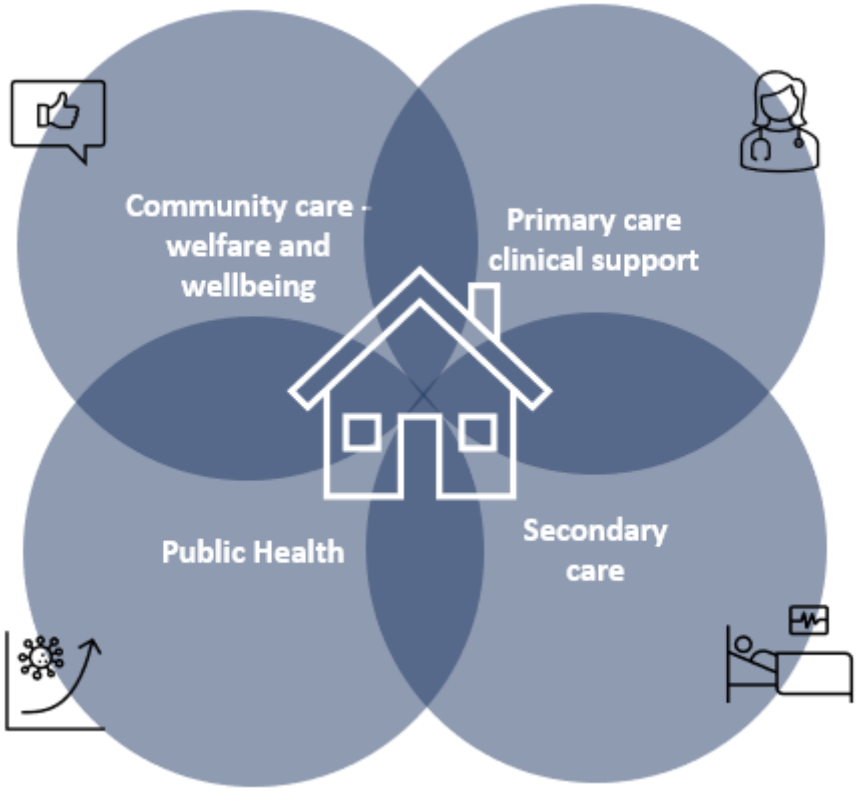


COVID-19 Care in the Community

Framework for Public Health, DHBs, PHOs, Providers, Social and Well-being Organisations

Version 1.7

30 November 2021

Unite against COVID-19

MINISTRY OF HEALTH
MANATŪ HAUORA

Abbreviations

Abbreviation	Full Name
BCMS	Border Control Management System
DHB	District Health Board
DPMC	Department of the Prime Minister and Cabinet
HSPP	Health System Preparedness Programme
HUD	Ministry of Housing and Urban Development
ICU	Intensive care unit
IT	Information Technology
MIQ	Managed isolation and quarantine
MoH	Ministry of Health
MSD	Ministry of Social Development
NCTS	National Contract Tracing Solution
PHO	Primary Health Organisation
PHU	Public Health Unit
PMS	Patient Management System
PPE	Personal Protective Equipment
SIQ	Self-isolation and quarantine
TPK	Te Puni Kōkiri

Authorised

Authoriser	Date	Signature
Robyn Shearer Acting Chief Executive		

Key resources for COVID-19 Care in the Community

Agency or Organisation	Dedicated COVID-19 Care in the Community website, phone number or organisational email
Department of the Prime Minister and Cabinet (DPMC)	Care in the community | Unite against COVID-19 (covid19.govt.nz)
	COVID-19 Healthline: 0800 358 5453 Healthline: 0800 611 116 Health advice about babies or children PlunketLine: 0800 933 922 Family Services: 0800 211 211 Work and Income: 0800 559 009 Mental health support: call or text 1737 Alcohol and Drug Helpline: 0800 787 79 Rural Support Trust: 0800 787 254 Business support: North Island 0800 500 362 South Island 0800 505 096
Ministry of Health (MOH)	Caring for people with COVID-19 in the community | Ministry of Health NZ
MOH: Health System Preparedness Programme	hsrrp@health.govt.nz
MOH: COVID-19 Care in the Community	managing.COVID-19.careinthecommunity@health.govt.nz
MOH: Border Control Management System	border-apps@contacttracing.health.nz
MOH: Personal Protective Equipment and other consumables	COVID.healthsupplychain@health.govt.nz
Ministry of Social Development (MSD)	COVID-19 - Ministry of Social Development (msd.govt.nz)
Kāinga Ora	https://kaingaora.govt.nz/tenants-and-communities/covid-19-information-for-our-tenants-partners-and-suppliers/covid-19-services-and-support/
Ministry of Housing and Urban Development (HUD)	COVID-19: Information for the housing and urban sectors | Te Tūāpapa Kura Kāinga - Ministry of Housing and Urban Development (hud.govt.nz)
Oranga Tamariki	COVID-19 | Oranga Tamariki — Ministry for Children

Contents

1. Introduction 6

2. Equity.....10

3. Roles & Responsibilities 11

4. Clinical Governance 12

5. Integrated Support Pathway.....14

5.1. Preparation.....16

5.2. Testing 16

5.3. Notification.....16

5.4. Assess Needs & Determine Pathway 18

5.5. Care and Support 21

5.6 Discharge, Follow-up and Onward Care.....22

6. Funding 23

7. Digital Enablement.....23

8. Next Steps 23

Appendix A: Accommodation checklist for individuals with COVID-19 isolating at home 24

Appendix B: Equity expectations 26

Appendix C: Key DHB resources for COVID-19 Care in the Community.....30

Appendix D: Metrics for COVID-19 Care in the Community.....31

1. Introduction

Whakataukī

He aha te mea nui o te ao? He tāngata, he tāngata, he tāngata

What is the most important thing in the world? It is the people, it is the people, it is the people

Context

As Aotearoa New Zealand's vaccination rate increases, people with COVID-19 will have the opportunity to isolate at home. When a person is confirmed positive for COVID-19, the requirement for them to isolate remains and is necessary to contain the spread of the virus and keep our wider community safe. For many, home isolation will represent an appropriate and safe option while infected with COVID-19. However, this will be determined in consultation with the individual and their whānau.

The COVID-19 Care in the Community (previously self-isolation and quarantine (SIQ)) model is defined as the period of isolation of the COVID-19 positive individual and their symptomatic close contacts as well as the identification and quarantine of household members. COVID-19 care in the community has been implemented successfully in other countries, including Australia and Canada.

Other options will be available including placement in a managed facility if necessary and, if severely unwell, hospital level care.

Purpose and Scope

The COVID-19 Care in the Community Framework ("The Framework") provides direction for organisations and providers who are caring for people with COVID-19 in the community. Care should be based on the needs of the person and whānau rather than those of the providing organisations. In earlier iterations this document was called "Operational Guidelines". After careful consideration, we determined that this document is not as prescriptive as operational guidance, but describes a framework of expectations; allowing regional, district and local contextual adaptation. As such, this document is now a Framework.

The Framework is for multiple stakeholders, including, but not limited to: Māori, Pacific, people working in the disability and mental health and addiction sectors, public health, residential aged care, Oranga Tamariki, clinical, and welfare providers to support people with COVID-19 and their whānau/household while isolating within the community.

The Framework leverages existing district health board (DHB) and local plans and processes, with the expectation that communities develop a flexible, local response to support COVID-19 positive people and whānau safely, effectively and equitably in the community.

The Ministry of Health and the Ministry of Social Development collaboratively share the expectation that health and welfare providers will coordinate their services as much as possible. The two Ministries acknowledge that each organisation has its own processes, and both are committed to ongoing collaboration and coordination.

The processes by which the Ministry of Health and the Ministry of Social Development coordinate remain in development and details will be provided in future versions of the Framework.

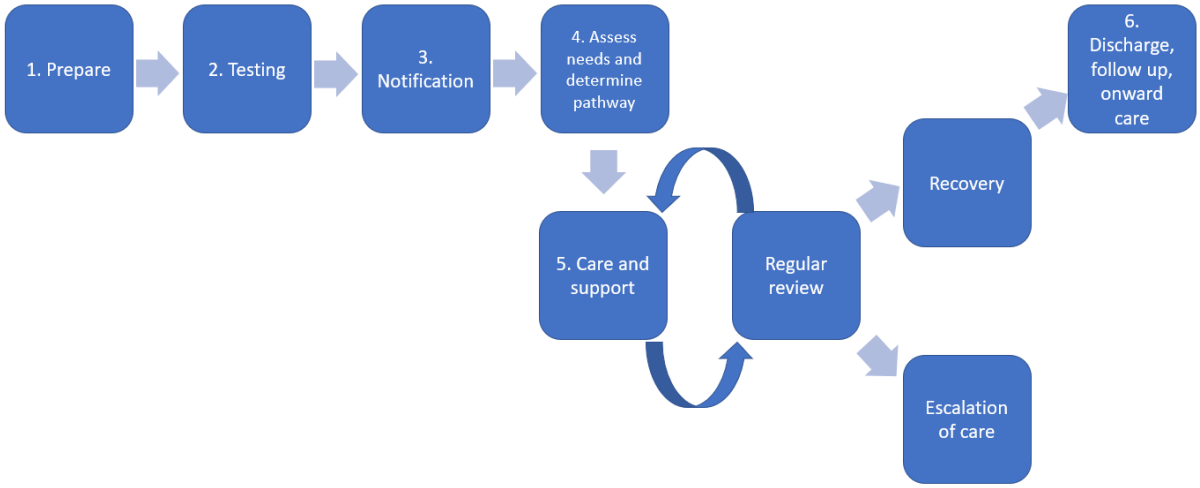
Framework Principles

The principles of the Framework are to:

- ensure all of those in New Zealand have access to all related COVID-19 health and support services, at no cost
- enact and embed our obligations to Te Tiriti o Waitangi
- ensure that people who test positive for COVID-19 and their whānau are given the opportunity to recover in isolation at a location of choice, within the boundaries of safety to self and others
- ensure equity of access and support to all
- ensure integrated support pathway services are person and whānau-centred
- ensure safe, high quality clinical and welfare care is flexible and tailored to the individual and whānau needs
- embrace and build on the natural care and support relationships already in place for many people with their health and social networks
- look for opportunities to leave the individual and the whānau better off than before COVID-19
- embrace existing interorganisational collaboration, whilst concurrently fostering new collaboration opportunities
- effectively balance centralisation with local flexible empowerment – centrally supported, regionally delivered, locally led
- update the Framework appropriately as the pandemic response continue.

Integrated Support Pathway

The Framework principles are informed by an integrated support pathway joining the public health, clinical, social and well-being supports through preparation, testing, notification, needs assessment and pathway determinations, offering appropriate care and support, discharge and follow-up. Care and support needs are regularly reviewed by clinical and welfare providers so that escalation is triggered when required.



Regional Delivery

The Ministry of Health is providing funding to four regional teams responsible for coordinating regional delivery of the Framework, with each team led by a regional lead. These four regions are grouped by DHBs.

Region	DHBs included
Northern	Northland, Waitematā, Auckland, and Counties Manukau DHBs
Te Manawa Taki	Bay of Plenty, Lakes, Hauora Tairāwhiti, Taranaki, and Waikato DHBs
Central	Capital & Coast, Hawke's Bay, Hutt Valley, MidCentral, Wairarapa, and Whanganui DHBs
Southern	Nelson Marlborough, South Canterbury, West Coast, Canterbury, and Southern DHBs

The Ministry of Social Development has regional service centres throughout the country. They are organised differently from the Ministry of Health Regions. They can be found at Find a Service Centre - Work and Income and are listed below:

1. Northland
2. Auckland
3. Waikato
4. Bay of Plenty
5. East Coast
6. Taranaki, King Country and Whanganui
7. Central
8. Wellington
9. Nelson, Marlborough and West Coast

10. Canterbury
11. Southern

While the regional organisational structures differ between the two Ministries, each will work together to ensure that regional structures do not become a barrier to providing care services.

2. Equity

In Aotearoa New Zealand, people have differences in health that are not only avoidable but unfair and unjust. Equity recognises different people with different levels of advantage require different approaches and resources to get equitable health outcomes.

COVID-19 has exacerbated inequities. This is evidenced in the demographic incidence of COVID-19 infections, hospitalisation, ICU care and death related to the 2021 Delta outbreak.

The following equity expectations must be considered by all health and welfare organisations involved in managing COVID-19 in the community.

The equity expectations for the COVID-19 Care in the Community Framework are:

- embed Te Tiriti in the response
- support Māori and Pacific-led teams to deliver the initial engagement with Māori and Pasifika
- support end-to-end services, care coordination and wrap-around support
- promote 'legacy services' to ensure whānau accessing care and support pathways wherever possible[1]
- design system enablers to drive equity for priority populations in the response; specifically:
    - ensure strong Māori (as Te Tiriti partners) leadership and decision-making at all levels of the care in community response
    - build community infrastructure by supporting Māori and Pacific providers, local services, and communities to drive local responses
    - enable Māori and Pacific communities to design tailored and targeted models that are holistic and culturally responsive, sensitive, and safe across the care in the community continuum
    - embed agile, flexible, and high-trust commissioning and contracting arrangements to enable local innovation and responsiveness
    - build systems that enable better cross-agency collaboration and coordination that put the needs of whānau first
    - ensure clear communication from all levels of government and service delivery while enabling localised initiatives
    - continue to strengthen data collection and public health systems and processes (including IT and digital enablement) to deliver on equity.

Appendix B provides greater detail on the framework's equity expectations.

[1] 'Legacy services' are designed to alleviate and address the negative impacts that COVID-19 and long-standing health inequities have had on vulnerable populations, particularly for Māori.

3. Roles & Responsibilities

When an individual receives a positive COVID-19 test result, they will likely experience a wide range of emotions and reactions. Some will be overwhelmed with fear or anxiety, while others who are asymptomatic may be shocked. The initial hours after receiving a positive test result are crucial to the health, safety, and wellbeing of the individual, whānau, and community.

The health, public health, social, and welfare sectors play key roles to keep the COVID-19 positive individual, whānau, and community healthy and safe. This includes, but is not limited to, DHBs, primary health organisations (PHOs), general practice teams, health and community care providers, public health units, Kaupapa Māori providers, Whānau Ora collectives, Pacific providers, and MSD partners.

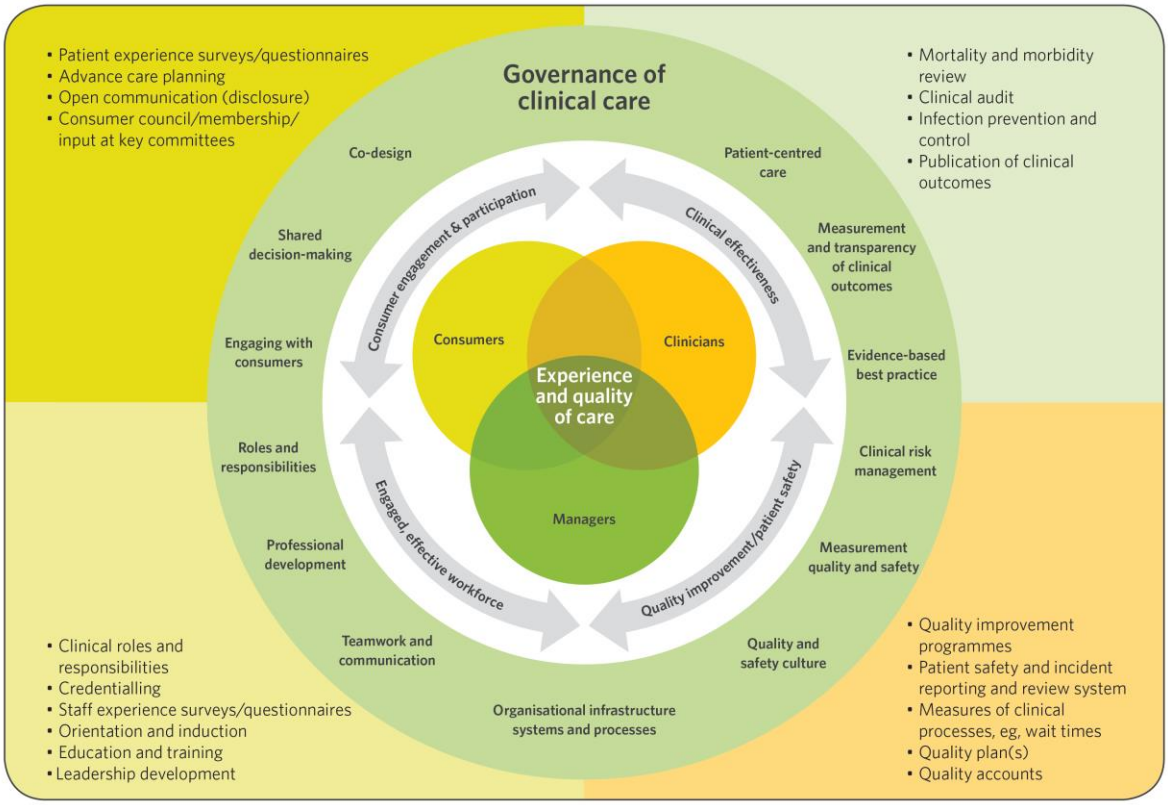
The local coordination function, as described earlier, is to enable a whānau-centred connection with public health, primary care, community care, specialist and hospital care services, ambulance, welfare, and well-being services. Health issues that emerge regionally that cannot be resolved should be escalated to the Ministry of Health. The Ministry of Social Development is leading the coordination of the welfare approach, working closely with key agencies across the health, housing education, economic and other sectors, and with iwi/Māori.The Ministry of Health and the Ministry of Social Development continue to work collaboratively to optimise our systems and processes. Table 1 outlines system functions and the respective accountable entities.

Table 1: COVID-19 Care in the Community functions and associated accountable entities

Function	Accountable entity
Health Funding	Ministry of Health
Welfare Funding	Ministry of Social Development
Digital enablers	Ministry of Health and Ministry of Social Development
Equipment supply and national delivery	Ministry of Health
Public messaging and communications	Ministry of Health and DPMC
Comprehensive welfare assessment, delivery, and coordination	Ministry of Social Development in partnership with local providers
Clinical governance	All clinical organisations
Iwi/hapū/Hapori Māori engagement, partnership and commissioning	DHBs and regional teams
Regional planning and coordination	DHBs in partnership with Ministry for Social Development
Public health measures	Public health units
Local distribution of equipment	DHBs and Care Coordination Hubs
First assessment including health and welfare screening	DHBs and Care Coordination Hubs
Health care coordination and delivery	DHBs, primary care, general practice, and Māori and Pacific providers. DHBs accountable for the safety net where the persons do not have a participating primary care provider

4. Clinical Governance

Clinicians and healthcare organisations providing health services to COVID-19 positive individuals must have robust clinical governance structures in place. These clinical governance structures must ensure that quality and safety are monitored, significant events are reviewed and analysed, and opportunities for quality improvement are identified and implemented.



Each of the four regions must ensure clinical governance groups are incorporating relevant local stakeholders. This includes but is not limited to DHBs, Māori and Pacific providers, primary health organisations, general practice, and pharmacy. The patient/consumer voice should also be represented within clinical governance forums.

Metrics for COVID-19 Care in the Community

Metrics are applied to all parts of the patient journey, from testing through to follow-up and discharge. Note that while these are the nationally determined metrics, additional locally determined metrics may be developed, but are not required to be reported to the Ministry of Health.

While locally led, devolved care is the preferred model of care, to have confidence in the care provided, metrics to track performance are needed. While the Ministry of Health has overall stewardship and oversight responsibilities, usual commercial performance management arrangements will apply between the commissioning agency and the contracted provider.

Having a success framework, metrics and a baseline enables ongoing monitoring of the health system's performance, provision of care in the community and identification of gaps that require

addressing in relation to the changing threat of COVID-19. Where targets have been attached to metrics, these focus on actions taken by the health sector to meet patients' and households' needs.

The metrics will be disaggregated by patients' age, ethnicity, and locality, to enable tracking of how well the model of care is responding to the needs of specific population groups, and the model can be updated to better reflect these needs. The metrics for COVID-19 Care in the Community can be found in Appendix D.

Consistent with the Data Protection and Use Policy, collection and sharing of information should be done in ethical and responsible ways. This should include consideration of issues related to data access and the use, relevance, and quality of data about Māori, and Māori Data Sovereignty.

5. Integrated Support Pathway

The six-step integrated support pathway relies on multiple stakeholders, including, but not limited to, iwi/hapū/Hapori Māori providers, Pacific providers, public health units, general practice and primary care providers, welfare and well-being providers. As such, organisational coordination throughout the care continuum is critical for successful outcomes for the patient and whānau.

Care Coordination Hubs

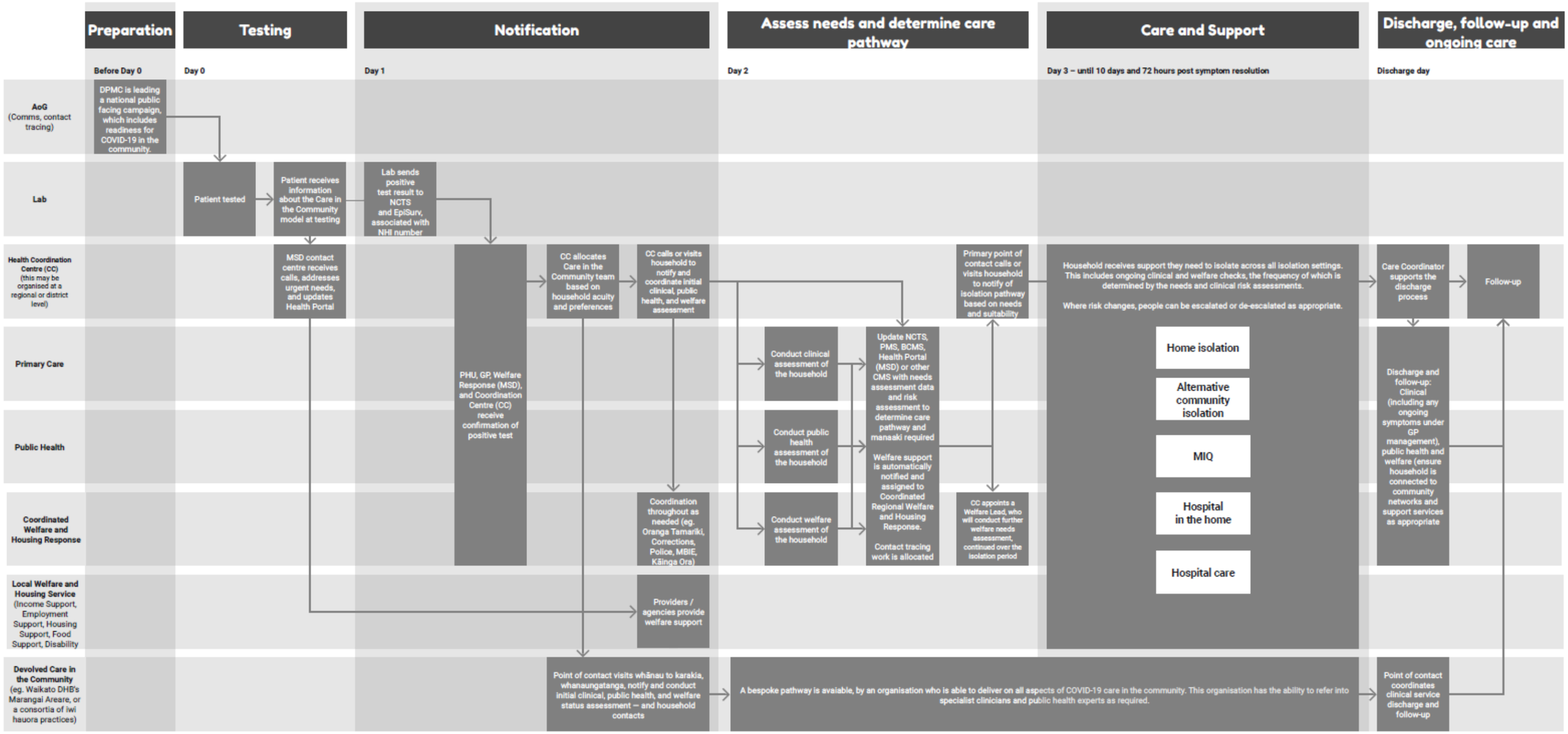
Because multiple stakeholders are involved with the individual and their whānau through the isolation period, the DHB and/or local entity will establish a **care coordination hub.** Stakeholders will establish local protocols and processes by which all positive COVID-19 cases are received, managed and discharged. The hub brings together public health, clinical health and welfare providers as well as the other stakeholders mentioned above.

MSD are the leading the welfare response and MSD Regional Commissioners and Regional Public Service Commissioners are working locally with other partners to plan and coordinate this inlcuding the regional alignment of the public service.

Once the needs of the individual and their household are identified, the care coordination hub will estblish a process to identify a community coordinator/ Whānau Ora navigator/ Kaupapa Māori provider/ Pacific provider/ Disability Connector, or community leader to serve as a primary point of contact. This person could also be a nurse, member of the iwi, or other individual determined by the care coordination hub to be the most appropriate community coordinator.

Integrated Support Pathway Model

How the Care in the Community model can be organised to address the experience of people and whānau



5.1 Preparation

Preparing for COVID-19 Care in the Community occurs at the system and individual level.

System preparation

- In partnership with iwi/hapū/Hapori Māori (Tiriti partners), DHBs, PHUs, local providers and welfare providers will need to design, implement, and resource community protection and preparedness plans to ensure their local communities are prepared for localised COVID-19 outbreaks.
- Staff within each locality should be aware of their regional health pathway (Regional pathways | Health Navigator NZ) to promote regional and local preparedness. Each locality will need to demonstrate that they are protecting their most vulnerable populations i.e., Māori, Pacific, those with disabilities and the unvaccinated.
- As a part of preparing for COVID-19 Care in the Community the local system should be assessed to determine its capacity in terms of the number of people and whānau that can be supported and have plans in place to scale up the response, should this be required.

Individual and whānau preparation

- Whānau and communities should be encouraged to develop plans in case someone in their whānau tests positive for COVID-19, similar to how they are encouraged to prepare for what to do in an earthquake or a tsunami warning.
- Providers should use messaging and communication materials developed by the Ministry of Health, DPMC and other national organisations. Providers may develop locally relevant materials to push out to their communities, based on national messaging.

5.2 Testing

Aotearoa New Zealand's COVID-19 testing programme is well-established; several resources exist for the general public and clinical providers:

- General Public: Assessment and testing for COVID-19 | Ministry of Health NZ.
- Clinical Providers: Case definition and clinical testing guidelines for COVID-19 | Ministry of Health NZ and COVID-19: Testing Strategy and Testing Guidance | Ministry of Health NZ

5.3 Notification

- As a part of the care coordination hub model, PHUs, DHBs, PHOs and providers will work with local welfare, Māori and Pacific partners and community leaders to develop an approach for contacting and notifying whānau members who have tested positive for COVID-19 within 24 hours of a positive result.
- Because Māori and Pacific people are disproportionately affected by COVID-19, Māori-led and Pacific-led teams should be enabled and resourced at this stage of the response to ensure the cultural needs of Māori and Pacific people are met.
- Positive and culturally safe engagement within the first 24 hours of confirming a positive case is essential to ensure ongoing engagement in the integrated support pathway. Regions

will determine which organisation has capacity and capability to make the initial contact with the whānau, and what content is included in that initial contact.

Notification to the individual with COVID-19 and initial clinical assessment

- In addition to delivering the positive result, the first contact with an individual should include an initial clinical assessment for immediate risk.
- As a part of the initial assessment, there should be discussion around what is important to the household, and identify if additional support and assistance is required, how additional health and wellbeing support can be accessed, and the best way to communicate with them.
- All decisions and plans in this step should be documented with the household and as a part of the individual's plan of care. Table 2 in section 5.4 includes a checklist and proposed order of assessments for anyone with COVID-19. If the individual or whānau is not enrolled with a general practice team, the care coordination hub, in collaboration with the individual and their whānau, will identify a provider to work with them. Enrolling people into a general practice who are not yet enrolled in one, should happen here if possible.
- A positive COVID-19 case result will be sent to the Public Health Units and the enrolled General Practice Team. The information and plan will be reviewed in the Care coordination hub, and designated to a care provider.

Escalation in the event of non-contact

- Past experience indicates that a person may not answer a phone call from the PHU or contact-tracing system because it is an unknown phone number or a wrong number or out of range. Up to six attempts should be made to contact the individual by cell-phone or landline, including at least one call out of hours.
- If an individual with COVID-19 cannot be found, iwi, Māori, or Pacific providers and community networks may be used to connect with the person.
- Under extenuating circumstances, the National Investigation and Tracing Centre Finder service will used to contact an individual.

Informed consent

Throughout the COVID-19 notification process, public health, general practice/primary care and welfare have different processes by which consent is done.

Public Health: COVID-19 is a notifiable disease, so all cases and contacts are required to cooperate with the Public Health Unit with the aim of reducing further transmission of disease. Where cases and contacts are non-compliant with Public Health requirements, they may be subject to Section 70 of the Health Act.[2]

Clinical care provider: An individual who is enrolled with a General Practice Team will likely have already established services for which care is already consented. If an individual wishes to enrol with a new provider, they will need to consent at the time of enrolment. To ensure confidentiality, the following statement should be included in initial conversations between the public health or clinical care provider and the individual:

[2] COVID-19: Epidemic notice and Orders | Ministry of Health NZ

- *Please be assured that all information gathered during this call is strictly confidential and will only be shared with other Health Care professionals when and if required. If you have a welfare need, information about that need will be shared with MSD and other agencies so they can help you. Please tell me if you don't want your information to be shared with them*.

Welfare providers: The process by which referrals and consent for welfare services are managed for individuals with COVID-19 and whānau is under discussion and will be updated in the next version.

Where a person is not competent to make an informed choice and give consent, someone who has the legal right can make decisions on the person's behalf; namely a legal guardian or someone who currently holds Enduring Power of Attorney for personal care and welfare.

5.4 Assess Needs & Determine Care Pathway

A 'Manaaki first' approach is used to ensure that critical actions are undertaken following notification of a positive case, ensuring clinical safety through welfare assessments. A Manaaki first approach puts the individual and whānau at the centre of their care.

As part of the notification and assessment process, the following assessments will occur per the care coordination hub's protocol:

1. Clinical triage to assess any immediate risk caused by Covid infection
2. Public health assessment to initiate contact tracing and provide guidance on duration of isolation.
3. Clinical risk to determine the level of clinical care required for potential complications and management.
4. Welfare needs of the individual (and their whānau) inclusive of health, welfare, employment, and wider wellbeing areas to ensure they are supported to isolate safely.
5. Appropriate referral pathways and follow-up as needed.

Table 2: Assessment Checklist

	Action	**Responsible entity**
	Notification of positive COVID-19 Result and initial clinical triage	Public health or entity determined by local protocol of the care coordination hub
	Public health assessment for assessment of isolation requirements and contact tracing	Public Health
	Clinical risk assessment for COVID-19 complications and management	General Practice or another designated clinical provider
	Welfare needs assessment	Designated welfare organisation determined by welfare provider or local care coordination protocol

The following key pieces of information should be collected and documented through the assessments listed above:

- Pre-existing relationships with clinical providers. If no relationships exist, DHBs are responsible for ensuring that a clinical provider is available to support the health needs of people and households who are not enrolled with a general practice.
- Pre-existing or new care or support needs related to household support, disability, mental health, aged care, home and community support services, child development, and maternity.
- Household member ages, medical conditions, ability to work or continue education from home, access to sick leave, special needs, ethnicity, and preferred language.
- Housing assessment determining if self-solation at home is safe or feasible for the household, e.g., housing tenure, number of bedrooms and bathrooms, bed sharing, any potential challenges for isolation or quarantine. Appendix A provides recommendations for isolating at home safely.
- Needs to support data, digital and connectivity through the isolation period
- Ability to access basic needs to ensure that the household has what they need to maintain a safe isolation period, e.g., rural access, income support, leave, food assistance, hardship support, etc.
- COVID-19 status and testing of household members (dates, results, symptoms, retesting).[3]

If the individual with COVID-19 requires immediate support to isolate safely or has additional complexities that require ongoing support, a local service provider will be identified by the care coordination hub with input from the individual. Māori and Pacific should be offered Māori and Pacific services as a first option, where available.

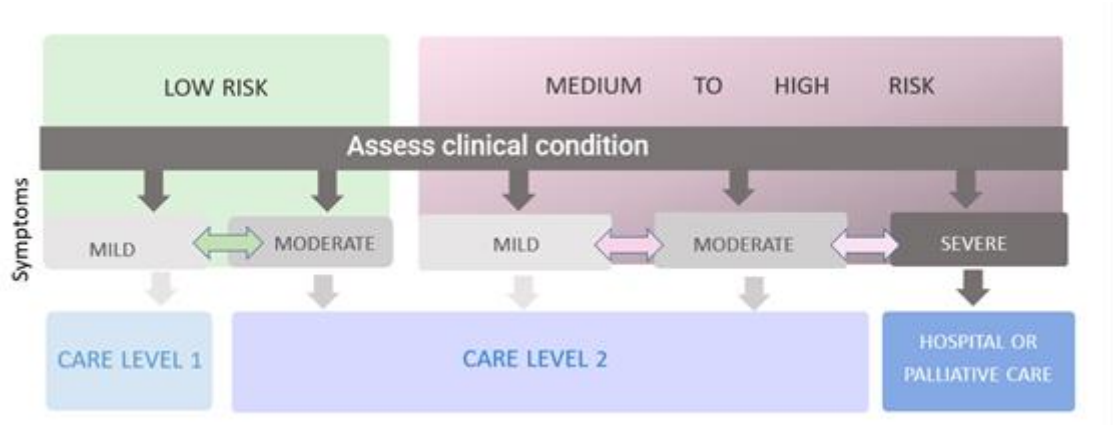
Based on the decisions made by the clinician, the individual and their household, the care coordination hub will develop a plan for delivering clinical care and welfare support as a part of the care continuum.

Assessing Clinical Needs

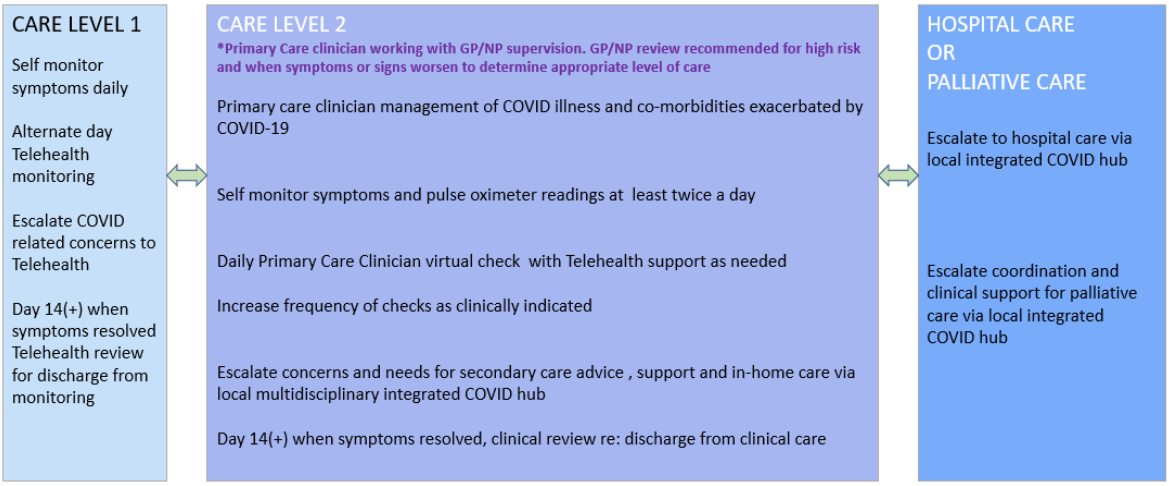
After the Public Health immediate notification and assessments are complete, the clinical risk assessment will be used to inform COVID-19 care levels.

- Clinical risk assessment and clinical pathways for people with COVID-19 and possible complications, co-morbidities and management implications can be found in Health Pathways via Health Navigator NZ.
- Individuals with COVID-19 will have their care needs categorised as either Care Level 1 (low risk care), Care Level 2 (medium risk care), or Care Level 3 (hospital or palliative care).
- Anyone experiencing severe signs and symptoms requires urgent hospital care, Level 3**.**
- Most young and healthy individuals experiencing no, or mild symptoms are deemed low risk and will initially require Level One clinical care. Those individuals who are 'at risk' or experiencing moderate symptoms will require more regular clinical care and should receive Level 2 care.

[3] All household contacts of a COVID-19 positive person require specific testing, education, and monitoring, as per standard public health processes. This is described in section 5.6 and is coordinated by PHUs.



Care levels explained[4]



Once the clinical care level is determined, the clinical provider will develop and establish a care plan, in coordination with welfare providers. Depending on the person's care level, there will be routine check-in points to ensure progress in recuperation.

Pulse oximeters

- Pulse oximetry, as a means of quantifying blood oxygen levels, has a role in monitoring the clinical status of some people with COVID-19. People who would benefit will be identified during their clinical assessment. Most people will not require a pulse oximeter to safely monitor their health.
- Individuals requiring pulse oximetry will be provided with a device and full instructions in its use. The data collected is to be relayed to the clinical team who are supporting the person in community isolation. Individuals will be advised when they should seek urgent help depending on the reading on the pulse oximeter.
- The delivery of pulse oximeters is considered the responsibility of the local care coordination team working with the Ministry of Health's COVID-19 health supply

[4] At the time of this table's development, isolation was at least 14 days long; it is now at least 10 days long.

chain. Given the variability in quality and connectivity requirements, DHBs and PHOs are advised to not independently secure pulse oximeters.

Assessing and providing welfare, wellbeing, and cultural needs

Welfare, wellbeing, and cultural needs are provided by a wide range of stakeholder organisations across the country. As described earlier, each locality should establish a care coordination hub where community and support services will coordinate with primary care teams to support the needs of the individual and their whānau.

The welfare provider, who is a part of the care coordination hub, ensures that individuals and their household are linked into the support services required for a safe home isolation experience. At a minimum, the following assessment information should be collected and documented in the Border Control Management System to inform welfare and wellbeing support services. The following should be documented:

- Ability to access basic needs to ensure that the household has what they need to maintain a safe isolation period, e.g., rural access, income support, leave, food assistance, hardship support, etc.

At this point in the integrated support pathway the individual with COVID-19 will have worked with clinical and welfare providers to complete assessments informing the individual's or whānau ongoing care during the period of recuperation.

5.5 Care and Support

Care and support describes the period of time after the needs assessments are complete and health pathway is determined. From this point forward there are regularly established health and welfare check-ins with the individual and whānau.

Compliance to home isolation

Expectations for compliance to home isolation are currently being determined and will be included in the next iteration.

Health deterioration

In the event that an individual's health deteriorates, the clinical care provider will assess the individual to determine the course of action and acute services required.

In the event of death

In the event that an individual with COVID-19 dies while isolating in the community, DHBs should follow their respective protocols to inform the relevant contacts and care for the deceased or tūpāpaku.

DHB death protocols should take into consideration religious and cultural beliefs and liaise with whānau to ensure the correct care pathways are followed for the tūpāpaku.

In all instances, care should be taken to:

- ensure a compassionate, empathetic approach
- support those close to the individual
- remain as transparent as possible, while respecting privacy.

5.6 Discharge, Follow-Up and Onward Care

Clinical guidelines on isolation and discharge timeframes for the individual with COVID-19 and their whānau or close contacts are updated regularly and can be found here:

Case definition and clinical testing guidelines for COVID-19 | Ministry of Health NZ

Follow-up and onward care requirements are determined in collaboration with providers involved in the individual's care.

6. Funding

The funding model for COVID-19 Care in the Community is in development and will be elaborated on once decisions have been finalised.

7. Digital Enablement

Aotearoa New Zealand does not currently have a standardised and integrated IT solution for health and social services. DHBs will need to work with systems already in place. It is critical that information from key disparate systems is shared where possible. As an interim solution this will be accomplished via the use of the Border Case Management System (BCMS). Health providers will input their assessments of each patient into their relevant medical records plus the BCMS.

All health providers will require training on the BCMS. To arrange access to the BCMS system, please contact border-apps@contacttracing.health.nz.

A more comprehensive system is in development to support the integrated care pathway. This solution will evolve over time to include a deeper level of integration with Primary Care PMS applications. More information will be provided as development progresses.

8. Next steps

The COVID-19 Care in the Community Framework will continue to evolve over time. As such, it will need to take account of changes in the virus itself, the prevalence of COVID-19 within the community, and the government's response to COVID-19.

Even more crucially, the Framework will evolve in response to what we learn about keeping people with COVID-19 and their households safe in the community, and the most effective ways of providing them with services and support, while balancing the safety and needs of our providers and workforce.

There will be significantly stronger engagement with the community in developing future evolutions of the framework. The immediate next step is to get a better understanding of how things are working for people with COVID-19 and their households, and the people who are supporting them.

APPENDIX A: Accommodation checklist for individuals with COVID-19 isolating at home

The following principles uphold the management of cases and household close contacts with regard to accommodation:

1. Confirmed individuals with COVID-19 should be separated from all others in the household as soon as possible to limit the spread of COVID-19.
    - This helps reduce the spread of disease to others living in the household and reduces the likelihood of prolonged isolation periods for households.
    - All household members of a case are considered close contacts and must isolate for a period of 10 days from the last exposure to a case. Every time a household member becomes a new case the clock resets. Household members are at greatest risk of disease transmission from a case - around 45% of household members will become cases if the index case is not separated from others.

2. Those isolating must have access to appropriate accommodation and essential services to ensure safe and successful completion of isolation/quarantine requirements.

3. The preference is that cases and household close contacts remain in their usual place of residence during isolation.

Checklist:

Individuals with COVID-19 should be separated as soon as possible from other household members to reduce the likelihood of the spread of COVID-19.
Separation can be achieved by the following options:

- separate room with ensuite;
- self-contained on-site alternatives, e.g., campervans or sleepout;
    - must have access to bathroom facilities (e.g., portaloo) or to a shared bathroom where cleaning protocol in place and use occurs separately to others.
- Cases or household contacts move to other suitable accommodation not on the property;
- As a last resort, alternative accommodation could include those sourced by the DHB or other provider, an MIQ facility, or other arrangements organised by whānau members.

Where cases cannot be separated from household members, the following should apply:

- Cases should minimise any contact with other household members by not spending time in the same area of the house and staying in their own room;
- Cases should wear medical masks and maintain physical distancing when they are in close proximity to others;
- Cases should sleep alone and in a separate room from others;
- If a separate bathroom is not available, then windows should be opened, to provide ventilation during and after use. Aim for 30 minutes before others use the bathroom. Surfaces touched by the case should be cleaned and disinfected after each use.

Cases could cohabitate where it is not possible to separate them from the household

- If there are multiple cases in the household, cases could share the same space separate from others to reduce the likelihood of further spread.

Accommodation requirements for safe isolation/quarantine

Cases and close contacts must have safe and sanitary living conditions to successfully complete isolation/quarantine:

- access to potable drinking water
- access to running water for personal hygiene
- access to appropriate sewage disposal
- access to heating and lighting
- access to reliable means of communication to enable monitoring of symptoms by a health provider and support for any welfare needs
- ability to ventilate the living space (e.g., open windows or mechanical system)

Further considerations

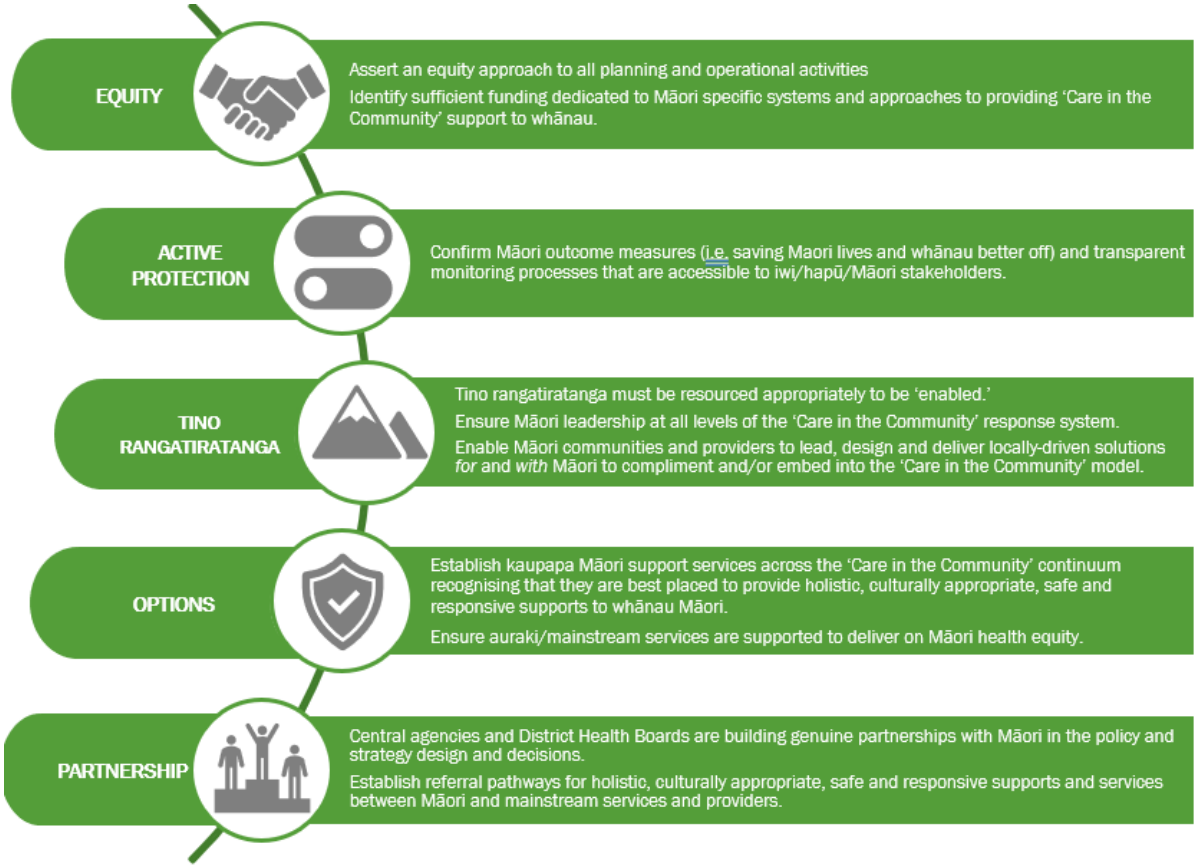
- Food – supplies and meals must be delivered in a contactless way. Cooking facilities are not essential if meals can be delivered. Access to shared kitchen facilities should be avoided. Cases should not be cooking for others and must eat separately.
- Cases should not use shared laundry facilities with others. Other household members can provide clean washing.
- Where a case is the usual carer of another individual, suitable support should be provided in their place.
- Cases should use outdoor space on the property only where they can maintain physical distancing from other household members.

APPENDIX B: Equity Expectations

The equity expectations under the COVID-19 Care in the Community Framework are described in greater detail here:

Expectation One: Embed Te Tiriti in your regional Care in the Community response
The principles of Te Tiriti o Waitangi, as articulated by the Courts and the Waitangi Tribunal, provide the framework for how we will meet our obligations under Te Tiriti in our day-to-day work.

The 2019 Hauora report recommends five new Te Tiriti principles for the primary health care system which have since been published in Whakamaua: Māori Health Action Plan 2020-2025. The following provides what a good Te Tiriti response could look like in a care in the community context:



Expectation Two: Establish and resource Māori and Pacific-led public health teams to deliver the initial engagement with Māori.
Positive and early engagement with households, within the first 48 hours of confirming a positive case in their home, will be essential in the Care in the Community response if we want to keep households safe and reduce the spread of COVID-19 in communities.
This is dependent on:

- households receiving a culturally safe and non-judgmental experience
- clear and accurate information
- households having a clear understanding of how to keep themselves, the individual with COVID-19, and the community safe, and having the resources and supports to do so
- ensuring the immediate needs of households are identified and addressed inclusive of health, welfare, employment and wider wellbeing areas to ensure they can isolate safely in their homes.

Embedding Māori and Pacific teams in the initial public health response is likely to drive-up engagement of Māori and Pacific and ensure greater compliance with self-isolation regulations. Recruitment for these teams could be sourced and trained locally with support from iwi, community organisations, Māori providers, DHBs, Ministry of Social Development, local employment agencies and through community-based campaigns.

Where these teams are based is dependent on the local ecosystem. Options could include in existing public health teams and Māori providers.

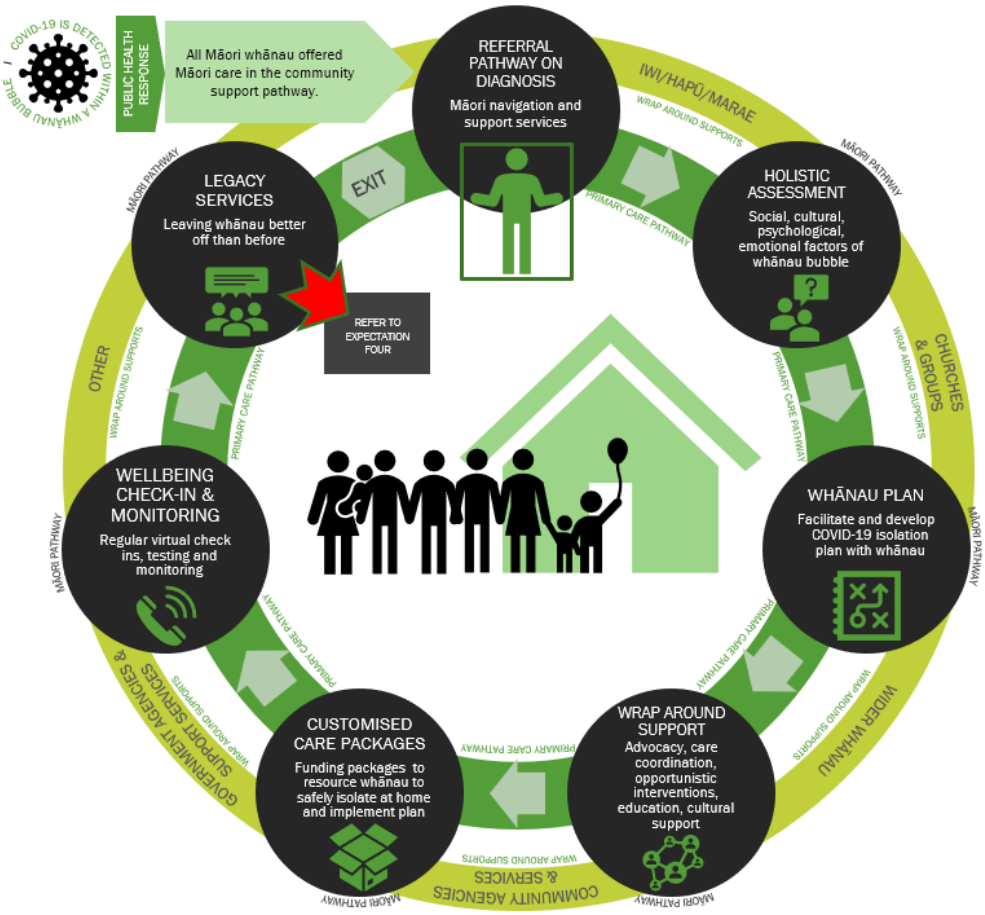
Expectation Three: Establish and resource 'Care in the Community' navigation pathways

Community-based services resourced to provide end-to-end 'Care in the Community' navigation services, care coordination and wrap-around support across health, welfare and other systems, will ensure the holistic needs of vulnerable households are met beyond the Care in the Community continuum.

Navigators have an ability to work across health, community, welfare, charity and iwi/hapū networks without constraint. They are a highly skilled and resourceful workforce - experts in whānau engagement, networking, coordination and connecting whānau to the right people at the right time for the right level of support and care.

There are existing navigation services working in the COVID-19 space and beyond across Ministry of Health, DHBs, Ministry of Social Development, Whānau Ora commissioning agencies, and Te Puni Kōkiri-funded providers. These could be further resourced and consolidated, to lead the COVID-19 Care in the Community pathway for households.

Embracing a 'funder agnostic' approach including co-commissioning components of community-based navigation services would bridge the welfare and health response and create a more seamless experience for households. The graphic below provides an example of what a community-based navigation service within a 'COVID-19 Care in the Community' response could look like, using a whānau ora approach.



Note:

- This approach is not to replace the COVID-19 Primary Care Clinical model. It is complementary.
- Māori, Pacific and community providers/groups will have a better handle on what their communities need and want in a service and, therefore, should be enabled to customise a suitable model.
- There will be providers who can deliver a comprehensive, end-to-end model inclusive of clinical, Whānau Ora and welfare pathways. These providers should be prioritised for funding in the first instance.
- Households who do not have legitimate New Zealand residency, should be guaranteed access to all 'COVID-19 Care in the Community' services, at no cost.
- This pathway embeds 'legacy services' – a care programme designed to alleviate the negative impacts COVID-19 has had on whānau and opportunistically address enduring inequities.

Expectation Four: 'Legacy services'

This framework upholds the principle that the COVID-19 Care in the Community programme should leave Māori and other vulnerable groups who have COVID-19 better off than they were before and will work towards that principle.

We will seek opportunities to engage people in health care where they may not have engaged in the past, specifically given the opportunity to enrol people in General Practice Teams when they were previously unenrolled.

Expectation Five: Design-in system enablers to drive equity for priority populations in the 'COVID-19 Care in the Community' response.

Funders and planners of COVID-19 Care in the Community services should embed the following seven system enablers in their COVID-19 Care in the Community response:

1. Ensure strong Māori (as Te Tiriti partners) leadership and decision-making at all levels of the COVID-19 Care in Community response.
2. Build community infrastructure by devolving funding to Māori and Pacific providers, local services and communities to drive local responses.
3. Enable Māori and Pacific communities to design tailored and targeted models that are holistic and culturally responsive, sensitive and safe across the COVID-19 Care in the Community continuum.
4. Embed agile, flexible and high-trust commissioning and contracting arrangements to enable local innovation and responsiveness.
5. Build systems that enable better cross-agency collaboration and coordination that puts the needs of whānau first.
6. Ensure clear communication from the centre while enabling localised campaigns and drives.
7. Continue to strengthen data collection and public health systems and processes (including IT and digital enablement) to deliver on equity.

APPENDIX C: Key DHB resources for COVID-19 Care in the Community

District Health Board (DHB)	Dedicated COVID-19 Care in the Community website, phone number or organisational email
Auckland DHB	https://www.adhb.health.nz/your-health/covid-19/
Bay of Plenty DHB	https://bopcovid.nz/
Canterbury DHB	https://www.cdhb.health.nz/your-health/canterbury-dhb-covid-19-information/
Capital & Coast DHB	https://www.ccdhb.org.nz/our-services/covid-19-changes-to-our-services/ https://www.ccdhb.org.nz/our-services/covid-19-community-based-assessment-centres-cbacs/
Counties-Manukau DHB	https://www.countiesmanukau.health.nz/covid-19/
Hawke's Bay DHB	http://www.ourhealthhb.nz/community-services/current-public-health-warnings-and-alerts/coronavirus/
Hutt Valley DHB	https://www.huttvalleydhb.org.nz/your-health-services/covid-19-community-based-assessment-centres-cbacs/
Lakes DHB	http://www.lakesdhb.govt.nz/Article.aspx?ID=12168
MidCentral DHB	https://covid19.mdhb.health.nz/covid-19-health-info/
Nelson-Marlborough DHB	https://www.nmdhb.govt.nz/quicklinks/about-us/emergency-management-and-planning/covid-19/
Northland DHB	https://www.northlanddhb.org.nz/home/covid-19/
Southern DHB	https://www.southernhealth.nz/COVID-19
South Canterbury DHB	https://www.scdhb.health.nz/info-for-you/covid-19vaccine
Hauora Tairāwhiti DHB	https://www.hauoratairawhiti.org.nz/your-health/covid-2/
Taranaki DHB	https://www.tdhb.org.nz/covid19/covid19.shtml
Waikato DHB	https://www.waikatodhb.health.nz/your-health/covid-19-in-waikato/
Wairarapa DHB	http://www.wairarapa.dhb.org.nz/news-and-publications/covid-19/
Waitemata DHB	https://www.waitematadhb.govt.nz/patients-visitors/covid-19-information/
West Coast DHB	https://www.wcdhb.health.nz/your-health/covid-19-formerly-known-as-novel-coronavirus/
Whanganui DHB	https://www.wdhb.org.nz/covid-19/

APPENDIX D: Metrics for COVID-19 Care in the Community

Step		Metric	Provisional target	Rationale
Test		Time of test to result being provided		
Notify	2.1	Percent of successful notifications by Primary Point of Contact within 24 hrs from positive test result entered in EpiSurv / total notification attempts	90% within 24 hours, and 100% within 48 hours.	Important to ensure people are informed about their diagnosis, and reinforces importance of isolation to protect community.
	2.2	Percent of referrals to the appropriate clinical, public health and welfare support within 24 hrs of the initial contact / total number of referrals	90% within 24 hours and 100% within 48 hours.	Important to ensure that people's clinical and welfare needs are met quickly.
Assess needs and pathway	3.1	Percent of cases isolating at home / total active cases	No provisional target.	The location for isolation will depend on the specific needs of each patient and household. May also run the risk of incentivising system to allocate people to home isolation when inappropriate.
	3.2	Percent of cases in managed isolation / total active cases		
	3.3	Percent of cases from home isolation to managed isolation or alternative accommodation within 48 hours of identified need following needs assessment / total isolating households	90% - Note how this can currently not yet be reported on, and we are looking into the feasibility of reporting on this measure with BCMS.	It is important to allow consideration of the needs of the individual and their whānau, to determine appropriate alternative accommodation.
	3.4	Percent of hospital cases / total active cases	No provisional target	This will depend on the needs of patients.
	3.5	Percent of ICU cases / hospital cases		
Care and Support	4.1	Percent of scheduled contacts from care representatives (welfare, clinical) on agreed days during isolation being on time / total scheduled contacts	90%	Ensures that people can communicate their needs and have these needs met.
	4.2	Percent of delivery of information / total active cases	100% within 24 hours	Ensuring people know what is required of them, and where they can go for help if needed.

	4.3	Percent of delivery of equipment / total active cases	90% within 24 hours	There may be delays outside the control of the health system regarding transport of equipment.
Follow-up and discharge	5.1	Percent of cases recovered and released from isolation / total active cases	No provisional target	This is determined by the number of active cases in the community
	5.2	Percent of deaths in hospital that originated in home isolation / total active cases		This is a clinical outcome
	5.3	Percent of deaths in home isolation / total active cases		