing

COVID-19 Response

Call For Medical Volunteers:
Urgent Need: If you are an EMT, LPN, RN, CHW, medical student, nursing student, or other healthcare professional

YOUR HELP IS NEEDED!

The Community Need...
To improve the surge capacity of area health systems and to improve public health in Columbus and Franklin County, the Community Shelter Board is coordinating a community response to provide shelter for homeless people not in need of hospitalization but require COVID isolation and quarantine.

The YMCA of Central Ohio is professionally managing dedicated and secure Shelters for Isolation and Quarantine (SIQ). We are seeking medical volunteers to help with patient intake and monitoring—personal protective equipment (PPE) provided.

How you can help...
Please volunteer for one or more shifts (7:00am-3:00pm or 3:00pm-11:00pm, 7 days a week) via the link provided.

Volunteers will work with onsite YMCA staff and remote SIQ medical advisors from OhioHealth Grant Addiction Medicine (led by Krisanna L. Deppen, MD) to provide medical support for homeless men, women, and families.

PPE Provided:
- Masks
- Gloves
- Face shields
- Shoe covers
- Gowns
- Safety glasses

Contact:
Please contact Jeff Biehl at jeff@biehlcollaborative.com or 614-906-2440 with your questions or feedback.

Healthcare Collaborative of Greater Columbus
Care Coordination in the COVID-19 Pandemic Early April:

Advice for you and your family regarding COVID-19 (Coronavirus) Outbreak

Ohio Governor DeWine has issued a “Stay at Home” order which requires all Ohioans to stay at home, and limit trips to essential errands only.

To avoid catching & spreading germs:
- Stay home. Ohio Governor has ordered that all Ohioans stay at home. You will still have access to the things needed to keep the community healthy and safe, including grocery stores, pharmacies and health care.
- Avoid contact with people who are sick
- Sleep well and eat healthy foods
- Wash hands often with water and soap (20 seconds or longer)
- Dry hands with a clean towel or air dry your hands
- Cover your mouth with a tissue or sleeve when coughing or sneezing
- Avoid touching your eyes, nose, mouth with unwashed hands or after touching surfaces
- Clean surfaces that are touched frequently often
- Call before visiting your doctor
- Practice good hygiene habits

For assistance from African American Alzheimer’s & Wellness Association:
Call: 800-489-6040 or 614-940-6091
email: contact@africanamericanalz.org

Central Ohio Pathways HUB

Signs of COVID-19 and who is most at risk:
- Fever, cough, and difficulty breathing.
- Most people who become sick do not require hospitalization, but older adults, people with chronic health conditions, and people with compromised immune systems are more likely to require more advanced care.
- NOTE: It is possible to have COVID but not have any symptoms. You can still pass it to others who might become more seriously sick. It is important that all people stay home as much as possible.

If you think you are sick or have been exposed to someone who is sick:
- Stay home and keep away from other people in your home
- DO NOT go to the Emergency Room or your doctor’s office. CALL FIRST. They will tell you if you should go in, stay home, or tell you where to go for COVID testing

Ohio Department of Health (ODH) has opened a call center to answer questions regarding coronavirus (COVID-19). The call center will be open 7 days a week from 9:00 a.m. to 8:00 p.m. and can be reached at 1-833-4-ASK-ODH (1-833-427-5634)
Care Coordination in the COVID-19 Pandemic

Inequities amplified, need for care coordination increased

New HUB Clients Per Month

<table>
<thead>
<tr>
<th>Month</th>
<th>New HUB Clients</th>
</tr>
</thead>
<tbody>
<tr>
<td>October 2019</td>
<td>63</td>
</tr>
<tr>
<td>November 2019</td>
<td>59</td>
</tr>
<tr>
<td>December 2019</td>
<td>66</td>
</tr>
<tr>
<td>January 2020</td>
<td>64</td>
</tr>
<tr>
<td>February 2020</td>
<td>77</td>
</tr>
<tr>
<td>March 2020</td>
<td>76</td>
</tr>
<tr>
<td>April 2020</td>
<td>88</td>
</tr>
<tr>
<td>May 2020</td>
<td>114</td>
</tr>
</tbody>
</table>

Stay at home order

Central Ohio Pathways HUB

Healthcare Collaborative of Greater Columbus
Contact Tracing

- Franklin County Public Health partnership with non-English speakers
- The HUB currently serves more than 1,000 clients, of which 80 percent represent minority, foreign-born, and non-English speaking populations.
- 1/3 of the CHWs in the HUB speak multiple languages including Spanish, Arabic, Somali, Nepali, French.
Contact tracing must involve resource coordination for vulnerable populations

- **The “Aftermath”:** Finding and treating COVID-19 patients is key in the short term. In addition, we see opportunity for the HUB to support populations affected directly or indirectly by COVID-19 in the long term.

- The pandemic is more than just a virus:
  - Employment interruptions/loss
  - Loss of health insurance/benefits
  - Food insecurity
  - School closure
  - Missed doctors appointments, prenatal screenings, vaccinations, etc.
  - Anxiety and depression amplified by all of these and more issues caused by the pandemic

---

**The Columbus Dispatch**

**Pediatric vaccine rates plummet in central Ohio, nationwide**

By Allison Ward
The Columbus Dispatch

By Megan Henry
The Columbus Dispatch
Posted Jun 22, 2020 at 5:15 AM

Fearing outbreaks of diseases like measles or whooping cough, area pediatricians are working with parents and community organizations to get children across Ohio caught up on vaccines they missed earlier in the pandemic. For example, an estimated 16,000 fewer children were vaccinated across the Nationwide Children’s Hospital primary care network during the months of March and April when compared with last year.
Contact tracing must involve resource coordination for vulnerable populations

- A designated medical professional, individual clients/family members, public health, or social service workers (anyone!) can refer patients to the HUB via an online referral form (http://www.hcgc.org/hub-referrals.html) after treatment and prior to discharge, when a need is expressed or a concern discovered.

- HUB CHW’s will make contact with patients in-person or via phone or other remote device (laptop, tablet) to enroll patients as a HUB client.

- The CHW will complete a comprehensive risk assessment with the client. Based on that risk assessment and agreement from the client, the CHW will determine goals, or Pathways, that help the client successfully access needed care and resources.

- CHW can begin the process of opening pathways that the client will need, particularly in this instance where COVID-19 patients exit isolation and re-enter the community. The CHW will continue to follow clients as they leave isolation, ensuring that they are supported with ongoing assessment and connection to vital services.

Healthcare Collaborative of Greater Columbus
Community Conversation
Thank you and Continue to Engage

www.hcgc.org