Interim National Guidance for remote Aboriginal and Torres Strait Islander communities for COVID-19

Revision history

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<th>Version</th>
<th>Date</th>
<th>Revised by</th>
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<td>1.0</td>
<td>16 April 2020</td>
<td>Communicable Disease Network Australia</td>
<td>Developed by the National Aboriginal and Torres Strait Islander Advisory Group on COVID-19</td>
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This Interim National Guidance is to be used in conjunction with Interim Coronavirus Disease 2019 (COVID-19) CDNA National Guidelines for Public Health Units (SoNG)

1. Need for this guidance document
Aboriginal and Torres Strait Islander communities are at increased risk of transmission and at having more people with severe disease. Therefore, suspect and confirmed cases and their contacts require early isolation to minimise the risk of ongoing transmission from these individuals to the rest of the community. As a general principle, early evacuation of cases and contacts from the community to the nearest regional centre is the preferred approach (although some communities may wish to vary this approach) until a time where widespread community transmission is occurring.

This document complements and expands on relevant aspects of the Communicable Disease Network Australia Series of National Guidance for Public Health Units on COVID-19 (the COVID-19 SoNG).

2. Forward planning
Wherever possible communities in partnership with their health service should co-design a local action plan. This should be done in consultation with the relevant public health unit (PHU) and outline how to manage individual suspect and confirmed cases and their contacts as well as how to address widespread community transmission.

The following should be included in the local plan:

1. Options for isolation and quarantine in the community in the event a retrieval is not possible and/or preferable
2. Identification of safe, appropriate sites in nearby centres for the evacuation of cases and contacts
3. Management of cases and contacts who do not adhere to self-isolation and quarantine including how to manage any potential community disharmony
4. Establishment of necessary partnerships, funding and logistics needed for patient transport in the case of relocation
5. Plans for community mobilisation and recommendations for communication within the community
6. Surge capacity (including roles, responsibilities and lines of reporting) in the event of widespread community transmission
7. Continuity plans for essential services in the case of widespread community transmission including essential services (power, water, rubbish removal etc), the community store, clinic and police.
3. **Definition of a suspect case**

The suspect case definition should follow the national case definition as outlined in the COVID-19 SoNG and relevant jurisdictional case definition, with the addition of the following epidemiological criteria:

- Travel outside of a designated area under the *Commonwealth Biosecurity Act (2015)* in the previous 14 days – in discussion with the local PHU
- Close contact with an individual exempted from 14-day quarantine under the *Commonwealth Biosecurity Act (2015)*

Individuals may also be considered a **suspect case** when there are two or more cases of illness clinically consistent with COVID-19 in the community, in consultation with the local PHU.

4. **Laboratory testing in remote areas**

Some rural and remote communities face long turnaround times for testing, limiting the capacity for suspect cases to remain in community while in isolation.

Newly developed Point of Care tests may be available in some remote communities. The only appropriate Point of Care tests to diagnose acute illness are ‘desktop’ Polymerase Chain Reaction (PCR) tests.

Tests that determine the presence of and antibody response (IgM and IgG) response to coronaviruses are not appropriate for acute diagnosis.

4.1. **Point of care PCR test**

Existing communities that have the Cepheid technology for GeneXpert machine for other infections (e.g. *Neisseria gonorrhoea*) will be able to diagnose COVID-19 with access to SARS-CoV-2 testing supplies and appropriate procedures, training and quality assurance frameworks. The capacity is being expanded by procurement and dispersal of additional machines. The procedures identified by Cepheid for performance of the test and safety of the operator while performing the test need to be carefully followed. **Note some jurisdictions have expressed safety concerns with these tests and will not be making them available in primary care settings at this stage. These concerns and safety requirements are being reviewed by PHLN.**

If there is not access to the GeneXpert testing, options include:

1. Urgently transporting samples – drivers could be employed to transport samples across multiple communities on a daily run, or commercial/charter light aircrafts and pilots could be on standby in each region for picking up swabs on a daily basis aiming for 24 hours until result.
2. If necessary, prioritising tests arriving from rural/remote centres for urgent processing on arrival to the lab
3. Prioritising tests on healthcare workers from remote/rural clinics, given the limited capacity of many remote clinics to cope with staff shortages

5. **Management of initial suspect cases and their contacts**

When an individual presents meeting the suspect case definition, the following steps should be undertaken, alongside clinical and public health management of the case:

1. Appropriate laboratory testing (see section above)
2. Interview of the case to determine where they are likely to have contracted disease (within or outside of the community)
3. Appropriate isolation of the case in a setting that minimises risk of transmission to other members of their household and community.

If point of care testing is not available, a decision should be made as to the likelihood of the suspect case becoming a confirmed case. This relies on the strength of the epidemiological link; e.g. an individual who meets the epidemiological criteria component of the case definition because they are a close contact of a confirmed case will generally have a higher probability of becoming a confirmed case than an individual meeting the epidemiological component of the case definition because they have returned from a different part of Australia where there is limited community transmission.

5.1. Decision on evacuation of suspect and confirmed cases and their contacts

In general, early evacuation (defined as relocation from the community to an appropriate place outside of the community via an appropriate transport service) of cases and close contacts out of the community to prevent onward transmission, is the preferred method of case management. However, this may not always be possible and public health and primary health care staff (especially Aboriginal staff) must collaborate regarding public health management of suspect and confirmed cases and their contacts on a case by case basis, incorporating their knowledge of the likelihood of any suspect case being confirmed, individuals and community involved, local processes and available resources. Key considerations include the timing of onset of illness in the suspect case, benefits of evacuation, the available infrastructure and the ability of cases and contacts to isolate in the community. Questions that can be used to guide this process can be found in Appendix 1: Key considerations to guide the decision to evacuate suspect and confirmed cases and their close contacts.

If evacuation of the case and their contacts is not possible then every attempt to isolate the case and quarantine their contacts in the community must be made. See Appendix 2: requirements for self isolation in the community and ‘considerations for cases and contacts remaining in community’ below. See also Appendix 3: Algorithm for decision making.

5.2. Public health management of suspect cases and their contacts taking into account index of suspicion

If there is high suspicion the individual will become a confirmed case:

1. The relevant PHU should be informed and immediate contact tracing and follow up of contacts should be undertaken. This should be done by local health staff (including an Aboriginal Health Workers or Aboriginal and Torres Strait Islander Health Practitioners) in partnership with the relevant PHU. Where required, interpreters should be involved.
2. The suspect case and their contacts should be isolated and quarantined as soon as practicably possible including consideration of early evacuation.

If there is low suspicion that the individual will become a confirmed case, the relevant PHU should still be informed, the case should be isolated and consideration given to contact tracing if resources allow this. However the decision to isolate the case and their contacts, and particularly to evacuate them from the community requires careful consideration as evacuation of a suspect case that proves to be unnecessary (due to the case testing negative) has significant implications for the suspect case with regards to potentially increasing their risk of disease (via transport and being in an area of higher transmission) and a prolonged absence from their community and potential entry restrictions on return to their remote community due as per the Biosecurity Act and applicable state-based legislation.
5.3. Coordination of evacuation for suspect and confirmed cases and their close contacts

After a decision has been made to evacuate a suspect or confirmed case, either for clinical or public health indications, the evacuation category should be discussed with local evacuation services by the attending senior medical practitioner.

If the person is stable, and for asymptomatic contacts, evacuation by road (with driver trained in infection control and wearing required protection) or on charter plane (appropriately set up) could be considered rather than through medical retrieval. Clinical criteria to determine the safety of road or charter evacuation will be made based on the expertise of the treating clinician in conjunction with discussions with the receiving service and the retrieval service. Strict attention must be paid to preventing disease transmission between cases, contacts and those involved in retrievals.

5.4. Return home of confirmed and suspected cases and their contacts

Confirmed and suspect cases who are evacuated and subsequently are medically cleared for release from isolation should be assisted in their return home. Close contacts of a confirmed case should be offered relocation back home once their period of quarantine has ended. Close contacts of a suspected case should be offered relocation back home once COVID-19 testing confirms the suspect case is negative. Arrangements for returning home should be developed by local health authorities and the community health service.

Depending on jurisdictional requirements (such as those outlined in a Determination under the Biosecurity Act 2015), returned cases and their contacts may need to remain outside of community for a period of time so that entry requirements are met.

6. Considerations for cases and contacts remaining in community

Depending on the setting, there may be a preference for early evacuation of cases, and where possible, their contacts or there may be a preference to keep cases and/or their contacts isolated in appropriate accommodation in their community.

Where it is not possible (for any reason) for cases and their contacts to be evacuated from the community, every effort should be made to enable to them to safely self-isolate and quarantine in the community (see requirements for self isolation and quarantine in Appendix 2).

The senior doctor of the primary health care service is responsible for clinical management of the case whilst they remain in community, liaising closely with Public Health Officers. Follow up of contacts should include regular monitoring for symptoms. Where required this should include assessment of temperature (using a self-administered or no touch technique if possible to conserve PPE). The need for self-isolation should be stressed at each encounter with the case and contacts, and they should be supported to adhere to necessary restrictions as much as possible, including the provision of PPE where indicated.

If cases and their contacts choose not to evacuate and there are no appropriate facilities for isolation, OR they are unable to comply with restrictions that would limit opportunities for transmission, this requires careful discussion between local health authorities and the relevant PHU. These discussions should include how to enforce restrictions on potential transmission risk within the community whilst maintaining the safety and confidentiality of the case and their contacts as well as broader community safety and community wishes. Where possible, a collaborative approach to improve adherence that works with the case, their contacts and their family should be used drawing on the experience of local staff to help negotiate this.
7. Community transmission (outbreak management)

7.1. Surveillance for community transmission

Once a single case has been confirmed there is increased likelihood of further cases and subsequent community transmission. Clinic staff should have a raised index of suspicion of further cases after an initial case, and, in consultation with the local PHU, consider testing any community member who presents with a respiratory illness and/or fever.

7.2. Decision that widespread community transmission has occurred

Information that suggests widespread community transmission has occurred would include new cases occurring in households or family groups outside known cases (indicating unknown transmission chains) or new cases occurring in those who are not close contacts or known cases.

The decision that widespread community transmission is occurring should involve a discussion between the community health service, public health and local health authority CEO or delegate and discussion with the peak Aboriginal health organisation in the jurisdiction, ideally the Public Health Medical Officer (noting that organisational structures will differ by jurisdiction). This decision is to be documented in writing and forwarded to all relevant organisations. While individual doctors, other individual clinicians or practice managers are not authorised to make this decision, they are at the frontline and well-placed to inform authorities about changes in frequency of disease presentations.

7.3. Case and contact management during widespread community transmission

Evacuation of cases and their contacts should continue whilst there is thought to be benefit to the community. When there is widespread community transmission the evacuation of cases and their contacts will no longer be of significant benefit in preventing further spread.

Once this decision is made, the community should be informed as this will explain the changes that will be visible to the community from previous practice. Every effort should still be made to work with local community staff members to:

- Contact trace all cases and encourage cases and their contacts to self-isolate as much as possible AND
- Monitor contacts for disease AND
- For the whole community to engage in behaviours (including regular hand hygiene and social distancing) that will prevent or slow the spread of disease, noting the difficulties of this in remote settings.

Evacuation of suspected and confirmed cases would be guided by the case’s clinical presentation and the capacity of the community health service to monitor and support the person in community. Early evacuation of cases who are at high risk of severe disease (e.g. have significant comorbidities and/or are greater than 50 years) should be considered. In some situations, where there is no capacity for cases to self-isolate in community, evacuation may also still be considered.

8. Surge capacity

Surge capacity is defined as the ability to manage a sudden, unexpected increase in demand that would otherwise severely challenge or exceed the current capacity of the healthcare system. Adequate surge capacity is achievable initially from internal resources by re-prioritising workflows and communicating these decisions effectively with the community. As there are no universal
quantitative indicators for ‘breaking points’ in service capacity that should trigger additional surge capacity, insight into capacity and service stress is critical in the public health response to COVID19. In remote and very remote settings, isolation can delay this recognition of need. There must be clear protocols for escalating requests for surge capacity.

Each local community response plan should describe who is responsible for monitoring and reporting capacity in:

1. **the local health clinic**: health service capacity, including personal risk to health care workers who may be in high risk groups, to see patients with COVID-19 symptoms as well as continuing to respond to other primary health care priorities
2. **public health capacity**: sufficient workforce to conduct contact tracing, educate and quarantine contacts, and
3. **community services**: stocks of food in the store, water supply, power supply, sanitation and garbage management, soap etc.

It is critical that each of these dimensions of the local response is objectively monitored and reported to local decision-makers.

Procedures for escalating unmet need for surge capacity in each of the three dimensions listed previously should be discussed, shared and described in the community response plan and invoked when required.

It is recommended that the relevant state/territory National Aboriginal Community Controlled Health Organisation (NACCHO) Affiliate be the first point of escalation for surge support by any of its members with respect to local clinic capacity. Remote clinics managed by government authorities should comply with their own internal escalation protocols. When the provider of primary health care is another service such as Royal Flying Doctor Service (RFDS), this service should comply with its own internal escalation protocols. With staff absent due to their own illness, pressures from travel restrictions and burnout on the job, surge capacity needs to be planned.

Public health capacity is equally critical. Models of service delivery vary by region. In remote and very remote communities, primary health care staff often perform the functions of contact tracing that public health staff would perform in other parts of Australia. Standards for contact tracing and effective quarantine are critical in the public health response for Aboriginal and Torres Strait islander communities. Staff must be trained in culturally responsive contact tracing and skilled in facilitating accurate understanding of disease transmission and benefits for the entire community of quarantine for contacts. Local staff input to facilitate this is critical.

### 9. Restricting movement from the community

Determinations under the *Biosecurity Act 2015* allow for movement restrictions into designated areas. These restrictions should be well understood for each community by all health staff and PHU.

When a case has been diagnosed in a community, and particularly where there has been widespread community transmission there is risk of spreading disease should community residents travel outside of their community. Therefore in the event of a case in a community, residents should be supported not to leave the community until the quarantine period of the case’s contacts is over. In the case of a community outbreak, residents should be supported not to leave until at least 14 days after the last case has resolved.
10. Relocation of vulnerable people from community

When a case of COVID-19 has been confirmed in a community, consideration should be given by clinical staff in consultation with the relevant PHU, to offering those at ‘high risk’ of hospitalisation/death from COVID-19 to relocate to an area where they have reduced risk of transmission e.g. an outstation. See relevant statement from the Australian Health Protection Principal Committee (AHPPC) for those at high risk of disease, note that this includes Aboriginal and Torres Strait Islander people with comorbidities aged 50 years and older. While the evidence so far shows that children with COVID-19 generally experience mild disease, this may be different among Aboriginal and Torres Strait Islander children, who have high rates of chronic disease including rheumatic heart disease and chronic lung disease due to prematurity. There should be ongoing data collection and analysis to better determine risk among this group.

Key considerations in this decision to offer relocation to vulnerable groups will be:

- Whether there is likely to be community transmission occurring e.g. a scenario where a single case presents, who developed symptoms one day after returning to community and was evacuated immediately is lower risk of causing community transmission than multiple locally acquired cases
- Availability of appropriate accommodation for relocation
- Availability of appropriate transport for relocation
- Availability of the individual to access appropriate health care if they become unwell after relocation
Appendix 1: Key considerations to guide the decision to evacuate suspect and confirmed cases and their close contacts

<table>
<thead>
<tr>
<th>Key consideration</th>
<th>Rationale</th>
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<tr>
<td><em>(Suspect cases only)</em> &lt;br&gt; What will be the time delay until results are received and is there a suitable location for isolation of the case and quarantine of their contacts which can be used in the short term?</td>
<td>Even if longer term isolation in the community is not possible, it may be feasible to isolate a case and their close contacts in temporary accommodation until test results are received if this will be a relatively short period e.g. 24-48 hours</td>
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<td><em>(Suspect cases only)</em> &lt;br&gt; Does the potential benefit to the community of early evacuation of a suspect case (with or without their contacts) outweigh the risks of evacuating a case and their contacts, when the true status of the case is unknown?</td>
<td>Evacuation of a suspect case that proves to be unnecessary has significant implications for the suspect case and their contacts with regards to increasing their risk of disease (via transport and being in an area of higher transmission) and a prolonged absence from their community. This must be balanced against the potential community protection. If a suspect case presents immediately after onset of symptoms, then given the median incubation period it may be feasible to wait for confirmation of diagnosis before considering evacuation of contacts, however every attempt should be made to keep contacts isolated within this time frame.</td>
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<td>Where is it likely the case acquired disease?</td>
<td>A case who has returned to the community within 14 days of developing symptoms is more likely to be an imported case. This lowers the probability of community transmission and provides a stronger rationale for early evacuation.</td>
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<td>What is the likely current status of community transmission?</td>
<td>If there is already likely to be a significant level of community transmission, as suggested by new cases who are not from the same household as previous cases, this decreases the rationale for case and contact evacuation as this action has less likelihood in preventing an outbreak (see community transmission).</td>
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<td>How long has the case been symptomatic for and what has their activity been during this time?</td>
<td>If the case has been symptomatic for some time (e.g. 3 days) and has had multiple contacts during this time, there is high likelihood of transmission having already occurred.</td>
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<td>Are the case and their contacts likely to adhere to self-isolation?</td>
<td>The case and their contacts need to have a high degree of understanding of the issue and why it is important to self isolate. Where a case and/or their close contacts are unlikely to adhere to medical recommendations around the need for self-isolation and quarantine in community, medical evacuation should be strongly encouraged.</td>
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<td>Does the case have mild illness, and <strong>not</strong> be at high risk of a poor outcome?</td>
<td>Current evidence suggests that clinical deterioration generally occurs in week 2 of the illness. For cases at particularly high risk (see AHPPC statement) and/or limited</td>
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<tr>
<td>Question</td>
<td>Answer</td>
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<td>access to medical retrieval there may be a preference for early evacuation.</td>
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<td>Does the case and their close contacts wish to remain in the community?</td>
<td>It is important to explain why evacuation benefits the case and the community, answer questions and offer evacuation even if clinically the person does not meet the conventional threshold for evacuation. A support person should also be made available to anyone evacuated.</td>
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<td>What is the community’s preference?</td>
<td>This should include consideration of potential disharmony if cases and their contacts are not evacuated</td>
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<td>Is there suitable accommodation for the case to self-isolate in community?</td>
<td>For a case to self-isolate in community, suitable accommodation must be available to ensure the patient is isolated in a house on their own or meets the minimums standards as specified by the WHO; if there is no suitable accommodation in community, early evacuation should be recommended</td>
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<td>Are there suitable supports available for the case to self-isolate?</td>
<td>Including provision of food, social and financial supports, regular health needs, cultural supports</td>
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<td>Does the clinic have capacity to safely monitor the case for signs of deterioration, and contacts for signs of developing disease?</td>
<td>If capacity to do this is limited (e.g. clinic staff are sick) then early evacuation should be considered</td>
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<td>Is the case able to be medically evacuated safely in the case of medical deterioration?</td>
<td>If there are restrictions on accessing timely medical evacuation, then early evacuation should be considered</td>
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<td>Is there suitable accommodation available for evacuated case(s) and their contacts in the evacuation location?</td>
<td>Cases should be admitted to hospital or offered safe accommodation (single room with ensuite). Contacts should also be offered safe accommodation. The facility needs to be able to provide close clinical monitoring as well as social and cultural support.</td>
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<td>Are there suitable supports available for cases and contacts in the evacuation location?</td>
<td>Supports must be available in regional isolation centres to ensure that cases and contacts are in culturally appropriate and safe environments that maximise the likelihood of the isolation period being observed</td>
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Appendix 2: Requirements for safe self-isolation and quarantine in community

While evacuation of confirmed and early suspected cases is strongly recommended by AHPPC, plans must also be developed for isolation and self-quarantine in the community. This is to provide community members with safe choices and to have systems in place in the event retrieval is not possible, either for initial cases or if community transmission becomes sustained. Due to the high prevalence of crowded homes and homes with faulty facilities for cleaning and personal hygiene, the community, health service, public health and other relevant organisations must together design options for self-isolation and quarantine outside of the household to protect the community. These should be articulated in the community co-designed local action plan. These options may require urgent erection of accommodations options with additional efforts to ensure failsafe arrangements for water, sanitation, power, food and access to medications.

Guidelines for safe isolation and quarantine can be accessed through the World Health Organisation

Separate facilities should be designated for confirmed and suspect cases and their close contacts (keeping these groups separate) where home facilities are inappropriate to allow for adequate separation of cases and contacts.

The ideal requirements for quarantine and self-isolation are a well-ventilated single room with access to a private toilet.

If single room cannot be provided, beds should be place at least 1.5m apart with no more than 1 person per 4m². Facilities need to be provided for;
- Provision of food, water, and hygiene
- Protection for baggage and other possessions
- Communication with family members who are outside quarantine
- Assessment by clinical staff
Appendix 3: Decision making algorithm for suspect and confirmed cases

Patient meets suspect case definition

If point of care PCR testing available

- Test negative: Exclude case, no further action
- Test positive: CONFIRMED CASE

If point of care PCR testing NOT available

- Inform PHU
- Immediate contact tracing

CONFIRMED CASE: Should the case and their contacts be evacuated? (see key considerations table)

- No: Isolate/quarantine in community in appropriate accommodation for at least 10 days (case) and at least 14 days (contacts) - see SoNG for further guidance
- Yes: Determine most appropriate mode of evacuation

CONFIRMED CASE: Isolate and quarantine outside community in suitable accommodation for at least 10 days (case) and at least 14 days (contacts) (note may be longer due to restrictions under Biosecurity Act)

Safe return home

SUSPECT CASE: Should the case and their contacts be evacuated? (see key considerations table)

- No: Isolate/quarantine in community in appropriate accommodation whilst awaiting test result
- Yes: Determine most appropriate mode of evacuation

SUSPECT CASE: Isolate and quarantine outside community in suitable accommodation until test negative (note may be longer due to restrictions under Biosecurity Act)

Test positive: CONFIRMED CASE

Test negative: Exclude case, no further action