



Draft Influenza Pandemic Plan

Part 5

Community-Based Assessment Services

February 2006

THE ESTABLISHMENT OF COMMUNITY BASED ASSESSMENT SERVICES IN THE WAIKATO DHB REGION

SECTION 1: BACKGROUND

As part of their influenza pandemic planning, DHBs are required to develop systems around the concept of Community-Based Assessment Centres.

However expressed (this may be a physical location or other type of service), the function of such a service is to:

‘Separate, as much as possible, patients who may have symptoms suggestive of an EID [emerging infectious disease] from those without such symptoms but who still require primary care services. The centres would be established and widely publicised as being specifically for people requiring EID-related assessment or services’. (*National Health Emergency Plan: Infectious Diseases, Ministry of Health, 2004*)

1.1 Role of Community Based Assessment

It is envisioned that the role of this type of service will be to:

- provide the primary care surge capacity arising from a sudden increase in demand.
- be a means of concentrating the initial assessment of people who may have influenza away from individual general practices and hospital emergency departments,
- support the provision of home-based self-care in association with teletriage and advice¹.
- Provides help and information to the community

1.2 Function of Community Based Assessment

The primary functions of community-based assessment will be to:

- I) provide clinical assessment and advice
- II) dispense the Ministry-held supplies of antivirals as per Ministry guidelines (and possibly antibiotics)
- III) provide triage and referrals to other primary health or secondary health care (as capacity allows)
- IV) enable health professionals to specialize in influenza and infection control
- V) provide advice on infection prevention and control;

1.3 Limitations of Community Based Assessment

- The community-based assessment service will not provide inpatient or observation services.

¹ The Ministry of Health has commenced work on the utilisation of teletriage and advice in a pandemic influenza and how the existing capacity within *Healthline* can be utilised and supplemented.

- At this stage there is no expectation that the provision of pandemic influenza vaccination will take place via community-based assessment centres.

SECTION 2: OPERATIONAL REQUIREMENTS

2.1 Planning considerations:

- Local health providers must have input into planning
- There must be community involvement in planning
- Consideration of how the service will be required to people who are less mobile and/or who do not have easy access to transport (in the Waikato Region 11100 households have no access to a car – 2001 census).
- Consideration of how the service can be delivered to isolated communities
- Social considerations, such as:
 - Approximately 45% of Waikato region residents score between 7 and 10 on the NZ Social Deprivations Scale (10 indicates high deprivation)
 - In the Waikato Region 5640 households have no access to a telephone. (2001 census),

2.1 Facility requirements

- locations that people are familiar with and can access easily
- easy drive-up access with separate entry and exit
- staff facilities such as toilets and hand basins are available
- there is available sufficient essential support systems such as water, electricity, and heating
- there is the ability to implement infection control practices
- staff, site and material security
- secure storage; and
- a means of disposing infectious waste.

SECTION 3 The WDHB Community-Based Assessment Project

Between March and June 2006 WDHB will run a discrete project to develop a district-wide approach to the establishment, operation, and resourcing of community-based assessment services. The project will be completed by June 30th 2006.

The outputs from the project will include:

1. A district-wide understanding of the role and relationships of CBACs with other emergency responses to the pandemic
2. A common approach to the establishment, operation, equipment and resourcing of CBACs;
3. Determination of an appropriate spread of CBA services throughout the district including the identification of suitable approaches for each area.

4. Alignment between inpatient and primary care plans, including resourcing.
5. Liaison with local government, emergency services and utilities to ensure that the work on the community-based health responses align with the broader Waikato response to pandemic planning.
6. A comprehensive plan relating to primary clinical care in the Waikato during an influenza pandemic, including, where appropriate, implementation plans.

SECTION 4 DRAFT PROJECT TIMELINES

Month	Activities	Deliverables
March	<ul style="list-style-type: none"> • Clarification and agreement re approach to CBA for WDHB, including: <ul style="list-style-type: none"> - how many CBAC and which locations (ie towns) - Other ways of providing community-based assessment if appropriate. • Identification of, and first contact with, key stakeholders • Research re social and other issues that may inform CBA planning 	<ul style="list-style-type: none"> • Scoping document • Agreement as to how community-based assessment will be approached for WDHB • Contact details for all key stakeholders • Identification of impact issues
April	<ul style="list-style-type: none"> • Identification of CBA approach for each designated area • Clarification of specific services to be provided • Clarification of specific facility requirements • Identification of suitable facilities and identification of facility owner • Collaborative development of draft assessment, triage and referral protocols • Collaborative identification of staff to work in CBACs 	<ul style="list-style-type: none"> • Service specification, including facility requirements • Draft clinical protocols • Draft staffing arrangements • Identification of suitable locations
May	<ul style="list-style-type: none"> • Arrangements re supply and delivery of equipment and supplies finalised. • Development of communications plan re informing the community about the function and location of CBACs • Arrangements re security finalised • Documentation requirements agreed and developed. 	<ul style="list-style-type: none"> • All CBAC sites identified and finalised • Communications plan • Standard documentation • Facility management agreed •
June	<ul style="list-style-type: none"> • Plans for activation agreed and tested. • 	<ul style="list-style-type: none"> • Final report

**Guidance on the Treatment and Care of
New Zealanders in a Pandemic**

Community Based Assessment Centres

Acknowledgements

The Ministry convened a working group to identify key elements of this guidance and gratefully acknowledges the time and contribution made by these people:

Sandra Bee, Emergency Planner, Hawke's Bay DHB

Matthew Callahan, Team Leader, Community Health Services, Kapiti, Capital and Coast DHB

Dr Tim Harvey, Pegasus Health, Christchurch

Dr Jonathan Jarman, Medical Officer of Health, Northland DHB

Dr Margot McLean, Medical Officer of Health, Regional Public Health Service; Hutt Valley DHB

Sandra Miller, Major Incident and Emergency Planner, Southland DHB

Cathy Mitchell, Practice Nurse, Brooklyn Central Health, Wellington

Dr Sally Talbot, GP, Khandallah Medical Centre, Wellington

Jim Turner, Ministry of Health (on secondment from College of General Practitioners)

Gillian Bohm, Ailsa Jacobson, Jennifer Davidson, Annette Pack, Ministry of Health

In developing this guidance the Ministry has borrowed heavily from the document, *Feasibility of Community Based Assessment Centres for Pandemic Illness* funded by the Ministry of Health and developed by Regional Public Health in association with Hutt Valley DHB, Capital and Coast DHB and Wairarapa DHB in November 2004. This document is available on the Ministry website:

www.moh.govt.nz

Aim of this document

The aim of this document is to provide interim guidance to District Health Boards and Primary Health Care Organisations on the role and function of Community Based Assessment Clinics in a pandemic. This document is draft advice and will be updated in early 2006 following the receipt of sector comment and the completion of additional work. Eventually this document will sit alongside other advice under development on the treatment and care of New Zealanders in a pandemic.²

Please forward any comments on this document by **20 January 2006** to

birdflu@moh.govt.nz or

CBAC consultation

Ministry of Health

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² This work includes tele triage and teleadvice, access to hospitals, infection control, the care of people in residential facilities, the care of people who normally require home support, workforce etc.

Introduction

New Zealand is planning for a pandemic with planning scenarios estimating up to 1.6 million cases of pandemic influenza. If this happens, the hospital and primary health care sector will not be able to cope, as:

- the number of additional unwell people will be beyond surge capacity
- the capacity of these sectors will be diminished by staff absences due to illness or health workers staying at home to care for family members; and
- many existing primary and hospital facilities will need to continue to provide care for people requiring treatment for other conditions. To minimise the risk of cross infection, access to these facilities by people who have pandemic influenza symptoms will need to be limited.

New models of community-based care are therefore required which allow for the most optimal care possible within a pandemic situation.

In 1918 the front line of the pandemic was in the community and in people's homes. Little has changed. In a future significant pandemic the front line will also be the community.³

The establishment of designated assessment and/or alternative care sites are common features of influenza planning at national and regional levels in other countries. There are, though, few instances of health authorities translating these concepts into more detailed planning and/or implementation exercises.

In the Ministry of Health's *National Health Emergency Plan: Infectious Diseases* (NHEP:ID) (Ministry of Health, 2004) District Health Boards (DHBs), in consultation with primary and community health providers, were asked to consider the use of Community Based Assessment Clinics (CBACs) to:

Separate, as much as possible, patients who may have symptoms suggestive of an EID [emerging infectious disease] from those without such symptoms but who still require primary care services. The centres would be established and widely publicised as being specifically for people requiring EID-related assessment or services.

Following the release of NHEP:ID, Regional Public Health developed the document *Feasibility of Community Based Assessment Centres for Pandemic Illness*, (November 2004) in association with Hutt Valley District Health Board, Capital and Coast District Health Board and Wairarapa District Health Board. The feasibility document is an appraisal of the CBAC model and identifies a

³ Geoffrey W. Rice, *Black November. The 1918 Influenza Pandemic in New Zealand*. University of Canterbury. Rev 2nd edn, 2005

number of features as well as additional work that is required to operationalise CBACs.

Role of Community Based Assessment Centres

During an influenza pandemic, the role of CBACs will be to provide the primary care surge capacity arising from a sudden increase in demand. These centres will be a means of concentrating the initial assessment of people who may have influenza away from individual general practices and hospital emergency departments, the usual first ports of call for people who are unwell. CBACs will be for influenza cases that meet the case definition and for people that are likely to benefit from available clinical intervention. As well, CBACs will support the provision of home-based self-care in association with teletriage and advice⁴.

Function of Community Based Assessment Centres

The primary functions of a CBAC will be to:

- (i) provide clinical assessment and advice
- (ii) dispense antivirals and antibiotics
- (iii) provide triage and referrals to other primary health or secondary health care (if capacity exists)
- (iv) enable health professionals to specialize in influenza and infection control
- (v) practice and provide advice on infection prevention and control; and
- (vi) provide a secure distribution centres for anti-virals in accordance with Ministry guidelines.

CBACs may provide other functions as determined by DHBs, for example the provision of outreach services into people's homes (if capacity exists). CBACs will not provide inpatient or observation services. It is anticipated that they will not be responsible for the provision of pandemic vaccination.

CBACs will be facilities for the community that:

- are an identified place for the community to seek help and information
- obviate the need for extensive travel (which might help slow the spread of the pandemic)
- will enable the community and the health workforce to be utilised in an efficient and effective way
- are responsible for rationing scarce resources in accordance with national policy

⁴ Work has commenced on the utilisation of teletriage and advice in a pandemic influenza and how the existing capacity within *Healthline* can be utilised and supplemented.

- have the capacity to stream patients into appropriate clinical pathways as available
- are a means of providing emergency public health interventions close to the community and concentrating on the problem immediately at hand; and
- have local leadership.

Essential Features of a Community Based Assessment Centre

CBACs will be a stand-alone facility set up for example in community centres, general practices or after hours clinics not being used for the treatment of other conditions, schools, marae, motels, hospital outpatient services, tents, marquees. In choosing a facility the following features will be a priority:

- they are places that people are familiar with and can access easily
- they have easy drive-up access with separate entry and exit
- they are suitable for undertaking the functions noted above
- they have staff facilities such as toilets and hand basins
- there is available sufficient essential support systems such as water, electricity, and heating
- there is the ability to implement infection control practices
- there is staff, site and material security
- there is secure storage; and
- there is a means of disposing infectious waste.

CBACs will have to be planned with the needs of the community in mind. Active consideration needs to be given to how they could provide services to people who are less mobile, who do not have easy access to transport, or are relatively isolated. There is no one size, or even range of sizes, that fits all. For example, a mobile CBAC model may be feasible in some circumstances.

Social factors should also be acknowledged in planning a CBAC location. Factors such as trust, and pre-existing relationships with a service or structure are important. Public health academic T.A. Glass comments "...people will go where they trust health care facilities, especially in a disaster situation."⁵

Ideally, CBACs will be open 24 hours a day, dependent upon workforce availability. Full time security will be necessary.

Resourcing a CBAC

⁵ Glass TA. Understanding public response to disasters. *Public Health Reports* 2001 supp 2, vol 116 pp.69-73.

The Workforce

A CBAC will require clear clinical leadership. This leadership will need to be drawn from existing public health, primary and secondary health care services and will utilize all health practitioners. Administrative staff, cleaning staff, and security personnel will also be critical to the operation of a CBAC. Trained community volunteers may also be utilised to undertake task-oriented functions under the supervision of clinical staff.

The workforce will need to be trained utilising resources such as the open web-based training package currently under development.⁶

Other resources

The document *Feasibility of Community Based Assessment Centres for Pandemic Illness* outlines a wide range of consumables that will be required. These include:

- antivirals from the national stockpile
- antibiotics
- personal protective equipment
- linen
- cleaning materials.

Provision will need to be made for information collection including the ability to record people's name, date of birth, address, ethnicity and critical clinical decisions. Facilities to control infection and monitor the health of staff will also be required, as will effective communications to enable telephone triage, or communication with referring and referred institutions.

Associated work is underway and needs to be completed on:

- the ability of CBACs to dispense medications
- the application of standing orders
- the development of antiviral policy
- informed consent procedures that would apply.

Subsequent drafts of this document will address these issues and will also include a planning template for DHBs. The purpose of this template would be to support DHBs to plan appropriately for CBACs in association with their wider community.

⁶ This package will cover the national pandemic planning strategy, influenza epidemiology, as well as more specific measures such as cluster control, infection control measures in the community, the use of Personal Protective Equipment, vaccines and anti-virals. It will be available early 2006 and will be widely publicized.

Funding a CBAC

Work is currently underway on how CBACs will be funded. It is critical that the services of a CBAC are free to the community. Information from some DHBs on the expected costs of running a CBAC will be a helpful input into this work.

Triggering a CBAC

The decision to activate CBACs will be made locally after a Code Red alert in consultation with the National Coordinator.

Planning for a Community Based Assessment Centre

The establishment of CBACs requires advanced planning and must, of necessity, be planned and organized by DHBs in partnership with primary health care and their communities. The early involvement of local government, civil defence and police will be important. It is essential, as part of a DHB's pandemic planning process, that initial work – the regional scoping of possible locations and workforce for CBACs – should proceed contemporaneously with the policy development of CBACs. This is because the timing of a pandemic is not known.

They will need to be established and operated in ways that do not worsen health inequalities.

Some initial work has been done on the maximum and minimum community size that could warrant the establishment of a CBAC. A very preliminary investigation in Canterbury put the optimum number at about 30,000, with the primary constraint being workforce resourcing.⁷ The population size served by a CBAC very much depends on the comparative dispersal of a population, transport and communication capacity, workforce and other resource availability and the availability of suitable sites. There will be an inevitable tension between the competing demands of providing wider population cover and reducing the need for people to travel and the need to reduce the number of CBACs for resource, logistic and security reasons.

The location, hours of operation, and services available of individual CBACs will require publicity in advance of their opening. CBACs will need to be able to link into broad-based information and education services such as 0800 telephone lines, web-based information and media communications. Contingency plans will need to be developed to take account of predictable and unpredictable events as an influenza pandemic unfolds.

DHBs should scope potential sites that meet as many as possible of the requirements as possible and establish agreements with the present occupants

⁷ However, smaller communities, particularly in rural areas, could effectively utilise this model of care as could larger populations.

that consideration will be given to utilizing these as CBACs in the event of an influenza pandemic.

DHBs may also want to develop a register of personnel with a range of workforce options including people from within the existing and trainee health workforce in the primary and hospital sector – including public and private hospitals, clinical personnel with the Red Cross and Defence Force, ambulance personnel etc. As an influenza pandemic progresses, a group of health workers will emerge who have recovered from the infection and they will form an immune workforce that will be a valuable resource. Systems will need to be established so that this immune workforce can be identified and fully utilized in a pandemic.

Next Steps

Please forward any comments you or your organisation has on this document to birdflu@moh.govt.nz by January 2006.