



Australian Government

Department of Health and Ageing

APPENDIX

to the PROTECT Annex

Guidance for Primary Health Care Workers Providing Care to Aboriginal and Torres Strait Islander people

of the Australian Health Management Plan for Pandemic Influenza

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CERTIFICATE OF AMENDMENT

The Office of Health Protection (OHP) within the Department of Health and Ageing (DoHA) in consultation with the Office for Aboriginal and Torres Strait Islander Health (OATSIH) is responsible for reviewing this document. Amendments to this copy of the PROTECT annex are noted in the columns below

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1. Background

This Appendix is written to support health care providers delivering services to Australia's Aboriginal and Torres Strait Islander population. It is consistent with the PROTECT Annex of the Australian Health Management Plan for Pandemic Influenza and includes practical advice regarding management of pandemic (H1N1) 09 infection as it affects vulnerable Aboriginal peoples and Torres Strait Islanders.

1.1 Who should read this appendix

This document has been written for **all primary health care providers** who are likely to provide care for Indigenous Australians. Many Indigenous people access medical services in the wider community and it is therefore important to be aware of the particular vulnerabilities of a proportion of the Aboriginal and Torres Strait Islander population.

Practitioners should assess all Aboriginal peoples and Torres Strait Islanders presenting with an influenza like illness (ILI) for chronic diseases and other risk factors. The information in this appendix will assist all medical practitioners and health care workers to optimally provide care to Aboriginal and Torres Strait Islander patients.

Health professionals, particularly those working in the wider community, should keep the following points in mind when assessing and treating any patients who may have pandemic (H1N1) 09:

- The low identification rates of Aboriginal and Torres Strait Islander status and therefore the need to actively identify Indigenous persons.
- The high prevalence of chronic diseases in Aboriginal and Torres Strait Islander populations that may predispose to severe outcomes and complications associated with pandemic (H1N1) 09 and the fact that in many individuals these conditions may be undiagnosed.
- The social circumstances and needs of patients that are identified as Aboriginal or Torres Strait Islander.
- The possibility that the patient may be residing with a person who is vulnerable, for example, due to the presence of chronic disease(s).

1.2 PROTECT Phase

The focus of the PROTECT phase is on identifying the people in whom disease may be severe and providing early medical care and interventions to reduce likely suffering. Key elements of the response include:

- Identifying the vulnerable, in whom pandemic (H1N1) 09 may have severe outcomes.
- A focus on early treatment of those identified as vulnerable and those with moderate or severe disease.
- Voluntary home isolation for those who are sick, with antivirals provided to those with mild disease only if they belong to a vulnerable group and are therefore at higher risk of more severe outcomes, or are in high risk settings.
- Contacts will no longer be placed in quarantine.

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- A re-focus of testing to identify pandemic (H1N1) 09 in those with moderate to severe disease, people who may be more vulnerable to severe outcomes and outbreaks in institutional settings.

Information from Canada suggests that Indigenous groups are more vulnerable to severe outcomes, and evidence from overseas has also shown that people with underlying chronic health conditions are also more vulnerable.

In the PROTECT phase of Australia's pandemic plan, population groups identified as vulnerable to severe outcomes include (PROTECT annex, p 13):

- Those with chronic respiratory conditions, including asthma and COPD.
- Pregnant women, especially in the 2nd and 3rd trimesters.
- Persons with morbid obesity.
- Indigenous people of any age with underlying chronic disease.
- Persons with chronic illness predisposing to severe influenza such as cardiac disease (excluding simple hypertension), diabetes mellitus, chronic metabolic diseases, chronic renal disease, haemoglobinopathies, immunosuppression.

Indigenous Australians are included due to the potential presence of underlying chronic disease(s), some of which may be undiagnosed, and for their higher level of social disadvantage.

Specifically;

- Indigenous Australians have a much greater burden of diagnosed chronic disease than non-Indigenous Australians.
- Risk factors for chronic disease are more prevalent in Indigenous Australians, and Indigenous Australians are more likely to have at least one risk factor for chronic disease.
- Indigenous Australians develop chronic disease at younger ages and the pandemic (H1N1) 09 virus preferentially infects younger people.
- Indigenous Australians are more likely to have undiagnosed chronic diseases.

Other factors that require specific consideration in Indigenous populations include:

- Approximately 50% of Indigenous Australians live in outer regional and remote areas.
- Many Indigenous peoples have limited access to primary health care and medicines.
- Indigenous Australians in urban areas are more likely to live in conditions that predispose to the spread of respiratory infections.
- Indigenous Australians access primary health care through a range of services including both mainstream primary health care and Aboriginal Community Controlled Health Services.

2. Case Management

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This guidance is intended to provide general principles rather than replace detailed local guidelines that have been developed for the management of patients. Information from Canada on the experience in Indigenous communities supports early treatment of vulnerable patients with ILI to improve health outcomes.

2.1 Case definition and assessment

During the PROTECT Phase, the clinical definition for an influenza like illness is fever ($\geq 38^{\circ}\text{C}$ or well documented history) with cough and/or sore throat.

- All patients that meet the clinical case definition should be assessed according to the 'Decision tree for management of cases of influenza like illness', (PROTECT Annex, p. 16).
- The assessment should include gaining information about the patient's contacts (see Contact Assessment and Management below). This is consistent with the PROTECT Annex which outlines (p.15) that close contacts who fall into vulnerable groups should be advised to present early if they develop ILI symptoms to enable early treatment.

Advice from professional supports within your organisation and external to your organisation may be needed.

2.2 Assessment for antivirals

As is the case when assessing anyone who falls into the vulnerable groups listed on page 13 of the PROTECT Annex, the decision about whether to offer antivirals to Indigenous Australians rests upon clinical judgement. While not every individual in these groups is necessarily more at risk, inclusion in the group is a signal to the treating medical practitioner of the need for investigation and clinical judgement. Antiviral treatment is only one component of a management plan — it is important to consider incorporating supportive therapy, infection control measures and education regarding hygiene messages.

The following should be used to guide the prescription of antivirals to individual patients.

- Primary factors for consideration:
 - The risk of deterioration of the individual patient based on their clinical presentation and the presence of chronic diseases and risk factors for chronic diseases.
 - Antivirals are most effective if commenced within the first 48 hours of developing symptoms and after that time have limited efficacy.
 - The likelihood of the presence of pandemic (H1N1) 09 infection, e.g., established community transmission in the area or contact with a known case.
- Other considerations:
 - Whether the person has contacts (household or community) that are vulnerable (e.g. the presence of chronic disease(s) or pregnancy), on the basis that treatment of the individual may reduce transmission to the contact(s).
 - If there is no established community transmission, particularly where many high risk vulnerable people reside, treatment may be considered to minimise risk of

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transmission into the community (see 'Public health measures applicable in isolated or remote communities' below).

In making clinical judgements about antiviral treatment refer to your existing professional supports, including within your organisation (e.g. nurse line manager, DMO etc.) and externally. Consultation with regional specialists may be beneficial e.g., infectious disease or respiratory physician or paediatrician. Advice from your local public health unit/ public health physician may be relevant if there is no established community transmission.

2.3 Health Care Workers

Antiviral treatment for health care workers should be considered especially in remote areas with very limited staff (see [CDNA Pandemic \(H1N1\) 2009 Infection 'Protect Phase': Guidelines for Australian Public Health Units](#)).

2.4 Laboratory Testing

Where testing capacity is limited, or results may be delayed due to remoteness or other factors, the decision to treat should be based on clinical assessment and not postponed awaiting test results.

- Referral for testing should be undertaken if the patient has an ILI and is being considered for antiviral treatment (because he/she is deemed vulnerable on the basis of, for example, underlying chronic disease, or has moderate or severe disease).
- Referral for testing should be undertaken, and treatment commenced, if there is limited or no transmission of the virus in the local area, (see Decision Tree, PROTECT annex. p 16).
- If the test comes back negative, consideration should be given to stopping antiviral treatment.

The decision to treat or not treat should not be based solely on a negative point of care test.

2.5 Infection Control

Challenges to infection control in Aboriginal and Torres Strait Islander communities are acknowledged. As such, isolating cases from those who are more vulnerable to severe outcomes and recommending keeping a distance of one metre from others may be a more manageable approach to preventing spread of disease.

- The voluntary home isolation of patients while infectious is strongly recommended to reduce transmission.
- Other measures such as patients using masks can be considered depending on the vulnerability of contacts and living circumstances.
- Information about hand hygiene (Hand washing and drying) and cough etiquette should be promoted to cases, contacts and community.

For health care workers further information is available in the [CDNA Pandemic \(H1N1\) 2009 Infection 'Protect Phase': Guidelines for Australian Public Health Units](#).

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3. Acute care for individuals in remote communities

Access to health care is an important issue, particularly for remote communities. Health care providers should proactively ensure that support services can be quickly contacted. Thus to enable timely and appropriate management:

- Ensure you know who to access clinical support from, and how to do this, both within your organisation (e.g., clinical line manager, public health medical officers, District Medical Officer) and using external specialist supports (e.g., regional hospitals, laboratory support, infectious diseases or respiratory physician, paediatrician, public health physician)
- Plan for emergency evacuations, by liaising with regular retrieval services (RFDS and AirMed) and acute care support services in your jurisdiction.
- Anticipate clinical deterioration early to allow timely transfer.
- Seek advice from experts as necessary (e.g. paediatrician, infectious diseases physician, respiratory physician in your region)

Further information, relevant to all pandemic (H1N1) 09 patients, about the recognition of moderate to severe illness and clinical deterioration, transport considerations, and rural and remote considerations is being developed.

4. Contact Management

In the PROTECT phase contacts are not routinely offered post exposure antiviral prophylaxis.

- High risk contacts should be identified, provided with education and strongly encouraged to present early if unwell.
- As outlined on page 15 of the PROTECT Phase Annex, in areas unaffected by pandemic (H1N1) 09, antivirals may be used for public health control activities. This should be considered in consultation with your local public health unit.

Further information regarding post-exposure prophylaxis for health care workers in specialised settings with high risk patients is located in the [CDNA Pandemic \(H1N1\) 2009 Infection 'Protect Phase': Guidelines for Australian Public Health Units.](#)

5. Public health measures in isolated or remote communities or town camp settings

Remote Aboriginal and Torres Strait Islander communities and town camp settings are at risk of outbreaks due to multiple factors including environmental conditions predisposing to transmission. In these settings, even in the absence of confirmed cases, it is important to minimise the impact of possible rapid spread. Early outbreak investigation and management should be considered in consultation with your local public health unit.

- If antivirals are being considered for public health control activities, every attempt should be made to test the patient for pandemic (H1N1) 09 so that the diagnosis can be confirmed or ruled out, to guide public health activities.

The public health response to a case of pandemic (H1N1) 09 will vary depending upon factors such as the number of previous cases in the community. The response to the first case in a community will be different to all other responses. As outlined on page 15 of the PROTECT Phase Annex, in areas unaffected by pandemic (H1N1) 09, antivirals may be used for public health control activities. This, along with outbreak investigation and management, should be considered in consultation with your local public health unit.

6. Access to antivirals and Personal Protective Equipment (PPE) from the National Medical Stockpile (NMS)

Access to antivirals and PPE from the NMS for the Aboriginal and Torres Strait Islander population is coordinated through the jurisdictions.

6.1 Coordination and distribution mechanisms

The NMS is managed by the Commonwealth government and distributed to states and territories on request from the Chief Health Officer of that jurisdiction. States and territories are then responsible for ensuring delivery to health care services, including Indigenous primary health care services.

- Some jurisdictions have pre-positioned stocks in remote and other areas to ensure communities have timely access to supplies when needed.
- To ensure effective and timely supply to your service, plan distribution pathways and work with your local or jurisdictional public health unit to request and ensure delivery of stocks.

For further assistance with identifying or linking with appropriate contacts, please contact your local NACCHO Affiliate or GP division.

7. Reporting and Monitoring

National pandemic and flu surveillance systems are being used to monitor the pandemic, adjust the response and guide future planning. Information gathered at the service level is an important component of the response and planning. To assist this:

- Ensure information collected at the service level is as complete and detailed as possible.
- Notify cases to public health units using usual systems. In particular, identify and report Indigenous status on all documentation and reports.
- Consider how you may use your routine patient management systems to monitor cases and suspected cases to help inform your local responses.
- Monitor workload impacts.
- Share forms or tools developed to make collecting case information easier at the local service level.
- Link and coordinate with jurisdictional systems for easy transfer of notifiable data.

DoHA is developing strategies to ensure the Indigenous population is adequately represented in national surveillance systems. There is an opportunity for your service or practice to be involved as a sentinel site in the Australian Sentinel Practices Research Network (ASPREN). For more information please contact adriana.parrella@adelaide.edu.au or telephone (08) 8303 7583.

Privacy considerations may be particularly relevant to Aboriginal people and Torres Strait Islanders living in small communities. For further detail refer to the relevant state/territory legislation.

8. Working Together

8.1 Governance and planning structures

Australia's response to pandemic (H1N1) 09 is based on partnerships between the Australian Government, state, territory and local governments and the community. Planning and response decisions are shared by governments at all levels.

To assist with the dissemination of information to health care professionals providing care to Aboriginal and Torres Strait Islander peoples, as well as advice on the response, an Indigenous Flu Network facilitated by OATSIH, within DoHA has been established. The peak bodies, the Royal Australian College of General Practitioners (RACGP) and the Australian General Practice Network (AGPN) have been contracted by the Australian Government to provide education and training and information dissemination to and support to general practitioners around the country, including practitioners in ACCHS.

State and territory governments have response plans which include primary health care services. Local health services, including Aboriginal community controlled health services, GPs and hospitals, should continue working closely together.

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Individual health services should maintain close contact with their local or regional public health units for advice. These public health units are able to supply information which is specific to your area, including working guidelines and protocols, and local contacts.

8.2 Training and education for health care professionals

Specific challenges to consider include difficulties accessing training due to geographical isolation and differing staff workloads, experience and skills. Training for the primary health care workforce (in the use of PPE, infection control, testing and other pandemic-related measures is): currently being provided by the RACGP in collaboration with the AGPN, through the Divisions of General Practice around Australia.

- To access this training, and to discuss specific issues/needs, please liaise with your state/territory NACCHO Affiliate, or local or regional GP Divisions.

Other resources are available through the health emergency website, including the RACGP pandemic flu kit.

8.3 Communication and Information

Health service providers are encouraged to maintain or develop communications within their jurisdictions through:

- State/territory NACCHO Affiliates, including the Public Health Medical Officer within Affiliates
- Local or regional public health units
- GP Divisions
- Clinical services – emergency department, evacuation services, specialists

Further information is available on the DoHA health emergency website, State and Territory health websites, and via the hotline 180 2007.

9. State and Territory Health Departments

NSW Department of Health

http://www.health.nsw.gov.au/publichealth/swine_flu.asp

Victorian Government

<http://www.health.vic.gov.au/ideas/diseases/swine-influenza>

Queensland Government

<http://www.health.qld.gov.au/swineflu/>

WA Health

http://www.public.health.wa.gov.au/2/949/2/swine_flu.pm

SA Department of Health

<http://www.flu.sa.gov.au/Swineflu.aspx>

NT Government Department of Health and Families

http://www.health.nt.gov.au/Centre_for_Disease_Control/index.aspx

Tasmanian Government

<http://www.pandemic.tas.gov.au/>

ACT Department of Health

<http://health.act.gov.au/c/health?a=da&did=10098808&pid=1240874209>

Useful Links

Public Information Line

Department of Health and Ageing Hotline for H1N1 09: **180 2007**.

Health Emergency Website

www.healthemergency.gov.au