



National Health Emergency Plan

Guidance on Community- based Assessment Centres and Other Support Services

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MANATŪ HAUORA

Request for Feedback

The use of community-based assessment centres to provide additional primary health services during a civil defence or health emergency will continue to evolve. The Ministry of Health welcomes your feedback on the structure, process and content of this guidance document, and will consider incorporating your suggestions in future versions.

Please send any comments to:

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Or email your comments to: nhep@moh.govt.nz.

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Introduction

During the 1918 influenza pandemic the front line was in the community and in people's homes.¹ Since then little has changed. In a future pandemic, or in the event of a mass evacuation or large hazardous substances incident, the front line will also be in the community.

In these types of health emergencies it is likely that:

- the number of additional unwell people will be beyond surge capacity
- the capacity of District Health Boards (DHBs) and primary health organisations (especially during a pandemic) will be diminished by staff absences due to illness or staff staying at home to care for family members
- access to existing facilities will be limited, either because the facility is non-operational due to the emergency or because there is a risk of cross-infection
- existing primary and hospital facilities will need to continue to provide care for people requiring treatment for other conditions.

New models of community-based care are required that allow for the best care possible in different types of emergency situations when existing primary and home-based services are overwhelmed.

Community-based assessment centres (CBACs) are one of the solutions planned for these circumstances, especially where there are large numbers of people involved. This document aims to provide guidance to DHBs and primary health organisations on the role and function of CBACs, home-based services and teletriage in a health emergency.

CBACs will provide assessment and triage and will supplement existing primary health care capacity. They are not field hospitals. In addition to CBACs, other services will be required for those people who are either unable or unwilling to visit a CBAC or a primary health centre. These services will include the use of home-based services and teletriage.

CBACs and other services may be activated by DHBs after they have activated their local health emergency plan. They may also be activated following the activation of the National Health Emergency Plan (NHEP), as outlined in the NHEP itself (see www.moh.govt.nz/emergencymanagement/NHEP).

¹ GW Rice. 2005. *Black November: The 1918 influenza pandemic in New Zealand* (2nd edition). Christchurch: University of Canterbury Press.

What are Community-based Assessment Centres?

Purpose of community-based assessment centres

The purpose of a CBAC is to provide additional primary-care capacity when there is a sudden increase in demand for primary care services. This demand may arise from the need to provide separate facilities for people with infectious disease symptoms during a significant outbreak such as an influenza pandemic, or when there has been a mass casualty incident or a large evacuation of the population within a DHB region.

CBACs will be facilities where staff can provide clinical assessment, advice, triage and referrals to other services. They will not provide in-patient or observation services, or operate as field hospitals. Clinical staff will be supported by clinical leadership, onsite management, administrative and other support. Other support services will be provided externally and/or remotely by DHBs.

These centres will be established when the resources for the planned clinical services can be provided. They will be located where they can best meet the needs of the local community. Different approaches will be required based on the type of facility being used, and community consultation will be required in the pre-planning stages.

The final decisions on the nature, location and activation of CBACs will be made locally by the DHB in liaison with the local community. These centres, once established, will need to have their purpose and location widely publicised.

Background to community-based assessment centres

Planning for the establishment of designated assessment and/or triage sites in the case of emergencies is common in other countries, but these concepts are now being translated into more detailed planning.

In July 2004 the Ministry published the *National Health Emergency Plan: Infectious Diseases* (NHEP: ID).² At that time the Ministry asked DHBs, in consultation with primary and community health providers, to consider the use of 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.

² Ministry of Health. 2004. *National Health Emergency Plan: Infectious Diseases*. Wellington: Ministry of Health.

During 2004 three DHBs in the central region worked together to research and produce a document on the feasibility of community-based assessment centres for pandemic illness. This document, *Feasibility of Community Based Assessment Centres for Pandemic Illness*, published in November 2004,³ identified a number of features as well as future work that would be required to operationalise a CBAC.

Early development of CBACs was limited to pandemic planning, but since 2004 there has been growing recognition in the health sector that CBACs may have a use in a variety of emergency situations.

Planning for community-based assessment centres

In 2004 the Ministry conducted initial modelling on the community size that could warrant the establishment of a CBAC. This modelling suggested that one CBAC per 30,000 population was the optimal arrangement, and that the primary constraint would be the availability of a suitable workforce.

The population size served by a CBAC very much depends on the density of population, transport, communication capacity and other resource availability, including the availability of suitable facilities. DHBs will need to balance the competing demands of providing wider population cover; reducing the need for people to travel; limiting the number of CBACs for resource, logistic and security reasons; and the ongoing costs of maintaining this capacity.

Types of staffing will need to be determined according to the nature of the emergency.

Role of community-based assessment centres

The role of a CBAC will be to provide temporary additional primary health care facilities to assist in the management of overwhelming health need arising from a sudden increase in demand. These centres will provide for the initial assessment of people who may be unwell. The focus will be on assessment, and they will process a large number of people quickly. They are not intended to be sophisticated investigative and treatment-type facilities.

In the case of a pandemic, CBACs will be utilised to triage influenza cases that meet the case definition and who are likely to benefit from available clinical intervention. In the case of a mass evacuation, CBACs will be able to provide initial assessment, triage and referral.

³ Hutt Valley District Health Board, Capital and Coast District Health Board and Wairarapa District Health Board Regional Public Health Unit. 2004. *Feasibility of Community Based Assessment Centres for pandemic illness*. Wellington. URL: www.moh.govt.nz/moh.nsf.

Functions of community-based assessment centres

The primary functions of a CBAC will be to:

- triage and provide clinical assessment
- provide advice
- make referrals to other primary health or secondary health care services
- gather information to inform the government, civil defence and emergency management groups and other agencies on the state of the public health.

In the case of a pandemic, CBACs will also be able to provide a secure distribution centre for dispensing antivirals and antibiotics.

More specifically, CBACs will be facilities for the community that:

- physically support screening carried out by teletriage and home-based services
- are an identified place for the community to seek help and information
- reduce the need for travel
- enable the community and the health workforce to be utilised in an efficient and effective way
- lessen the load on hospital-based services through effective screening
- are responsible for rationing scarce resources in accordance with national policies
- have the capacity to stream patients into appropriate clinical pathways, as available
- may help slow the spread of a pandemic
- are a means of providing emergency public health interventions
- protect other primary health care personnel from increased exposure to infection in the case of pandemic
- provide protection to other primary health care services and the community in a pandemic
- support primary health care and hospital-based secondary and tertiary services.

Provision of medicines and equipment

CBAC staff will provide prescriptions and a limited range of medicines to individuals. During a pandemic they will dispense antivirals and may dispense antibiotics.

Medicines will generally be dispensed using a 'standing order'. CBAC staff will not dispense 'over-the-counter' medicines such as panadol and will not hold stocks or dispense routine medicines like antihypertensive medicines. They will not provide personal protective equipment such as face masks or gloves for the public, or other personal supplies such as osteomy equipment.

Associated work is being undertaken by the Ministry on the ability of CBACs to dispense medications, the application of standing orders and the informed consent procedures that would apply.

Essential features of community-based assessment centres

CBACs will probably be stand-alone facilities. They could be set up in primary care facilities, disused hospital or institutional sites, after-hours accident and medical centres not being used for the treatment of other conditions, hospital outpatient facilities, community centres, schools, marae, motels, tents or marquees. CBACs may also be mobile units.

Some of the advantages and disadvantages of using various facilities are listed in Appendix 1. In choosing a facility, the following features will be a priority:

- **location** – the site should be familiar to the community and have acceptable proximity to hospital and pharmacy services
- **capacity of the facility** – the facility will need to be able to accommodate, patients, staff and administration appropriately
- **layout** – this must support safe practice (ie, provide effective infection prevention and control appropriate to the use of the CBAC)
- **storage** – the facility must have the ability to safely store medicines, equipment and supplies
- **other requirements** – it must also be able to meet other building requirements (eg, governance, insurance, compliance, fire protection).

Appendix 2 contains a checklist of the preferred site characteristics.

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, as people will be more likely to access services they trust. Overall, CBACs will have to be planned with the needs of the community in mind. There is no one size, or even range of sizes, that fits all emergencies or all DHBs.

Resourcing Community-based Assessment Centres

Workforce

Each CBAC will require clear leadership and management. The manager and health professionals will be drawn from existing public health, primary and secondary health care services. Administrative staff, cleaning staff and security personnel will also be critical to the operation of a CBAC.

The demand for a CBAC to be fully functional in an emergency means there will be little time during or immediately prior to an emergency for education and training in basic competencies. Staff that are likely to be involved in a CBAC will need education and training prior to the activation of a CBAC, and probably some refresher training immediately before the CBAC opens.

The ability to deliver an education programme that requires no face-to-face teaching will be important. In recognition of this aspect, the Ministry is developing an education resource to train staff in the establishment and maintenance of a CBAC. This resource is expected to be available in electronic format by mid-2009.

Volunteers

Volunteers may be used to undertake various functions under the supervision of clinical or administrative staff. They are an important part of the health sector. Every day, large numbers of individuals – either independently or as part of a volunteer organisation – support patients and staff in hospitals.

As the health sector has been planning for pandemics and other health emergencies it has become apparent that during any event that reduces the numbers of health staff and services available through the usual channels, different ways of providing health services to communities need to be identified. Services will be reliant on members of the community assisting with their operations, and *Guidance on the Use of Non-health Volunteers in Community Based Health Services in an emergency* is available (www.moh.govt.nz/emergencymanagement) to help DHBs develop the processes they will need to implement when they start establishing these services and recruiting 'non-health'⁴ volunteers. It is strongly recommended that each DHB designate a person to specifically manage the volunteer programme.

DHBs may also want to develop a register of personnel with a range of workforce skills who may be available to help staff a CBAC in a health emergency. These may include people from within the existing and trainee health workforce in the primary and hospital sector, such as those from public and private hospitals, clinical personnel within current volunteer organisations (eg, Red Cross, Salvation Army, etc), and ambulance personnel.

⁴ People not currently employed in a health care setting or registered/credentialed to provide health care.

Funding

The Ministry provides funding to all DHBs to support and enhance emergency management preparedness and response. Funding is adjusted for each DHB's population mix, 'hazardscape', tertiary loading and rurality. Further information on funding is outlined in the NHEP (www.moh.govt.nz/emergencymanagement/NHEP).

Management of Community-based Assessment Centres

Activation

CBACs will be activated following the activation of a Health Emergency Plan by a DHB or as part of the NHEP. Activation will occur during a Code Yellow phase in the response period, as outlined in the NHEP. The decision to activate a CBAC will be made locally by a DHB in consultation with the Ministry. The plan to operationalise the CBAC will need to be fully implemented, and the location of the CBAC will need to be widely advertised in accordance with the CBAC communication plan.

Deactivation

The Ministry anticipates that CBACs will be disestablished as soon as possible in a health emergency once operating conditions no longer warrant this type of facility. The date and time of the official deactivation of the CBAC will be determined by the DHB in consultation with the Ministry. Following deactivation, the DHB should advise the Ministry (see www.moh.govt.nz/emergencymanagement/NHEP).

Information management

CBACs may be the first point of contact for some of the general public. DHBs will be able to disseminate public information through their CBACs, which will be in a prime position to educate the general public attending the facility. As a result, the DHB will be able influence and educate the wider community.

CBACs will also feed information back through WebEOC, which is the health sector's web-based emergency management information system. WebEOC is the primary tool for the management of significant incidents and emergencies at a local, regional and national level. It provides a system to manage information produced during an emergency. Information on WebEOC is shared with other key emergency management agencies.

CBACs must be able to capture and transmit the Pandemic Minimum Data Set to their DHB. This data set has been designed to capture epidemiological, administrative and stock management data to assist in the management of pandemic influenza and national reserve supplies such as Tamiflu.

The data must be forwarded to the Ministry of Health, where it will be used to assemble a national picture and inform, among other things, decisions about replenishing DHB stocks of antiviral medicine or other national reserve supplies. The Ministry is working to develop an electronic reporting system which will enable rapid and easy Pandemic Minimum Data Set reporting, either on a direct-entry basis or an after-event basis from the CBAC forms.

Provision for the suspension or modification of certain emergency statutory legislation

The Ministry is working to improve emergency management by removing statutory impediments. In October 2006 Cabinet directed the Ministry to ‘start preparing regulations directed at matters of that Ministry’s oversight ... that will modify, suspend or waive compliance with statutory responsibilities and deadlines during an epidemic’. This refers to the ability to issue ‘Prospective Modification Orders’ under the Epidemic Preparedness Act 2006. These orders provide for the suspension or modification of certain statutory obligations, but they sit dormant until activated by an epidemic notice issued by the Prime Minister.

Several potential impediments to effective pandemic management have been identified in the following legislation:

- Health Practitioners Competency Assurance Act
- Health and Disability Safety Services Act
- Burial and Cremations Act
- Medicines Act
- Misuse of Drugs Act (and associated Regulations).

While looking at the pandemic issue it has become apparent that it is necessary to explore ways to suspend statutory obligations during other emergencies – not just epidemic emergencies. Managing ways of suspending those obligations that do not involve regulations is also being evaluated.

The Ministry of Health is expected to have the options and recommendations to Cabinet by May 2009.

Future planning considerations

DHBs must investigate the provision of CBACs that meet as many of the essential features as possible. They should make agreements to ensure they can implement CBACs when required. The establishment and operation of these CBACs should be tested through exercising to ensure they will be effective when activated. Ongoing exercising of CBACs will also increase the pool of appropriately trained people who are able to provide services in a health emergency.

Other Services

Home-based community services

In the event of a major health emergency such as a pandemic or major earthquake, existing home-based services are likely to be overwhelmed. The demand for home-based services may increase markedly when there are more sick people within a community. Normal staffing levels may be severely reduced, resulting in many people not receiving their usual level of care.

DHBs should consider how they will extend their provision of home-based services if this situation occurs. It is likely that the use of volunteers under the supervision of clinical staff will be necessary to support an increase in home-based services.

In a pandemic the 'stay at home and phone' message will be widely communicated. Many people may want to distance themselves from CBACs and other medical facilities, where their risk of contracting infection will be higher. This will place extra demands on non-hospital services.

Teletriage

Telephone triage enables the provision of advice to people with access to a telephone. These systems are a public information management tool that:

- provides almost instant access to standardised automated advice
- includes the option for callers to speak with someone if necessary
- can cope with large volumes of callers calling simultaneously
- can re-route people to their local calling area for local advice
- reduces the immediate need for callers and/or their families to travel
- reduces road traffic
- reduces the need for personal contact, thereby minimising the risk of cross-infection, providing one of the safest methods of communicating health advice to a large number of people in a pandemic
- can be used to redirect people to additional services such as CBACs, or to direct home-based services to people if they are unable to travel
- optimises the efficiency and effectiveness of the health sector.

Teletriage is a useful communication tool when people are being encouraged to stay at home. People are more likely to comply with instructions if they can access professional advice by telephone. The establishment of a national teletriage service with the capability and capacity to respond to large volumes of callers throughout New Zealand is being investigated by the Ministry.

Further Information

Hutt Valley District Health Board, Capital and Coast District Health Board and Wairarapa District Health Board Regional Public Health Unit. 2004. *Feasibility of Community Based Assessment Centres for pandemic illness*. Wellington. URL:www.moh.govt.nz/moh.nsf

Ministry of Health. 2008. *National Health Emergency Plan*. Wellington: Ministry of Health.

Rice GW. 2005. *Black November: The 1918 influenza pandemic in New Zealand* (2nd edition). Christchurch: University of Canterbury Press.

Appendix 1: Advantages and Disadvantages of Different Types of Facilities

Publicly owned hospital facilities

Advantages

- The location may have advantages (eg, staff and equipment are available, and would have close proximity to inpatient beds if needed).
- It may be possible to screen all patients presenting at the ED and divert infectious people to the appropriate unit.
- The CBAC could be set up or converted more easily, with less disruption to the community.
- It may have advantages for exercising and ongoing testing.
- The facility could have a dual use in non-emergency situations (eg, training).
- Staff are already in place.
- Equipment is already in place.
- There are established links with other secondary and emergency services.
- The community is familiar with the location.
- IT and communications are in place.
- Support systems are in place.
- There is access to parking.
- The facility may have an established public transport service.

Disadvantages

- The location may attract additional people on to the site, contributing to demand problems.
- The location may not reduce the public's need to travel.

Privately owned medical facilities

Advantages

- Some staff may be available.
- Equipment is in place.
- There are established links with secondary and emergency services.
- The community is familiar with the location.
- IT and communications are in place.

Disadvantages

Privately owned medical facilities may:

- be too small
- have limited physical access
- limit access to non-pandemic care
- not have a suitable layout for infection control
- be too costly, because it would result in loss of business to the facility owner
- not be able to be rapidly converted
- not be able to be used for routine exercising and testing.

Other types of facilities

Advantages

- Depending on size, other types of facilities could accommodate large numbers of staff and patients.
- It may be able to be rapidly converted.
- It may be less costly.
- It could be an adjunct to an existing facility.
- There are multiple site location options.

Disadvantages

- It may be necessary to import everything into the facility.
- It may be harder for staff to work in due to the layout.
- The layout may not be ideal for infection control

Mobile units

Advantages

- A mobile location enhances access.
- It could have dual use; eg, with the PRIME (Primary Response in Medical Emergencies) scheme for rural trauma.

Disadvantages

- Costs (unless dual uses can be found) could be high for the low volume.
- Telecommunications and information management will be more complex.
- Size – it is probably going to be smaller than a stand-alone facility.
- It may need other temporary facilities surrounding it.
- It may be difficult to maintain supply lines from the DHB.
- A mobile CBAC will not be known to the community, so the location will need advertising.
- Hygiene facilities will be needed.

Appendix 2: Preferred Site Characteristics for a CBAC

Location characteristics

The ideal CBAC would:

- be in a location that is familiar to the people living in the area
- be able to be operated 24 hours a day
- be easy to access, preferably via drive-up access with separate entry and exit points
- have access and parking for the public and staff
- have access and parking for emergency services
- be accessible to the public arriving by foot or public transport
- be accessible to the majority of potential users
- be accessible to hospital transport for delivery and pick-up
- be close to other referral or treatment facilities
- be close to a pharmacy
- be able to be secured or cordoned off
- be able to support a staging area and crowd control
- have minimal effects on nearby residents/roads, businesses
- have support signage
- be supported by local authorities (Police, Fire, Emergency Services).

Facility characteristics

The assessment area should have:

- an entry point with hand washing / hand gel
- a registration area (with a glass screen to minimise droplet spread)
- a waiting area with washable furniture and washable floors, and no toys, magazines or newspapers
- screens
- a triage area that can be closed off, with sufficient space or screening to permit social distancing by staff when not carrying out physical examinations, and with minimal equipment in the room, washable surfaces on the furniture, pedal-operated rubbish bins, linen skips and arm-operated taps
- a transfer and pre-hospital area
- a patient education/information/counselling area
- a discharge and pick-up area
- a mortuary area with pick-up area.

The overall facility should:

- have a layout that supports safe practice (ie, approved as suitable by infection prevention and control practitioners)
- be big enough for a number of staff needing to work and rest, as well as for patients and their supporters
- toilets, hand basins with arm-operated taps, disposable paper towels, pedal-operated rubbish bins, showers
- kitchen catering and cooking
- secure storage
- a staff education/teleconferencing multipurpose area for conducting training and meetings
- laundry facilities (clean and dirty)
- sufficient storage for essential support systems such as potable water, electricity (emergency generators), natural gas, heating and cooling
- a means of disposing of infectious or hazardous waste and food waste.

Human resources

There should be access to:

- a range of staff with a wide range of clinical and support skills, which may include staff with expertise in mental health
- additional and relief staff
- interpreters contactable by telephone, if required
- security for the site 24 hours a day, seven days a week, so that the staff and materials (eg, antivirals and information systems) are secure, and for crowd control
- support staff and maintenance services (eg, plumbers, building maintenance, electricians)
- training materials
- telephone lists.

Medicines, equipment and supplies

There should be available:

- disposable equipment (masks, gloves, gowns, antiseptic hand-rub, water-soluble liner for linen bags, biohazard bags, disposable clothing, paper tissues)
- aural scope thermometers for taking temperatures
- medicines as appropriate (eg, antivirals)
- supplies (eg, stationery)
- telecommunications systems for internal and external communication (eg, phones, fax)

- information systems that enable staff to receive, record, scan and transmit essential health information
- access to additional emergency equipment such as personal protective equipment from the DHB, as needed
- secure storage for medicines, medical supplies, patient records, stationery, personal protective equipment, cleaning materials and other supplies
- approved cleaning solutions, products and equipment.

Other items for consideration

You may need to consider:

- the current governance and legal status of the facility
- resource consents
- other compliance requirements
- insurance for the facility and staff
- fire protection.