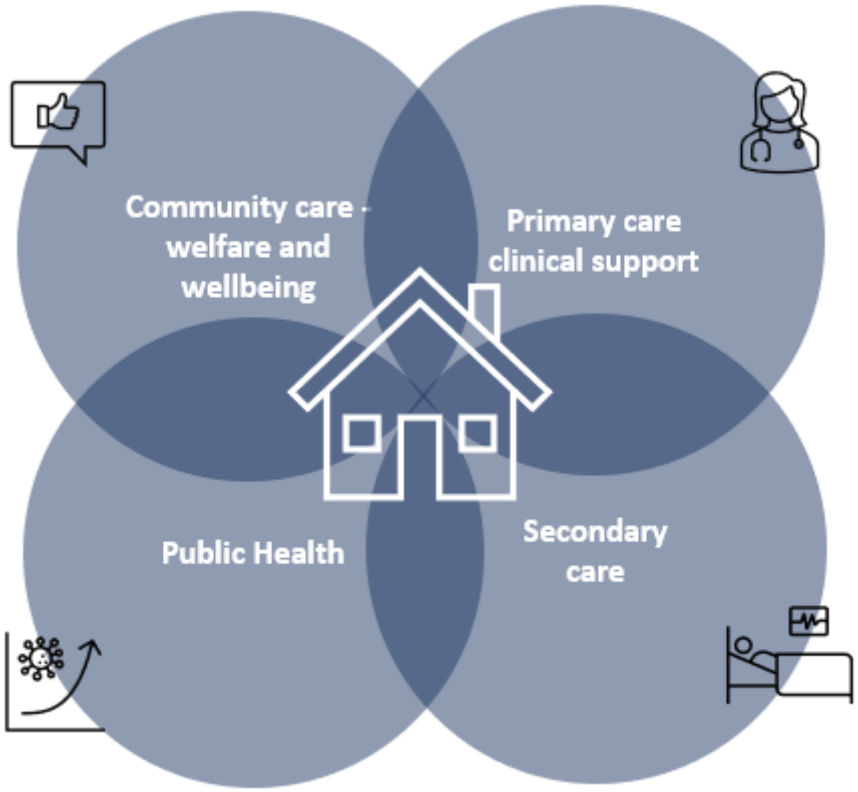


COVID-19 Care in the Community

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

Version 2.0

20 December 2021

Unite against COVID-19

MINISTRY OF HEALTH
MANATŪ HAUORA

Abbreviations

Abbreviation	Full Name
BCMS	Border Clinical Management System
DHB	District Health Board
DPMC	Department of the Prime Minister and Cabinet
HQSC	Health Quality and Safety Commission
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 Contact 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		

COVID-19 Care in the Community Resources

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)
	Family Services: 0800 211 211 Work and Income: 0800 559 009 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 Clinical Management System	border-apps@contacttracing.health.nz
MOH: Personal Protective Equipment and other consumables	COVID.healthsupplychain@health.govt.nz
National Telehealth Services (Specific COVID-19 Services)	COVID-19 Healthline (General Public): 0800 358 5453COVID-19 Home Isolation Healthline: 0800 687 647Mental Health and Addictions Support: Call or text 1737
Ministry of Social Development (MSD)	COVID-19 - Ministry of Social Development (msd.govt.nz)
MSD Regional Service Centres	Find a Service Centre - Work and Income
Kāinga Ora	https://kaingaora.govt.nz/tenants-and-communities/covid-19-information-for-our-tenants-partners-and-suppliers/covid-19-services-and-support/ COVID-19 notification number: 0800 006 077COVIDnotifications@kaingaora.govt.nz
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

Summary of Changes to Version 2.0, 15 Dec 2021

Section	Summary of Changes
Entire document	• References to disability and mental health and addictions populations strengthened throughout document
3. Roles & Responsibilities	• Roles and Responsibilities section expanded to reflect MOH and MSD roles and structure at a national, regional and local level; • Expectation and description of Care Coordination Hubs • Workforce requirements language included
4. Clinical Governance	• Language updated by HQSC, including two appendices offering guidance on clinical governance structures and adverse event review guide
5.3 Notification	• Escalation in the event of non-contact language has been updated
5.4 Assessing Needs	• Language on assessing needs around alternative isolation accommodation included • Pregnancy language included
5.5 Care and Support	• Compliance to isolation language has been added; in review with Health Legal and Public Health
7. Digital Enablement	• Language updated to reflect “Fit for Now” content
Appendix B	• Roles and Responsibilities Tool for Care Coordination Hubs
Appendix C	• Initial guidance for establishment of quality and safety governance
Appendix D	• COVID-19 Care in the Community Adverse Event Review Guide

Contents

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.

1.1 Context

As Aotearoa New Zealand's vaccination rate increases, we can expect that disease transmission and serious illness requiring hospitalisation will be reduced. This means that where suitable, 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. 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)) Framework covers 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[1]. A care in the community approach to COVID-19 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.

1.2 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 the needs 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. Therefore, this document is now considered a Framework for organisations and providers to follow.

The Framework is for health and support providers, including, but not limited to Māori, Pacific, people in the disability and mental health and addiction sectors, public health, residential aged care,

[1] The SIQ model began implementation in August 2021 when Aotearoa New Zealand was still under a COVID-19 elimination plan. Because Aotearoa New Zealand has shifted to a suppression model, the SIQ model is phasing into the COVID-19 Care in the Community model. This Framework uses "COVID-19 Care in the Community" to describe the period of isolation within the community.

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 people with COVID-19 and whānau safely, effectively, and equitably in the community.

The Ministry of Health and the Ministry of Social Development have a shared 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.

1.3 Framework Principles

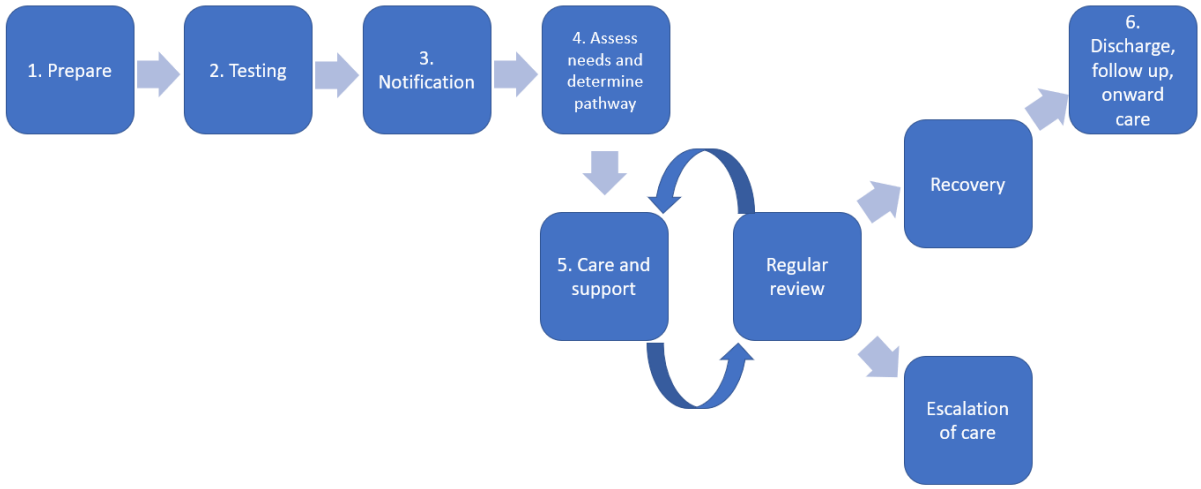
The principles of the Framework are to:

- ensure people with COVID-19 and the whānau have access to COVID-19 health and support services, at no cost
- enact and embed our obligations to Te Tiriti o Waitangi
- 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 – locally-delivered, regionally-led and centrally supported.

1.4 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.

Figure 1: The Integrated Health and Support Pathway



2. Equity

In Aotearoa New Zealand, people have differences in health outcomes that are not only avoidable, but unfair and unjust. Equity recognises different people with different levels of advantage require different opportunities and resources to have 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[2]
- 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
    - ensure that responses both build on and align with support provided by disability and mental health services as priority populations
    - 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 A provides greater detail on the framework's equity expectations.

[2] '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

This section outlines the roles and responsibilities of the health and welfare sectors in coordinating and implementing the COVID-19 Care in the Community Response at a national, regional, and local level. The health, public health, social, and welfare sectors play key roles to keep the COVID-19 positive individual, their whānau, and the 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 welfare partners.

3.1 National Level

The COVID-19 Care in the Community response brings together two Ministerial agencies to provide integrated care and support at a national, regional, and local level. The Ministry of Health leads the health response; the Ministry of Social Development is leading the coordination of the welfare response.

The table below describes the functions and accountability for COVID-19 Care in the Community.

Table 1: COVID-19 Care in the Community Functions and Accountable Entities

Function	Accountable entity
Health Funding	Ministry of Health
Welfare Funding	Ministry of Social Development
Digital enablement	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
Coordination of the welfare response	Ministry of Social Development
Alternative isolation accommodation – identification of, and contracting for, alternative isolation locations	Sub-regional accommodation groups, including Kāinga Ora and MHUD, SIQ Coordinators, and DHBs
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

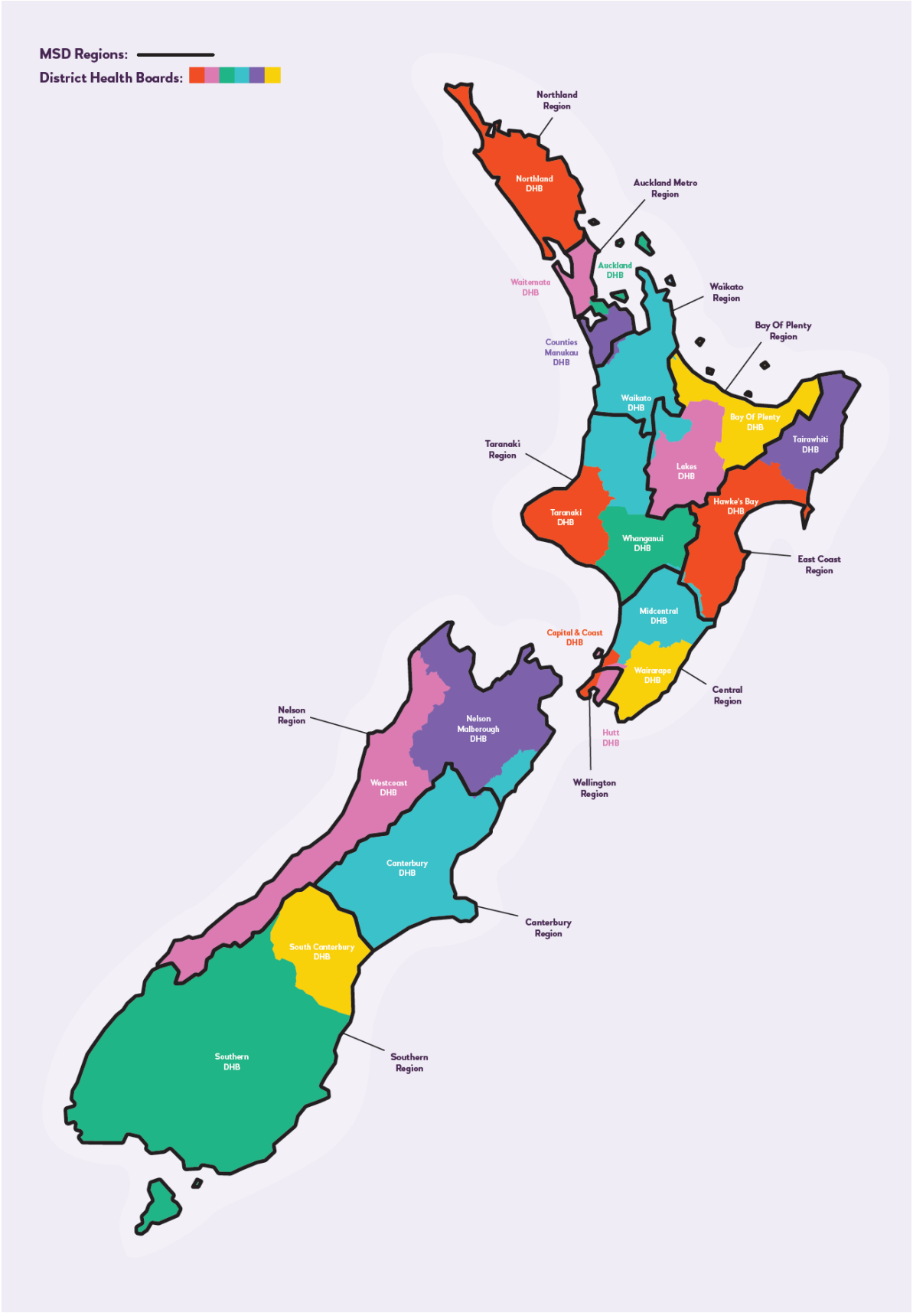
3.2 Regional Level

The MOH and MSD have different regional administrative boundaries, which could present challenges in establishing roles and responsibilities within Care Coordination Hubs and welfare providers. The table and map below highlight boundaries of the 11 MSD regional offices and 20 District Health Boards. Additionally, the MOH has four health regions, encompassing the 20 DHBs. Each of the four health regions has a regional health lead and coordination function.

Table 2: Health Regions, DHBs and MSD Regions Side-by-side

Health Regions	DHBs included	MSD Regions
Northern (NRHCC)	Northland, Waitematā, Auckland, and Counties Manukau DHBs	Northland, Auckland, and Waikato (partial)
Te Manawa Taki	Bay of Plenty, Lakes, Hauora Tairāwhiti, Taranaki, and Waikato DHBs	Bay of Plenty, Waikato (most all of), Taranaki, King Country and Whanganui (partial)
Central	Capital & Coast, Hawke's Bay, Hutt Valley, MidCentral, Wairarapa, and Whanganui DHBs	Wellington, East Coast, Taranaki, King Country and Whanganui (partial) and Central
Southern	Nelson Marlborough, South Canterbury, West Coast, Canterbury, and Southern DHBs	Southern, Canterbury, Nelson, Marlborough and West Coast

Figure 2: MSD and DHB regional borders



3.3 Local Level and Care Coordination Hubs

The local coordination function should enable a person and whānau-centred connection with public health, primary care, community care, and welfare services throughout their COVID-19 recuperation.

Because multiple stakeholders are involved with the individual and their whānau through the isolation period, care coordination is essential and best established via a coordination hub or hubs. The success of community isolation for COVID-19 relies heavily on well-developed processes and clarity regarding responsibilities.

The Care Coordination Hub model facilitates the inter- and intra- agency nature of this work. In most situations, cases will arise that local health and welfare providers are capacitated to address, leveraging existing systems and processes. However, because of COVID-19 the hubs should be used to facilitate ongoing care when services delivered are led by different agencies. COVID-19 Care in the Community does not seek to establish new structures and processes where they are not needed. Wherever possible, hubs should rely on systems and processes that already exist.

DHBs are accountable for there being a COVID-19 Care Coordination Hub or system that coordinates care services for people in the community with COVID-19. If a DHB or region opts to have more than one hub to coordinate services, we strongly suggest that there are processes in place that describe how the different hubs work together to ensure that all people receive the same level of care.

As a part of DHB accountability for COVID-19 Care in the Community, DHBs must have a clear understanding of the following roles, responsibilities, and processes:

- Ensuring positive test results are rapidly transmitted to the relevant clinical, welfare, and public health teams.
- Establishing clarity in how patients are contacted – it is crucially important that for Māori, Pacific, disabled and mental health & addiction patients wherever possible, the first contact is made by someone known to and trusted by the patient. Cultural appropriateness is critical, especially for those who may have low trust in the health system.
    - DHBs should liaise with local health providers for certainty about which health partner will contact a positive patient and if there are differing strategies needed out-of-hours for differing providers.
    - Ensuring clarity between DHBs and General Practice regarding roles and responsibilities, including what role post-diagnosis General Practice plays for a patient who is low risk and remaining well (for example if this case is handed to a national telehealth service for follow-up).
- Establish clear protocols for handling un-enrolled patients and out-of-town cases (domestic tourists).
- Where there are multiple parties and processes involved, assessment can happen concurrently. The primary focus is ensuring the health and welfare needs of the patient and their household are first assessed and addressed, whilst at the same time allowing Public Health to perform their role.
- Ensuring clinical needs are determined via the agreed clinical pathways, which then establishes subsequent follow-up approaches.
- Ensuring Welfare partners including local providers and MSD all agree roles and responsibilities.

- Ensuring arrangements are in place to transfer COVID-19 positive cases to facilities if required.
- Ensuring secondary care discharge arrangements include agreed pathways to notify the community care coordination hub of a COVID-19 positive patient being discharged to on-going community care, such as disability support providers.
- Ensuring that Care Coordination Hubs have coordinated with community-based partners who can implement door-knocking services in the event that contact with a positive case cannot be made by telephone.
- Ensuring Planned Care continues as resources allow, with particular emphasis on not allowing existing health inequities to worsen.
- Ensuring community services requiring face-to-face contact are able to be provided (for example, disability support).
- Ensuring local services and pathways are notified to National Service providers to facilitate appropriate integrated responses by those organisations – e.g. Ambulance Services or Healthline
- Requesting support that the region may require from the National Telehealth Service, via the Ministry of Health. Service components could include:
    - Referral coordination, Telehealth Checks (Daily & initial assessments for specific population groups), Release processing.
    - After-hours (and in-hours) access to the dedicated COVID-19 Home Isolation Healthline.
    - Back-up support across the pathway to support a surge in cases.

Once the needs of the individual and their household are identified, the care coordination hub should establish a process to identify a community coordinator/ Whānau Ora navigator/ Kaupapa Māori provider/ Pacific provider/ Disability Connector, mental health providers 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.

Health issues that emerge locally and regionally that cannot be resolved should be escalated to the Ministry of Health. The Ministry of Health and the Ministry of Social Development continue to work collaboratively to optimise our systems and processes.

Appendix B is a tool for Care Coordination Hubs to map the roles and responsibilities of the Care Coordination Hubs. This tool has been used as a part of the ongoing discussions between MOH, DHBs and other partners to map the roles, responsibilities and processes.

3.4 Workforce requirements

Ensuring a health workforce with the capacity, capability, and wellbeing to manage COVID-19 care in the community effectively is critical to the success of this effort. The Ministry of Health and the health sector are responsible for supporting the health workforce to meet these objectives and remove barriers to do this.

Care Coordination Hubs will have valuable insight around specific workforce needs. Hub leadership should work with sector organisations to identify and articulate workforce requirements so they can be addressed appropriately.

Operational workforce matters should be addressed locally and regionally, using existing workforce mechanisms including the DHB workforce leads. There are central workforce support tools (for example, access to the Hands Up database) to support workforce needs.

High-level, strategic workforce matters that need central support at a national level (for example, policy and regulatory adjustments) should be directed through the Regional Health Leads (described in Table 2), in conjunction with the DHB workforce leads.

4. Clinical Governance

Clinicians and healthcare organisations providing health services to COVID-19 positive individuals must have robust clinical governance structures in place. 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.

Across Aotearoa New Zealand, systems are being developed for COVID-19 Care in the Community. There are considerable risks where change is constant, roles, responsibilities and processes are not fully established, and information (IT) systems are not well integrated. There are also challenges related to Māori health and equity, with Māori twice as likely to have severe illness and be hospitalised than non-Māori. Clear, effective, and consistent governance for quality and safety is critical in this context.

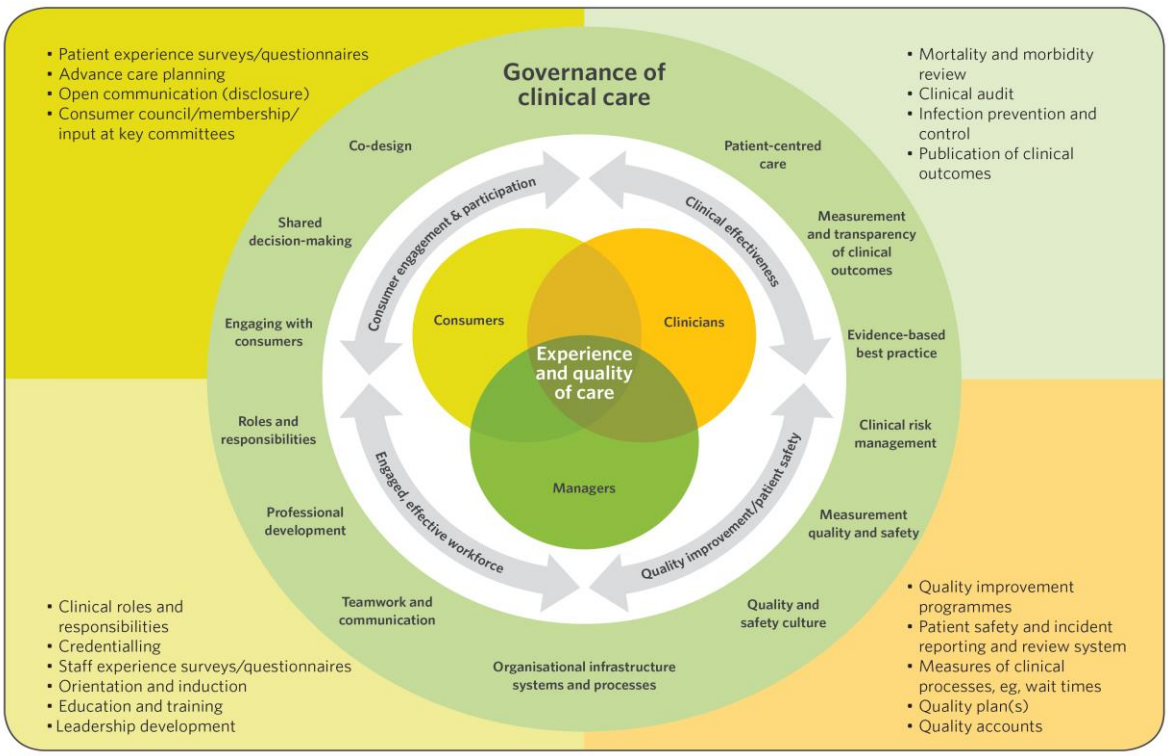
4.1 Purpose

This section and related appendices provide guidance for district health boards (DHBs) and other key stakeholders and partners establishing local quality and safety governance for COVID-19 Care in the Community. It does not include Managed Isolation and Quarantine Facilities (MIQF) or hospital-based settings. It does include transfers into and out of secondary care and MIQF.

4.2 Context

Whilst the guidance is based upon the Health Quality and Safety Commission's (the Commission) clinical governance framework, it is acknowledged the scope of the model is greater than clinical care and incorporates social and wellbeing aspects; neither does it capture mātauranga Māori. The term 'quality and safety governance' is used in this document to reflect these differences.

Figure 3: Clinical Governance Framework



Appendix C describes Initial guidance for establishment of quality and safety governance for COVID-19 Care in the Community.

Appendix D is an Adverse Event Review Guide for COVID-19 Care in the Community.

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 identifying gaps to address 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.

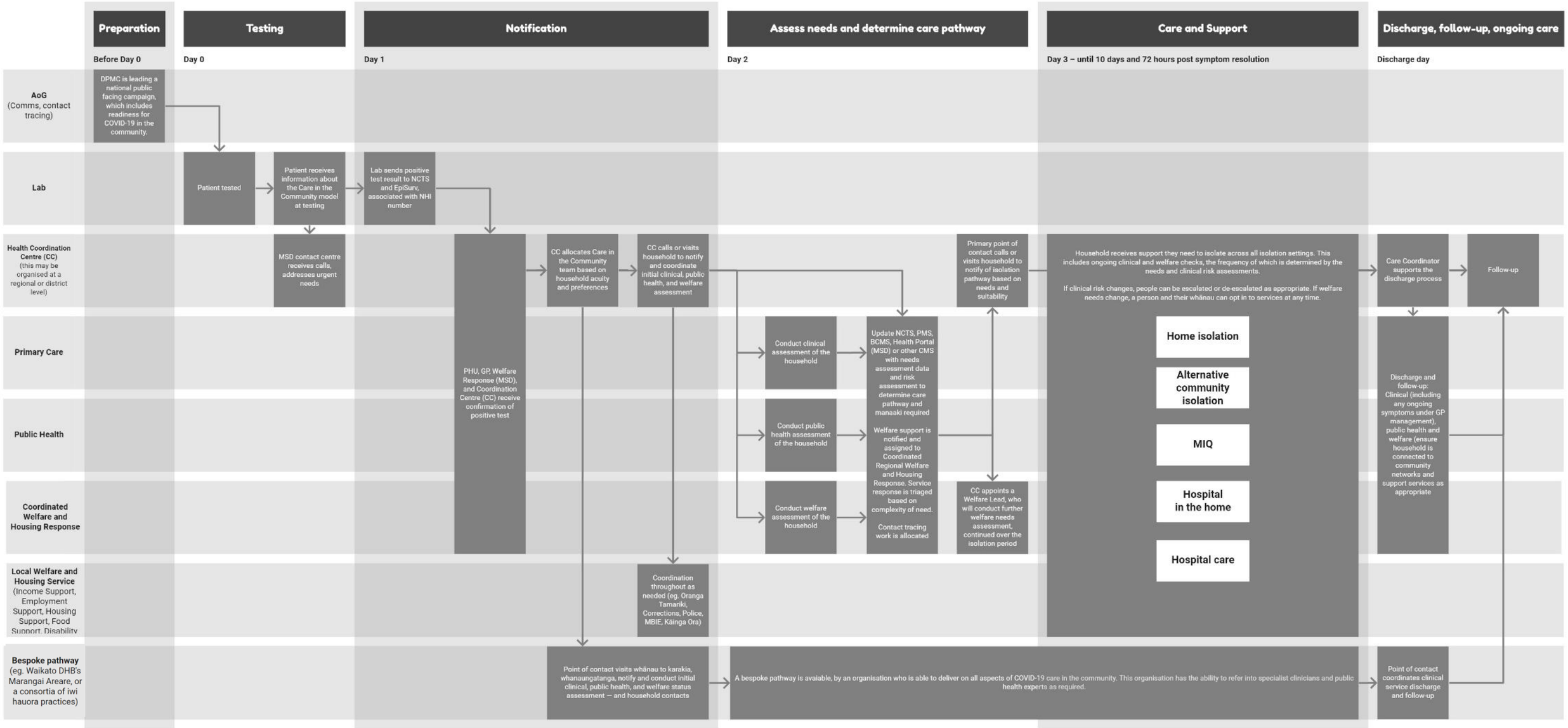
The metrics will be disaggregated by patients' age, ethnicity, and locality, to track how well the model of care is responding to the needs of specific population groups. The model can be updated to better reflect these needs. The metrics for COVID-19 Care in the Community can be found in **Appendix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

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

5. Integrated Health & 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. Organisational coordination throughout the care continuum is critical for successful outcomes for the patient and whānau.

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

- DHBs, PHUs, local providers, and welfare providers will need to design, implement, and resource community protection and preparedness plans in partnership with iwi/hapū/Hapori Māori (Tiriti partners) 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.
- People who rely on external care services, such as people with disabilities and people utilising mental health and addiction support, should have conversations with their support staff to ensure continuity of care in case they get COVID-19.
- 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 delivery of the test result is a clinical matter involving personal health information, a clinician or PHU will be involved with

delivering the results. However, the care coordination hub should include support to the clinician to ensure that a cultural advisor, such as a Kaupapa provider, is available as needed.

- 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. The care coordination hub 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

- A positive COVID-19 case result will be sent to the Public Health Units and the enrolled General Practice Team. Notification of the individual will occur per local Care Coordination Hub processes.
- 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, identify if additional support and assistance is required, how additional health and wellbeing support can be accessed, and the best way to communicate with the household. This may also include consideration of supports that are already in place such as those related to disability.
- 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.
- 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 within 24-hours to contact the individual by cell-phone or landline, including at least one call out of hours.
- If the individual cannot be identified after 24-hours, please refer to Finders, part of National Contact Tracing Solution (NCTS) to search for new contact numbers.
- The purpose of the Finders service is to find contact details for cases and disease contacts within NCTS, for any NCTS users working on cases or high priority contacts.
- In order to do this, Finders liaises with a number of external and internal sources of info, such as customs, GP practices, Police and IRD, as well as the Audit and Compliance team within the Ministry, providing as much detail as has been gathered by case investigators or contact tracers as necessary.
- Finders also uses a range of data sources to identify contact information, such as testing and immunisation databases, as well as enrolment data.
- Finders provide additional contact details for cases and contacts as well as helping to definitively confirm the identity of individuals for whom identifying details may be limited.

- Finders also makes calls to the next of kin and GP practices where available, in addition to emailing contacts directly when phone details are not provided.
- If an individual with COVID-19 still cannot be found, iwi, Māori, or Pacific providers and community networks may be used to connect with the person.
- If this the person still cannot be found, consider referring to the Police to locate the case.

Informed consent and privacy

Throughout the COVID-19 integrated care pathway, public health, general practice/primary care, and welfare have different processes by which consent is obtained.

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.[3]

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:

> *Please be assured that all information gathered during this call is strictly confidential and will only be used to support you while you are isolating. It will only be shared with other health care professionals when and if required. If you have a welfare need, information about that need and your contact details will be shared with the Ministry of Social Development which is coordinating welfare services and will connect you with a service that can help you.*

Welfare providers: If an individual with COVID-19 indicates that they do not need or do not want welfare services, their information will not be passed on to the regional MSD body coordinating welfare providers. Consenting for welfare services is managed and determined by local providers.

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.

Information packs

Within the first 48 hours of receiving a positive test result, households should receive an information pack with health and welfare advice. The pack may include a pulse oximeter if needed, and if so, should include instructions on how to use the oximeter.

These packs should be tailored to suit the needs of the local community and can be branded by the local DHB and other supporting agencies. The pack should include:

- Support for if you get COVID-19: care-in-the-community-support-if-you-get-COVID-19.pdf (covid19.govt.nz)

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

- ‘Do not enter, we are isolating’ posters - available on Brandkit with physical copies able to be ordered from Bluestar (links coming shortly)
- Contact details of the household’s main support person
- Symptom diary
- What to expect timeline https://covid19.govt.nz/assets/resources/posters/care-in-the-community-self-isolating-timeline.pdf
- Information on mental health or addiction support
- General advice for self-isolating What to expect when self-isolating at home | Unite against COVID-19 (covid19.govt.nz)
- Cleaning advice How to safely clean your home after a COVID-19 diagnosis | Ministry of Health NZ
- How to keep your family safe Advice for people with COVID-19 | Ministry of Health NZ
- Care in the community booklet - available on Brandkit with physical copies able to be ordered from Bluestar

More details can be found on the Unite Against COVID-19 website: Getting extra support if you have COVID-19 or are self-isolating | Unite against COVID-19 (covid19.govt.nz)

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, and ensuring clinical safety through welfare assessments. A Manaaki first approach puts the individual and their whānau at the centre of 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-19 infection.
2. Public health assessment to initiate contact tracing of the individual with COVID-19 and their whānau and provide guidance on duration and suitability of current location of isolation.
3. Clinical risk to determine the level of clinical care required for potential complications and management of the individual with COVID-19 and their whānau.
4. Welfare needs of the individual with COVID-19 and their whānau inclusive of health, welfare, employment, and wider wellbeing areas to ensure they are supported to isolate safely.
5. Ensuring continuity of existing health, disability, mental health and addiction supports.
6. Appropriate referral pathways and follow-up as needed.

Table 2: Assessment Checklist

Action	Responsible provider
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 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 E** provides recommendations for isolating at home safely.
- Data, digital, and connectivity needs throughout the isolation period.
- Access to 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).[4]

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 peoples 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 Accommodation Needs

Until recently, the self-isolation and quarantine (SIQ) service called for 5 – 10 additional locations to be procured by DHBs as an alternative isolation. However, as Aotearoa New Zealand shifts away from an COVID-19 elimination to suppression goal, additional alternative isolation accommodations will need to be procured for people who cannot isolate in their home. In most cases, the individual with COVID-19 and their whānau should be able to isolate within their home.

Some people, however, will not be able to isolate at home. Criteria for determining if an individual with COVID-19 can remain in their home, or if they need to be moved to alternative isolation accommodation or MIQF, is a part of the PHU assessment.

This assessment should include determining if the individual or whānau can comply with the requirements for isolation (if not, consider alternative isolation or MIQ) and determine if their house is suitable for isolation (if not, consider alternative isolation or MIQ).

[4] 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.

Suggested criteria for isolation accommodations is included in **Appendix F**. These criteria are a guideline and represent an ideal enviornment; the reality on the ground may not allow for all of these criteria to be met.

Guidance for isolating in an apartment can be found here.

Guidance for isolating over summer holidays in a motel or campground is forthcoming.

Identifying and Contracting Alternative Accommodation

Discussions to determine a long-term funding plan for alternative isolation accommodation are ongoing.

For the near term, over the summer, the SIQ service will use an existing funding pool to support the identification of, and contracting for, alternative isolation accommodations for individuals with COVID-19 and their households.

Sub-regional accommodation groups led by Kāinga Ora, including other agencies, iwi and other community partners, are connected with the regional MSD commissioner and will determine how they will provide support to SIQ coordinators and DHBs in the effort to identify appropriate alternative isolation accommodations.

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.
- Some clinical providers may use six steps for staging individuals with COVID-19. These should align to the three care levels described here.

Figure 4: COVID-19 risk and care levels

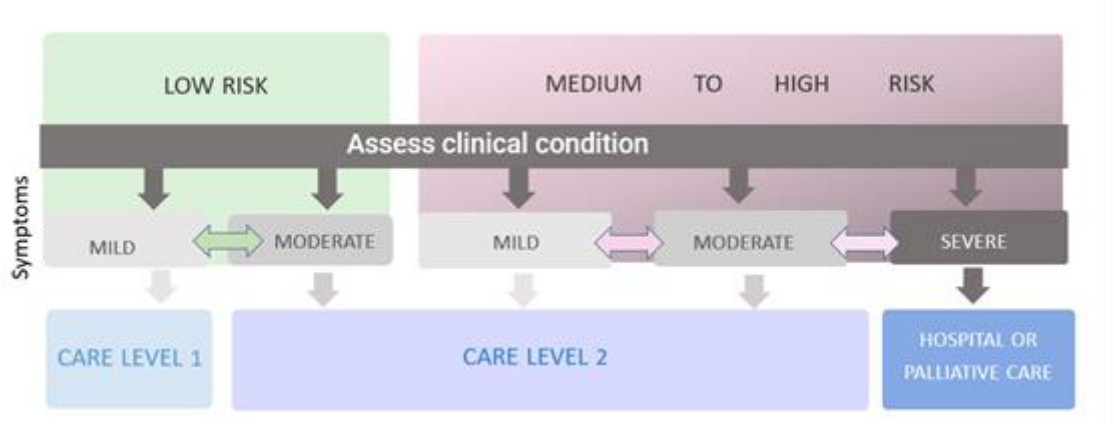
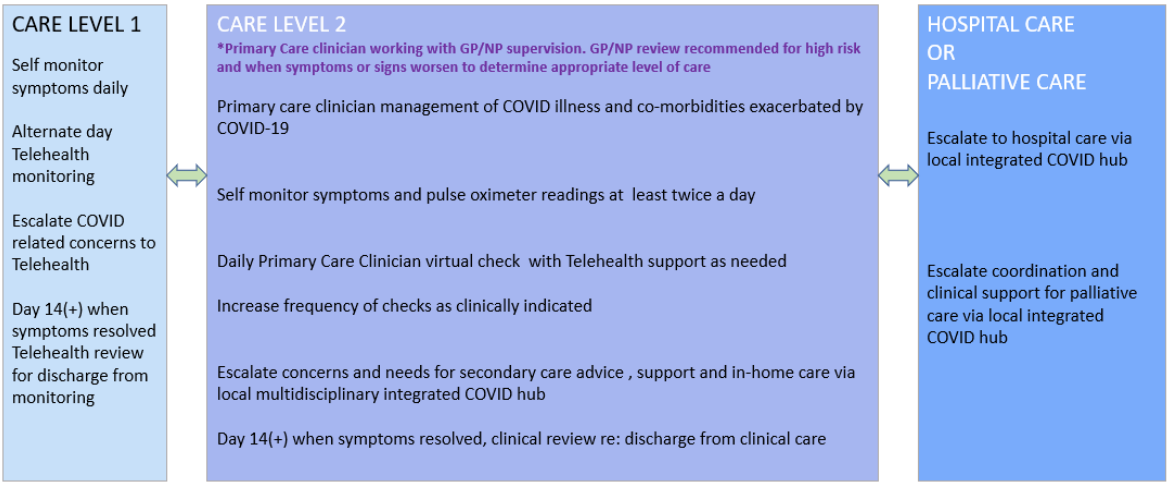


Figure 5: COVID-19 care levels explained[5]



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.

Pregnancy

Clinical guidance for GPs and LMCs care of pregnant people with COVID-19 in the community has been agreed upon by the Maternity CAG. This includes risk stratification and escalation triggers for referral to secondary care. This guidance has been passed to the HealthPathways team; they are working rapidly to review this guidance on the national platform.

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

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

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 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. 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. This may include consideration of any existing support services in place. At a minimum, the following assessment information should be collected and documented in the Border Clinical 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 describe the period of time after the need's 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 with home isolation

When there is effective communication, good relationships are established on the outset, and needs are met, compliance is good with few 'bubble' breaches. In general, individuals and whānau with COVID-19 agree to the placement and conditions recommended by their care coordination hub. Establishing a 'high-trust' model is the most effective way to ensure that the public health risk associated with non-compliance is managed.

In instances of non-compliance with isolation, these have largely related to unmet welfare, health, and accommodation needs. Ensuring that individuals, whānau, and households who are isolating have wraparound support can minimise the risk of breaches. Care Coordination Hubs should

consider the following as they assess the compliance risk of the individual, whānau, and/or household:

- Have they indicated they will be unwilling to comply with the isolation/quarantine requirements if they were to self-isolate at home, including the requirement to remain in their location of isolation and to have no visitors?
- Are there any whānau members, including children, who may struggle with complying with isolation requirements if they were to self-isolate at home?
- Is there substance dependency? If so, have you engaged your local working with your Community Alcohol and Drugs Service to minimise any breaches.

The level of compliance assurance required is determined on a case-by-case basis. This may range from daily phone check-ins during the health check, to a security presence around the property. The least intrusive options needed to assure compliance should be chosen.

For very few cases the high-trust model may not be enough to ensure that the isolation bubble will be maintained. In these instances, Care Coordination Hubs may assess that in order to protect public health. The Ministry of Health expects that every care coordination hub will have processes in place to ensure compliance based on what it deems appropriate on a case-by-case basis. Examples of how health Care Coordination Hubs may choose to support compliance of isolating individuals and their whānau include:

- engaging local Māori and Pacific Wardens
- local leadership and community groups
- local compliance champions.

In a small portion of cases, the individual or their household may be non-compliant. In these instances, the Care Coordination Hub should convene to discuss the case and determine the best path forward, based on the risk to public health.

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 that an individual's health deteriorates during after hours, the individual should use Healthline services.

If someone is suffering from life-threatening symptoms, please urge them to call 111.

Care Coordination Hubs should plan for appropriate afterhours care services. If not already established, this may include establishing arrangements or requesting services through the national telehealth service.

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 to support the delivery of COVID-19 Care in the Community will be considered by Cabinet in late December 2021.

7. Digital Enablement

Aotearoa New Zealand is developing a Fit for Future standardised and integrated IT solution for COVID-19 Care in the Community. At present, the MOH Data and Digital team have established an interim solution (Fit for *Now*) for COVID-19 Care in the Community.

Under Fit for *Now*, Data and Digital have brought together existing national COVID-19 information platforms used in Contact Tracing, Testing, Border Management, and Vaccine Register to support the community care so patient clinical and welfare needs are visible and shared across the system.

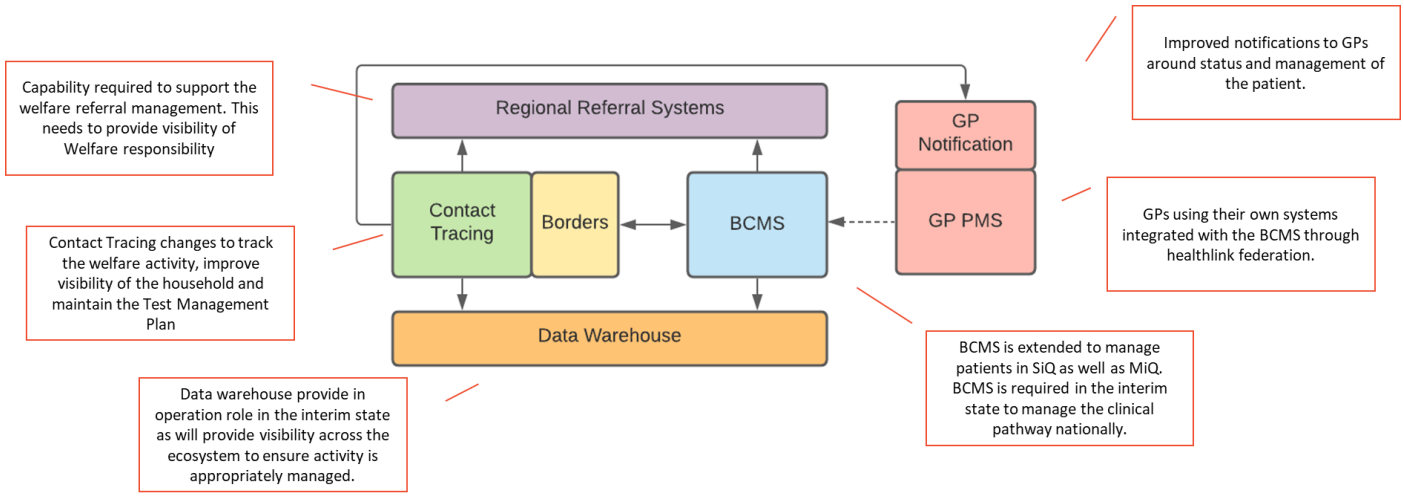
This approach builds upon existing systems in a centralised mode in order to support the clinical and welfare process quickly with minimal changes and risk. This technical solution is designed to monitor the three pathways: Clinical Pathway / Contact Tracing Pathway / Welfare Pathway.

Transfer and acceptance of COVID-19 cases and associated information to support the Care-in-the-Community model can occur in two ways:

1) the Border Clinical Management System is being offered to DHBs/PHUs who need it to be able to manage patients in the community as well as MIQ. BCMS is required in the interim state to manage the clinical pathway nationally.

2) General Practice Teams also have the option of using their own patient management systems integrated with the BCMS through Healthlink Federation.

Figure 7: Proposed architecture for the interim state



For health providers requiring access and training on the BCMS system, please contact border-apps@contacttracing.health.nz.

Note that there are separate streams of work developing the target state architecture, the operating model, Sector engagement, and rollout plan. These will be shared as they are updated.

8. Next steps

The COVID-19 Care in the Community Framework will continue to evolve over time, taking into account 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.

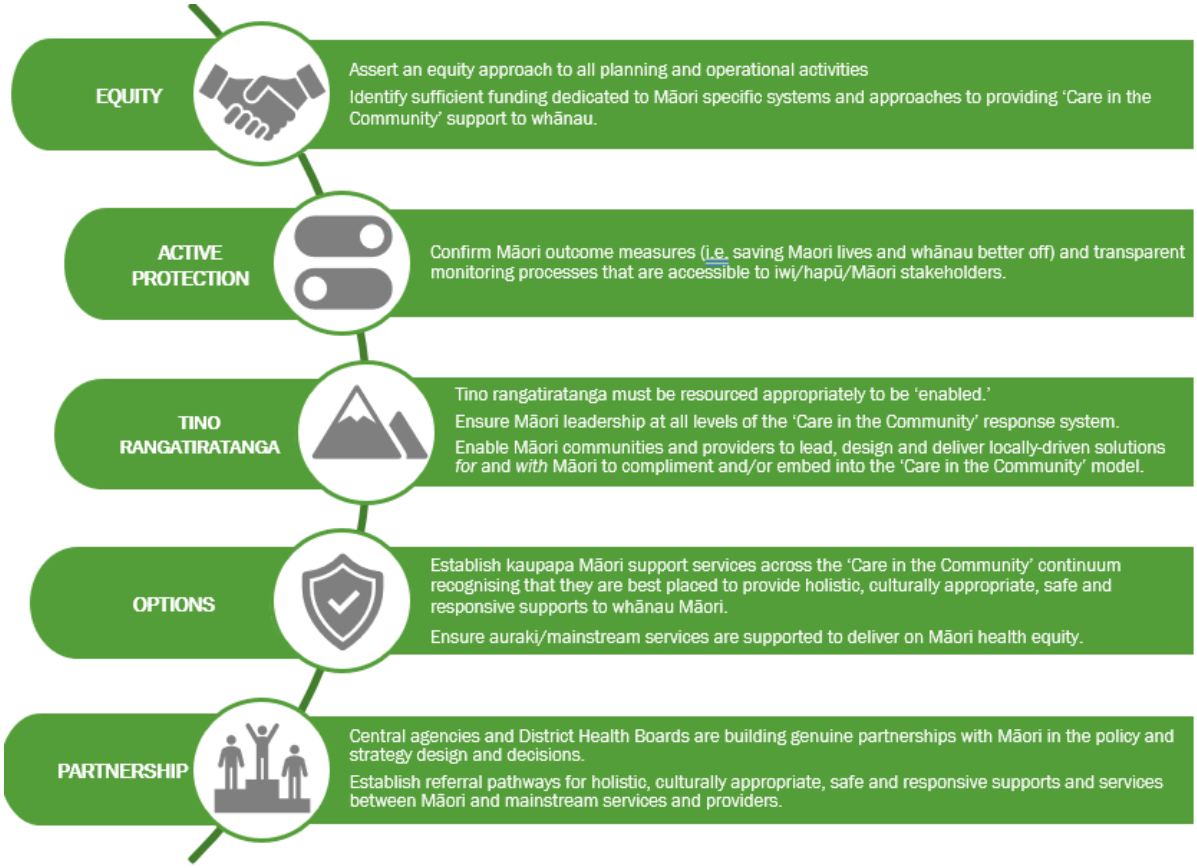
Future evolutions of the Framework will demonstrate stronger engagement with community. The immediate next step is to better understand how the integrated health and support pathway is works for people with COVID-19 and their households, and the people who are supporting them.

APPENDIX A: 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

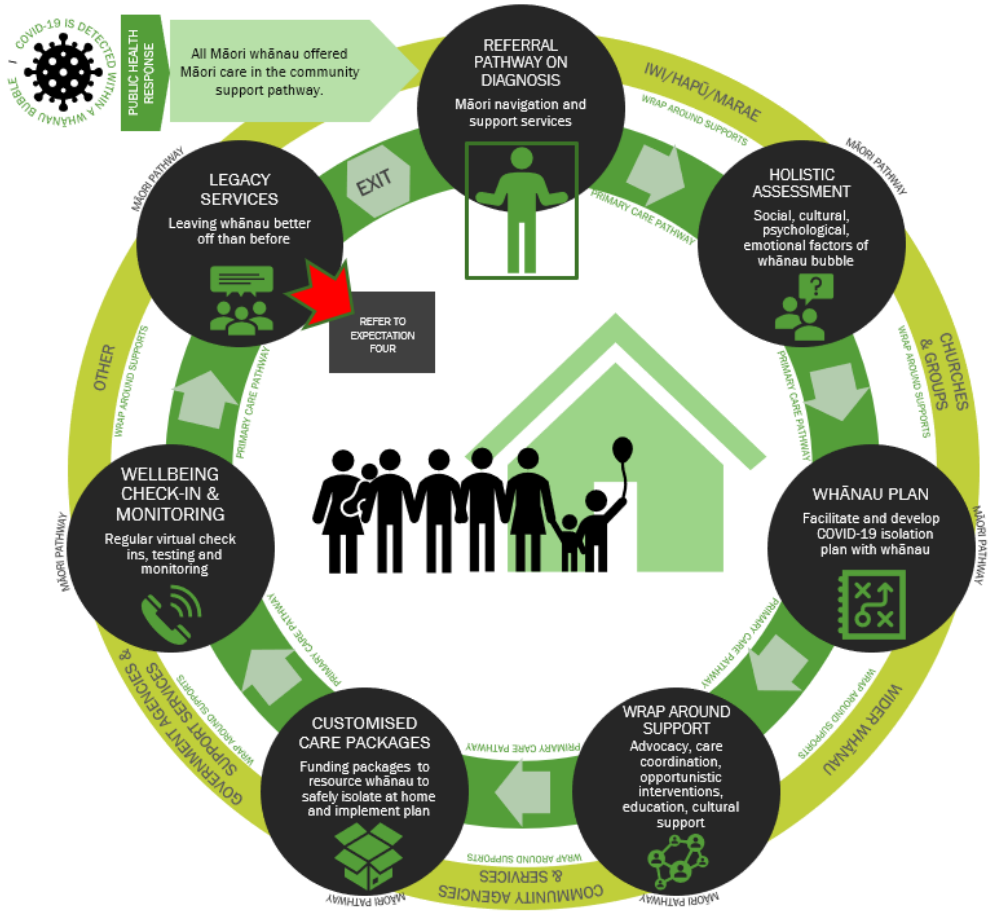
Community-based services resourced to provide end-to-end 'Care in the Community' navigation services, care coordination and wrap-around support across health, welfare and other systems, will ensure the holistic needs of vulnerable households are met beyond the Care in the Community continuum.

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.

Figure 8: Care in the Community Navigation Pathway



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) and Pacific 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 (including disability services), and communities to drive local, targeted responses for priority populations.
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 B: Care Coordination Hubs – Roles and Responsibilities Tool

Focus on Roles and Responsibilities - EXAMPLE

What are the Tasks?	RESPONSIBLE Who completes this task?	HAND OFF Where are there hand off? Which are manual?	TEAM OVERSIGHT What team manages accountability for operational oversight?	TECH What tech will you use?	GAPS / QUESTIONS What are the gaps?
Allocates calls / roles to Providers					
PHU Call					
Clinical Call					
Daily call(s)					
Escalation pathways					
Welfare delivery					
Uncontactable					
After hours process					
Release processes for CitC					
Secondary Care					

APPENDIX C: Initial guidance for establishment of quality and safety governance

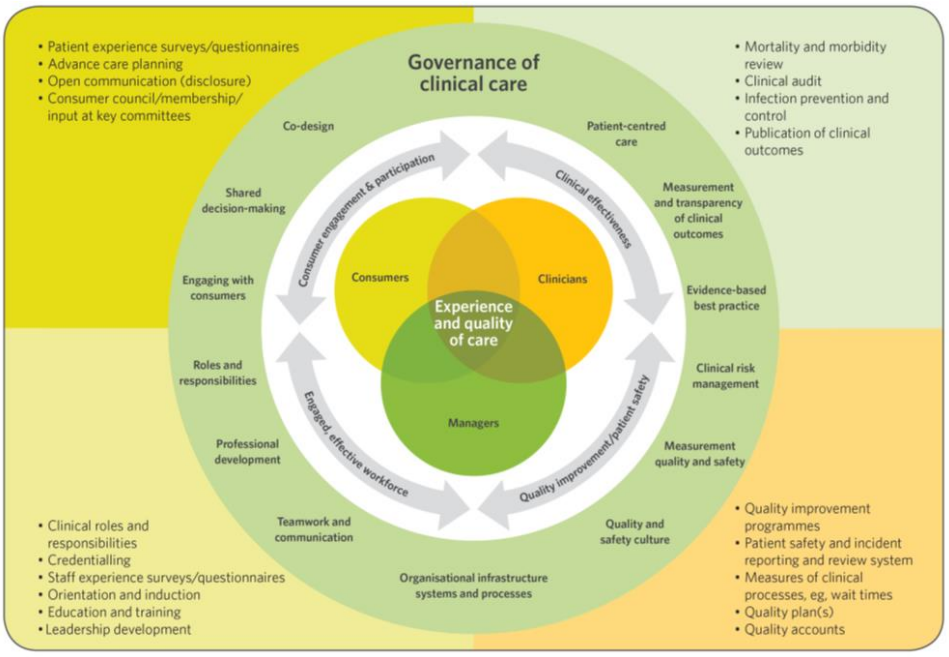
Background
Many New Zealanders with COVID-19 are now being cared for in their homes with clinical care provided remotely, or face to face in homes. Concurrently, welfare needs are addressed by a range of providers. Together this is known as COVID-19 Care in the Community (CCC). It is essential that people with COVID-19 and their household contacts (referred to in this document as 'whānau') are supported to isolate safely whilst receiving a high standard of care that ensures wellbeing – taha tinana (physical health), taha whānau (family health), taha hinengaro (mental health), taha wairua (spiritual health).

Problem definition
Across Aotearoa New Zealand, systems are being developed for CCC. There are considerable risks where change is constant, roles, responsibilities, and processes are not fully established, and information (IT) systems are not well integrated. There are also challenges related to Māori health and equity, with Māori twice as likely to have severe illness and be hospitalised than non-Māori. Clear, effective, and consistent governance for quality and safety is critical in this context.

Purpose
This document provides guidance for district health boards (DHBs) and other key stakeholders and partners establishing local quality and safety governance for CCC. It does not include Managed Isolation and Quarantine Facilities (MIQF) or hospital-based settings.

Context
Whilst the guidance is based upon the Health Quality and Safety Commission's (the Commission) clinical governance framework, it is acknowledged the scope of the model is greater than clinical care and incorporates social and wellbeing aspects, neither does it capture mātauranga Māori. The term 'quality and safety governance' is used in this document to reflect these differences.

Figure 9: Clinical Governance Framework



Establishing local quality and safety governance groups

Approach

While the articles of Te Tiriti o Waitangi provide the constitutional settings for our response to CCC the new principles following the Wai 2575 claim provide some practical guidance for the establishment of local quality and safety governance groups. These principles should be applied collectively and include:

Principle of Partnership	Partnering and shared decision making for quality and safety is informed by Māori experiences and Māori provider knowledge.
Principle of Options	Quality includes having available viable Kaupapa Māori services in CCC so that Māori are not disadvantaged by the lack of choice.
Principle of Tino Rangatiratanga	Ensuring that Māori receiving CCC have the "right to autonomy" and to manage the full range of their affairs in accordance with their own tikanga.
Principle of Active Protection	Actively protecting, supporting and empowering Māori receiving CCC, and Māori organisations to provide services that support wellbeing.
Principle of Equity	Provision of culturally and clinically responsive mainstream CCC services that are equitable in terms of access, process and outcomes. Power and control is shared equitably by Māori and non-Māori.

Figure 1: Wai 2575 Te Tiriti o Waitangi Principles

The role of a quality and safety governance group must be grounded in the strategic direction for the COVID-19 response locally; this is a rapidly changing environment as the CCC systems are established across regions. A suggested objective is to ensure that processes and systems are in place to deliver high quality, coordinated, culturally safe, and responsive care that is continuously monitored and

improved. The group with designated responsibility should meet regularly and adjust frequency of these meetings as systems are embedded, and should be developing and monitoring a set of measures relevant to the local situation.

Guiding values and principles
A set of values and principles have been developed that will drive local COVID-19 CCC quality & safety governance groups. These include:

- whānau at the centre – people with COVID-19 and their whānau receive safe, culturally tailored, high-quality care
- open and transparent culture – individuals/whānau and staff feel safe and are encouraged to express their views and speak up when care is not at expected standards
- accountability – all organisations and individuals are clear about their responsibilities for quality and safety
- privacy and trust are paramount – the health and welfare information of whānau should be treated with respect, following all protocols for ensuring data quality, governance, sovereignty, privacy, and confidentiality.

Membership and chairperson
As the Crown agent responsible for the funding and provision of health services each, DHB should oversee the establishment of the local quality and safety governance group. A partnership approach to leadership of the group is recommended, specifically that an iwi/Māori chairperson or co-chairperson be considered.

Membership should reflect the local population and those impacted most by COVID-19 in the community. Given that Māori represent over half of current cases, strong consideration must be given to a governance structure which provides at least 50 percent Māori. In some groups this is likely to include iwi/Māori health or social service providers. Members can also include representatives from the range of services delivering and funding care in the community – primary care, Māori providers, Pacific providers, DHB planning and funding, Ministry of Social Development and/or local welfare providers, individual/whānau, public health and relevant quality and safety leadership. Others that may be included or called upon when appropriate are ambulance services, other agencies such as Oranga Tamariki, Kāinga Ora – Homes and Communities, New Zealand Police, Ara Poutama Aotearoa | Department of Corrections, infectious diseases and, infection prevention and control expertise.

Domains of quality and safety
The following identifies critical components to support the establishment of local quality and safety governance that incorporates the Wai 2575 principles for Te Tiriti o Waitangi (identified in **Figure 1** above), which provide practical guidance for how this can be achieved successfully.

Individual and whānau engagement
Individual and whānau voices need to be central to the design and governance of the way care is delivered in their communities. This can be achieved by:

- ensuring iwi/Māori and individual representation on all local quality and safety governance groups and in groups developing and adapting models of care/clinical pathways
- ensuring there is a mechanism for capturing and rapidly learning from the experiences of individuals/whānau. This may include seeking feedback when interacting face to face or utilising existing DHB or primary care feedback processes

- prioritising listening to iwi/whānau Māori, seek qualitative responses and use to adapt models of care as needed
- providing support for individuals/whānau to share decision-making and be involved in their own care planning. This includes having options for the provision of for Māori, by Māori care; shared goals of care and for end-of-life care in the community.

Clinical effectiveness
Local application of the model of care should be regularly reviewed and updated to reflect evidence acquired locally and from national and international experience by:

- ensuring pathway and guideline development incorporates evidence-based practice and partnership with iwi/Māori and other individuals
- co-design measures relevant to local care in the community priorities, stratified by ethnicity, and deprivation level where appropriate
- supporting learning through multi-disciplinary morbidity and mortality meetings and clinical audit.

Quality improvement and patient safety
Local governance groups must establish mechanisms to ensure care is being provided in a safe way and identify opportunities to constantly improve this. Central to this is that governance groups:

- have an agreed process for the reporting, rapid review, and learning from adverse events that occur in the COVID-19 care in the community setting (see the Commission's COVID-19 Care in the Community Adverse Event Review Guide)
- review local performance in Ministry of Health measures on a regular basis (Ministry of Health metrics for Care in the Community (see Appendix D of Ministry of Health Framework)
- commit to continuous quality improvement, ensure there is access to improvement science capability and Te Ao Māori approaches
- ensure clinical risk management processes are in place. This could be through a clinical risk register where the circumstances that put individuals/whānau at risk of harm are identified, and action is taken to prevent or control risks
- ensure coordination and clarity of the pathway of care and transitions, to ensure care is safe and reducing the risk of gaps or duplication
- ensure clear processes for those who enter CCC following hospital discharge or MIQ stay.

Engaged and effective workforce
The workforce is critical to ensuring care is delivered in a safe way whilst identifying potential areas to continually improve the quality of that care. Local governance should:

- aim for a workforce that reflects the population being provided with care
- ensure cultural safety is well understood by all staff and visible in activities
- seek feedback from the range of service providers: iwi/Māori, Pacific, non-governmental organisations – use to adapt CCC approach as needed
- ensure orientation and induction of new staff occurs, and education and training is provided to all staff. This is particularly important in the context of rapid change and new protocol development
- articulate roles and responsibilities of the different parts of the system and within models of care. Ensure staff have the appropriate knowledge, skills, and tools required to fulfil their roles
- foster teamwork and make communication easy: allocate time to build relationships within and between teams, develop handover processes and collective problem solving

- consider how staff wellbeing will be monitored and maintained throughout the response.

APPENDIX D: COVID-19 Care in the Community Adverse Event Review Guide

COVID-19 Care in the Community Adverse Event Review Guide

This guide is designed to support a rapid review of adverse events (AE) involving consumers and whānau receiving Covid-19 Care in the Community (CCC). It enables an understanding of the care provided with the intention of keeping consumers and whānau safe (physically, psychologically, and culturally) and avoiding hardship, while receiving care for Covid-19 in the community.

An AE is defined as an event with negative or unfavourable reactions or results that are unintended, unexpected, or unplanned.[6] In the context of CCC, this can be understood as an event that results in harm or has the potential to result in harm to a consumer or their whānau. See appendix 1 for COVID-19 Care in the Community Severity Assessment Code examples.

The rapid adverse event review template was informed by the Safety Engineering Initiative for Patient Safety (SEIPS Model),[7] a well-established process for taking a 'systems approach' in safety improvement and the Yorkshire Contributory Factors Framework.[8] It endeavours to reflect the COVID-19 Care in the Community Framework (the Framework).[9] The development of this template is iterative and anticipated to change as further information becomes available, reflecting the evolving environment of COVID-19 care requirements. We also expect the list of severity assessment code examples in appendix one to be added to, as more is understood about the process of care in the community.

Adverse event reviews are required[10] to be built on the following principles:

- **Open communication** – consumers and their whānau are ethically and legally entitled to truthful and open communication at all times following an AE. In Aotearoa New Zealand, health and disability (H&D) service providers have a legal duty to take steps to ensure that open communication is practised by staff and supported by management.
- **Consumer, whānau and care provider participation** – AE need to be considered within the context of the whole consumer and whānau experience of care. Including the consumer perspective in the review process enables a broader understanding of the circumstances surrounding an AE. It is expected that, at a minimum, consumers and whānau who have been involved in an AE will be offered the opportunity to share their story as part of the review process and that review findings and recommendations will be shared with them. Service providers should also consider involving independent consumer representatives in the review process.
- **Culturally appropriate review practice** - the cultural viewpoint and practices of a consumer and their whānau should be considered in the open communication, reporting, review and learning process.

[6] https://www.hqsc.govt.nz/assets/Reportable-Events/Publications/National_Adverse_Events_Policy_2017/National_Adverse_Events_Policy_2017_WEB_FINAL.pdf
[7] https://qualitysafety.bmj.com/content/qhc/30/11/901.full.pdf
[8] https://improvementacademy.org/tools-and-resources/the-yorkshire-contributory-factors-framework.html
[9] https://www.health.govt.nz/system/files/documents/pages/301121-covid-19-care-in-the-community-framework-dga.pdf
[10] Ibid

- **System changes** - reporting is only of value if it is accompanied by meaningful analysis that leads to system changes designed to prevent recurrence of AE and near misses. Lessons learnt must be shared locally by individual H&D service providers who are also strongly encouraged to share learnings with other providers and centrally with the Health Quality & Safety Commission (the Commission). The Commission's role is to share lessons learnt nationally and promote a national approach to reporting, review, and learning.
- **Accountability** – this is provided by assuring consumers, whānau and the wider community that when adverse events and near misses occur, action is taken at both the local and the national level. Action at the local level focuses on learning, improving safety and reducing the possibility of recurrence.
- **Reporting must be safe** - consumers, whānau and staff must be empowered to report adverse events and near misses without fear of retribution. Adverse events must be investigated with a focus on determining the underlying system failures and not blaming or punishing individuals. Health and disability service providers must ensure a just culture prevails, so individuals are not held accountable for system failures. Incidents that involve a criminal act, substance abuse by a health practitioner, a deliberate unsafe act or deliberate consumer harm will be managed in a separate process and may involve the relevant regulatory authorities.

Users of the rapid adverse event template will need to consider how they are meeting these principles during the review process.

Equity

When reviewing AEs, the reviewers must be mindful that in Aotearoa New Zealand, inequities in health, and in the determinants of health, are pronounced. Of concern are the large and persistent inequities experienced by Māori. The reviewers should not only consider the factors that impacted care within the health care setting or service, but also the wider socioeconomic determinants that can impact outcomes. Social determinants, such as living conditions, are a significant cause of inequity in the health and wellbeing of Aotearoa New Zealand's population. That is, they shape the wellbeing of individuals and their families/whānau and influence their outcomes. The reviewers should also consider factors that impacted on the continuum of care at individual, societal and health systems levels.

Additionally, reviewers should consider how the health services may have contributed to any inequities, as well as how they may have contributed to reducing inequities. When developing recommendations, reviewers must consider how the recommendations may affect health inequalities and inequities. The Health Equity Assessment Tool [11] (HEAT) or Health Impact Assessment [12] (HIA) tool can be used to assess recommendations for their future impact on health equity.

Although some of the prompts in this guide focus on equity issues, it is not possible to list all factors that influence equity. Users of this tool will need to consider how equity of outcomes was, and can be, supported when reviewing AEs.

How to use this guide

This guide is intended to provide a rapid review of an adverse event. It is designed for events involving CCC.

[11] www.health.govt.nz/publication/health-equity-assessment-tool-users-guide
[12] www.health.govt.nz/our-work/health-impact-assessment

Due to its rapid nature, it may not provide the same depth of learning as other review methods. If, during the gathering of information, it appears that there are issues with underlying policies and processes, as opposed to the implementation of them, then a more detailed review, such as a learning review[13], may be required.

It is important to note that whilst the rapid adverse event review template is in a 'list layout' this does not imply a linear process, rather consideration must always be given to the complexity of CCC and the interactions between all agencies.[14] This is further demonstrated in appendix 2 and the SEIPS model.

The rapid adverse event review template is designed to be used by all agencies providing CCC. It is expected that agencies will work together to carry out one review per event, and there is no expectation that events will be reviewed multiple times by different agencies. It is the responsibility of all agencies providing care to determine who is best placed to lead, and/or carry out the collaborative review.

Sharing experiences to learn

It is important that there are robust clinical quality and safety governance structures at a local and national level supporting CCC, to ensure lessons are shared and recommendations are implemented and followed up. The Commission's supplementary paper 'Initial guidance for establishment of quality and safety governance' provides guidance for district health boards, and other key stakeholders and partners, establishing local quality and safety governance for CCC. Governance ensures clear processes for:

- reporting (SAC1 & 2 to the Commission) and investigation of adverse events (AEs)
- quality systems improvement and quality assurance
- consumer and whānau engagement
- workforce oversight, support for wellbeing, and education.

[13] www.hqsc.govt.nz/our-programmes/adverse-events/publications-and-resources/publication/4249/

[14] 'Agencies' refers to the multiple stakeholders noted in the COVID-19 Care in the Community Framework page 6

REPORTABLE EVENT NUMBER: [*insert local event identification*]	
Consumer's name:	Location of event:
NHI Number:	Date of birth (dd/mm/year) / **Age**:
Ethnicities: Iwi affiliation:	Gender:
Date and time of event:	Primary Health provider:

REVIEW TEAM – **reflects lead care agencies involved and when an adverse event involves Māori consumers, at least half the review team should be Māori, in line with the Te Tiriti partnership.**	
Role:	**Designation:** Review Leader
Role:	**Designation:** Consumer representative
Role:	**Designation:** Māori representative Pacific representative
Role:	**Designation:** Māori representative Pacific representative
Role:	**Designation:** Team member
Date review completed: / /	

REPORT CONFIRMED AND AUTHORISED BY:			
Signature 1:		**Signature 2:**	
Name:		**Name:**	
Role:		**Role:**	
Date:	/ /	**Date:**	/ /

EXECUTIVE SUMMARY

REVIEW		
a. Background- succinctly describe the event		
b. System Influences		
Situational Influences		
Team factors		
Individual roles and responsibilities were clearly delegated		
Multidisciplinary team referrals were made		
The model of care supported teamwork		
All required agencies were aware of roles		
Mechanisms were in place to alert staff of changes to consumer circumstances and changes in clinical pathways		
Individual staff influences		
Staff were safe to perform home visits e.g., de-escalation training provided, not expected to make face to face visits alone		
Staff had access to clinical supervision and/or debriefing services as required?		

Staff received appropriate breaks during working day, and regular rostered time off		
Task characteristics		
Staff had appropriate resources available to be able to carry out role		
The initial assessment of COVID-19 Care in the Community allocated the consumer as care level 1 or Level 2.		*Did a change in level occur?*
Consumer and whānau influences		**Comments**
There was a safe and appropriate environment to stay during isolation period		
The consumer's underlying health was good enough that they could safely isolate in the community		
The consumer's primary healthcare provider was contacted to obtain further information about the consumer's medical history if more information was required to determine the appropriateness of community care		
Toileting needs were addressed		
Communication/vision/hearing needs were addressed		
A support person was available for consumer and whānau with 24/7 contact details provided to them		
Financial and practical resources to obtain necessities such as groceries and medication was available to consumer and whānau		
Communication resources such as phone and internet access was available to consumer and whānau		
Cognitive impairment/confusion/delirium was assessed		
If not safe to mobilise independently, the consumer and		

whānau were provided with appropriate aides.		
Care provided met the cultural needs of consumer and whānau		
Care provided met the spiritual needs of consumer and whānau		
The consumer and whānau understood the process and could participate as required		
Information was provided to consumer and whānau in an appropriate format/language		
Consumer's consent for isolation was documented		
Other factors?		
Local Working Condition influences		
Workload and staffing issues		
Adequate staff were available to carry out tasks		
Available staff had appropriate skills and knowledge and knew how to get specialist assistance as required e.g., medical, cultural, social support		
Actual availability and skill mix of staff matched need		
A plan was in place to mitigate demand outstripping staffing resources		
Leadership, supervision, and role influences		
All agencies had a clear understanding of roles and responsibilities		
Processes were in place for handovers to ensure no loss of information or continuity of care		
A lead agency was appointed		
Delegations were appropriate		
Clear escalation pathways for concerns existed		
Medications, equipment, and supply influences		

Appropriate PPE was available for staff		
Fit testing of masks was carried out for staff		
SpO2 device was available if indicated, incl. batteries/charger/appropriate instructions (verbal and written, in an appropriate language and health literacy level)		
Medical equipment provided was suitable for consumers and whānau of all ethnicities and dids not reinforce existing inequities		
Appropriate PPE was provided for consumer and whānau use with appropriate instructions in terms of language and health literacy		
Cleaning supplies were provided to consumer and whānau		
Consumer and whānau were trained on use of PPE, SpO2 devices, and any other requirements in a manner that met their language and health literacy needs		
Organisational Influences		
Physical home environment		
Mitigation was in place for any hazards present (for example ability to ventilate)		
The home was assessed as suitable to isolate in		
Support from other agencies		
IT system access was provided to all who needed it		
All staff/agencies had prompt and simple access to required information		
Pathways were in place to transfer/escalate care as necessary		
Staff training and education		
Training was provided for any IT systems used e.g., training on use		

of the Border Clinical Management System (BCMS)		
Staff were trained in correct use of PPE		
Clinical staff were able to identify basic welfare needs		
Support staff were able to identify basic health needs		
Te Tiriti o Waitangi considerations		
Whānau were given options for their care ie access to Kaupapa Māori services if desired		
There was self-determination in service delivery for consumer and whānau ie they could shape how care was delivered		
The care plan was designed within a partnership model between providers and consumer and whānau ie the decision-making power was shared		
External influences		
Coordination of care plan		
Initial clinical assessment was undertaken to define level of care required and frequency of check-in points was adhered to		
Identified care coordinator for household was conveyed to consumer and whānau and achievable contact mechanisms were in place (see communication above in consumer section)		
Appropriate equipment was provided to consumer and whānau with verbal and active demonstration of how to use the equipment and interpret the results (if required), including information in appropriate language (e.g., pulse oximeters)		
Any equipment given to consumers and whānau was checked for functionality e.g., calibration within required timeframe		

If a pulse oximeter was used it was provided through care in community team (that is not sourced independently)		
A welfare assessment was completed, and needs provided with regular follow up and review of ongoing needs e.g., accommodation, household needs, essential needs		
National policies and guidelines		
COVID care in the community framework informed care planning		
Covid-19 case management in adult's health pathway followed		
Communication and Culture Influences		
Safety culture		
Cross agency openness to raise concerns of patient safety occurred (for example safe for patient, safe for health care providers attending the home)		
The views and experiences of involved care providers were captured in this review (work-as-done)		
What trade-offs or workarounds (adaptations) occurred to support safety to the consumer or care providers		• *What prompted the adaptation?* • *How was the need for adaptation anticipated?* • *What purpose did the adaptation serve?* • *What made it work/not work?*
Could the adaptations be helpful in the future		• *How does the adaptation relate to everyday practice?* • *Who should know about it/be involved?* • *Who will be affected?* • *Is it useful to make it standard practice?* • *Are there any risks?* • • *What would help in the future?*
Verbal and written communication		
Appropriate handover systems between healthcare agencies were available		
Huddles to share information at the beginning of day for team input and review of care took place, information was discussed with consumer and whānau as required and care plans reviewed		

A full clinical picture was able to be obtained from documentation (e.g.,no non-standard abbreviations, illegible notes, inadequate documentation)		
The consumer, whānau and staff from different agencies could contact key personal as required		
Pathways were in place for inter-agency sharing of information		
There was evidence of a shared goals of care discussion and decision and transfer of this information if consumer required higher level of care		
Independent interpreting services available and used as appropriate		

c. Key Findings (determine underlying systems or process issues involved in adverse event)	
1.	
2.	
3.	

d. Additional Findings (identified as a quality issue)	
4.	
5.	
6.	

RESOLVE - **Act to help reduce the chances of it happening again**

a. SMART Recommendations

Finding	**Recommendations**

b. Organisational learning informed through understanding work-as-done

Ensure learning is practical and meaningful informed from experiences and adaptations that relate to everyday practice

Adverse Events Recommendation Action Plan					
RE number:		**Service:**	**Report date:**		
Key finding	**Recommendation**	**Actions required & progress**	**Person/role responsible**	**By when**	**Date completed**
1.					
2.					
3.					

Authorising Signature (1): Date:

Authorising Signature (2): Date:

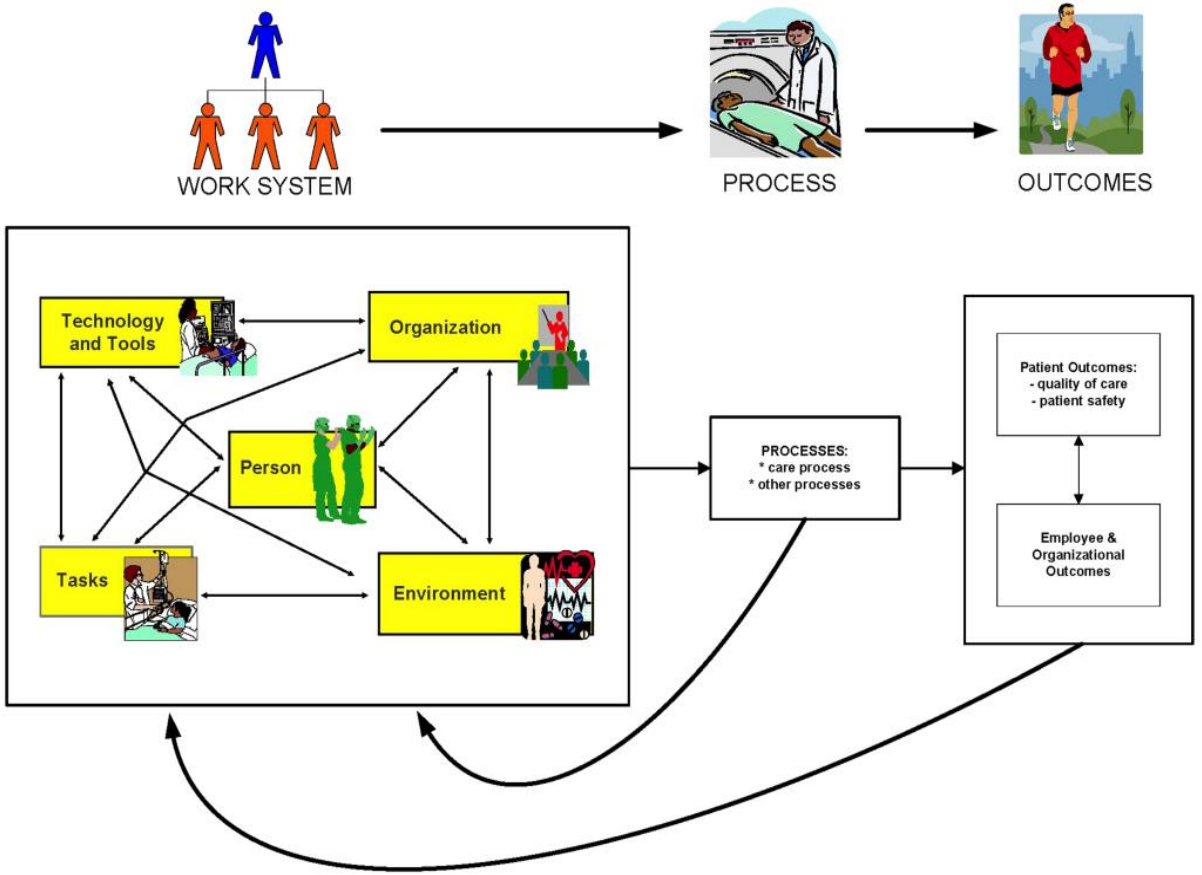
COVID-19 Care in the Community (CCC) Severity Assessment Code (SAC) examples 2021–2022

This list is for guidance only. All events should be rated on actual outcome for the consumer and whānau while receiving CCC. The always report and review list 2018–2019, general SAC examples, and SAC rating and triage tool for adverse event reporting contain more guidance on adverse event reporting. It is expected that agencies will work together to carry out one review per event, and there is no expectation that events will be reviewed multiple times by different agencies. It is the responsibility of all agencies providing care to determine who is best placed to lead, and/or carry out the collaborative review.

SAC 1 **Death or permanent severe loss of function**	**SAC 2** **Permanent major or temporary severe loss of function**	**SAC 3** **Permanent moderate or temporary major loss of function**	**SAC 4** **Requiring increased level of care OR no injury, no increased level of care; includes near misses**
• Delayed recognition of consumer deterioration resulting in permanent disability or death	• Suspected suicide or serious self-harm by a consumer • Delayed recognition of consumer deterioration resulting in admission to intensive care, cardiopulmonary resuscitation and/or intubation • Eclamptic seizure within 48 hours of routine antenatal or postnatal assessment • Development of a venous thromboembolism prior to commencement of VTE prophylaxis for a high-risk pregnant woman	• Unplanned admission to hospital from community setting outside of agreed escalation pathways*	• Unplanned in-home clinical assessment outside of agreed escalation pathways • Initial clinical assessment of consumer was not completed within 48 hours of positive COVID-19 result timeframe* • Routine check-in points of consumer did not occur within 24 hours of the timeframe determined by the level of care • Consumer's manaaki, including welfare needs, identified in initial assessment.

* *COVID-19 Care in the Community Framework for Public Health, DHBs, PHOs, Providers, Social and Well-being Organisations*. 2021. Ministry of Health.

Figure 10: Safety Engineering Initiative for Patient Safety (SEIPS)



APPENDIX E: 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.

Step		Metric	Provisional target	Rationale
	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		

APPENDIX F: 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, 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 G: 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/