HNELHD COVID-19 Update #3

23/03/2020

PHN providing daily update bulletin to all Primary Care Clinicians
- Should be automatically subscribed or visit subscription link on the PHN home page

HealthPathways is the other Source Of Truth for clinical advice from PHN
HNE PatientInfo site is the updated source for patients http://patientinfo.org.au/

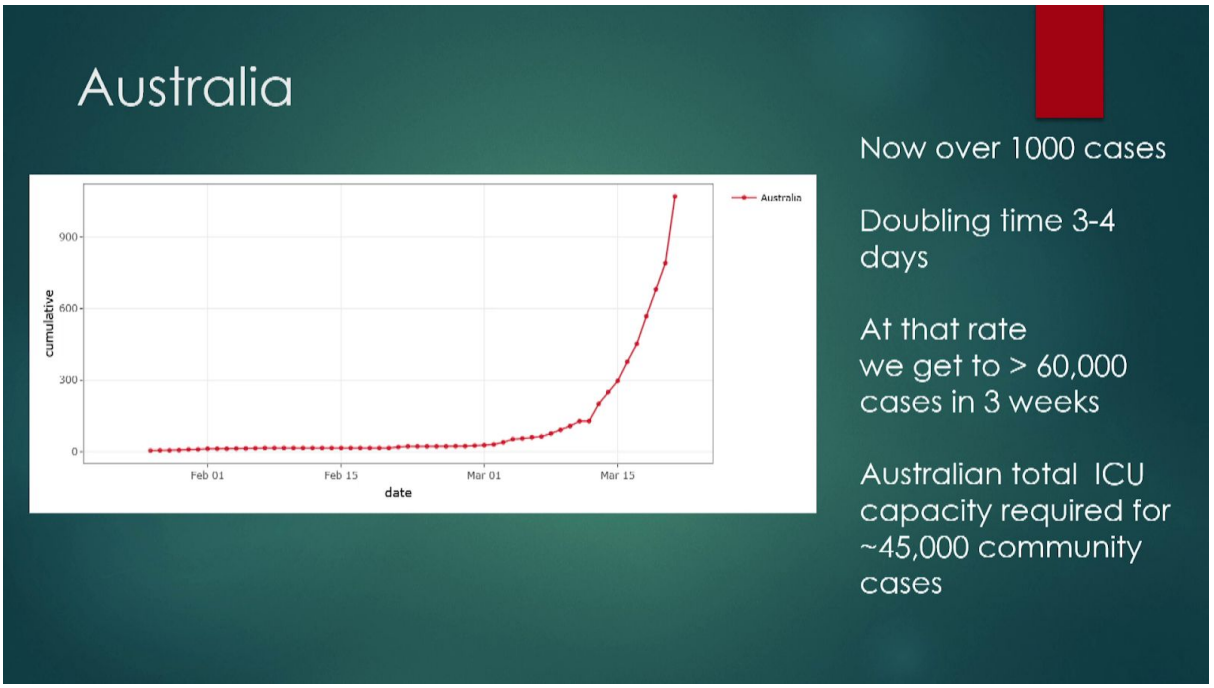
100 Commonwealth Respiratory clinics to be provided in addition to PHN clinics
- NOT drive-through clinics
- For mild-moderately unwell
- Raymond Terrace will be closest one to Newcastle centre
- https://www.health.gov.au/resources/publications/covid-19-national-health-plan-primary-health-respiratory-clinics

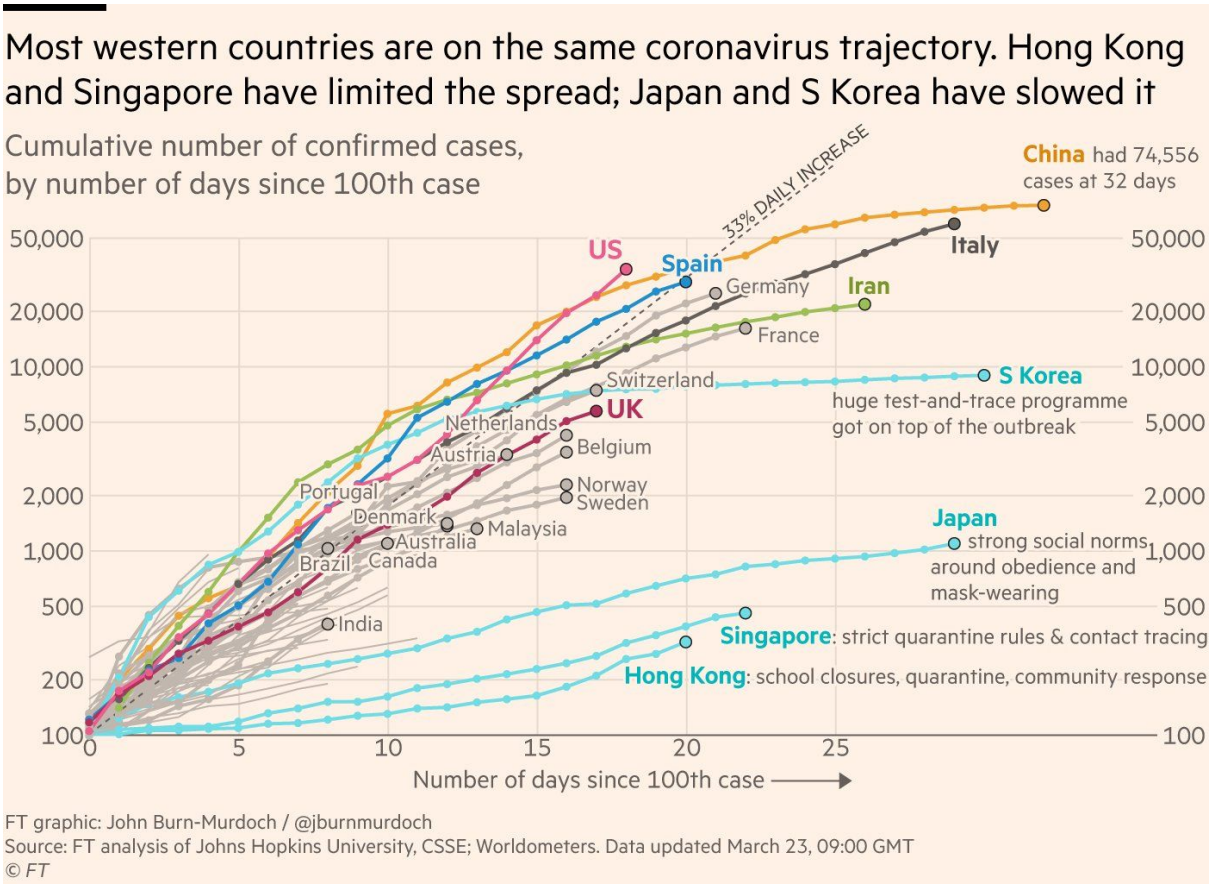
New Extended Telehealth items
http://www.mbsonline.gov.au/internet/mbsonline/publishing.nsf/content/news-2020-03-01-latest-news-march
https://www1.racgp.org.au/getmedia/01955a3f-778b-401f-b815-fcd12b5b1bf2/Expansion-of-telehealth-services-23032020.PDF.aspx
The extended telehealth item numbers are available to health care providers who are:
- Aged at least 70 years old
- Indigenous and aged at least 50 years old
- Pregnant
- A parent of a child under 12 months
- Immune compromised
- Have a chronic medical condition that results in increased risk from coronavirus infection.

Elderly & Residential Aged Care resources
- Infection control training being rolled out
- Workforce management and secondary triage capabilities being provided
- Involving local Geriatrician, GPs and nursing staff
- Rolling out Capacity Assessment tool for measure capacity of local Residential Care

PPE
- National short supply as well as international short supply
- Will take some time for production to spool up
- Hand sanitiser now available in bulk purchase to practices
- Will be a how-to-order link in tomorrow's PHN bulletin
- National stockpile is currently being replenished
- Out of eye protection and gowns currently

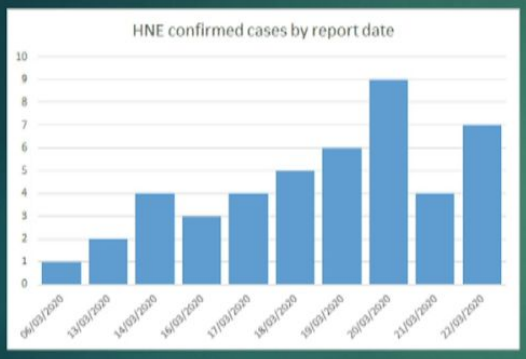
Global Snapshot 22-23/03





Source: https://twitter.com/jburnmurdoch (updating graph regularly)

Hunter New England

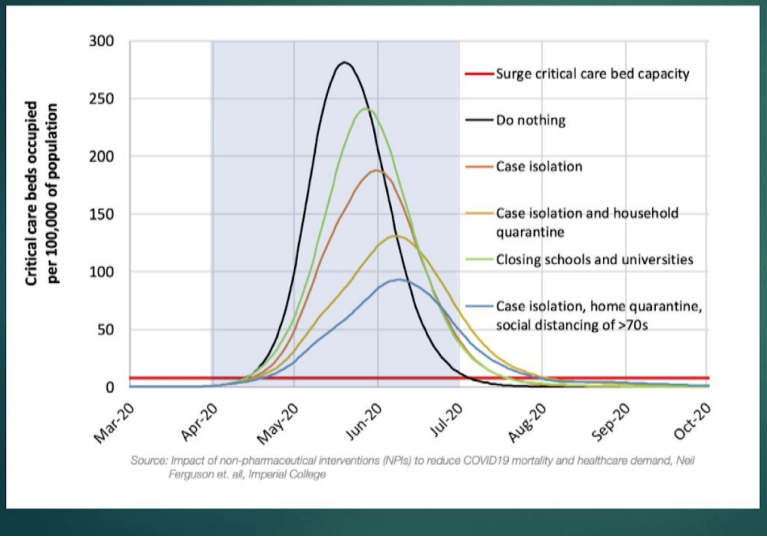


Source	Number	Percent
Overseas travel	16	53
Linked to a confirmed case	6	20
Linked to a known exposure site	3	10
Unknown	4	13
Under investigation	1	3
Total	30	100

Time from onset to report is a median of 4 days ie data lag real case numbers, which are likely 2+ times higher

Ferguson Report modelling that guided UK strategies, note the UK ICU capacity line at base

How much social intervention is enough?



Source: Impact of non-pharmaceutical interventions (NPIs) to reduce COVID19 mortality and healthcare demand, Neil Ferguson et. all, Imperial College

3 month mitigation (blue), UK setting

No action: ICU bed capa city exceeded x 30

Combination of CI, HQ, SD70 reduces deaths by 50%, ICU bed capacity exceeded x 8


16 March 2020 Imperial College COVID-19 Response Team

Impact of non-pharmaceutical interventions (NPIs) to reduce COVID-19 mortality and healthcare demand

Neil M Ferguson, Daniel Laydon, Gemma Nedjati-Gilani, Natsuko Imai, Kylie Ainslie, Marc Baguelin,

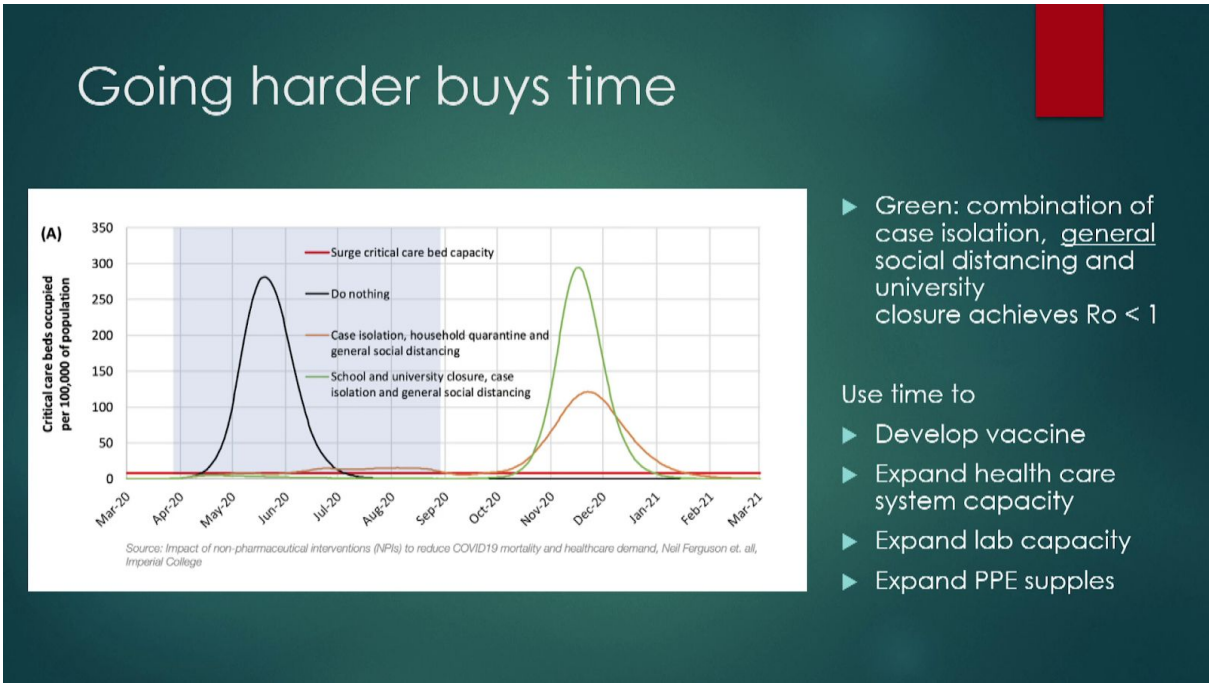
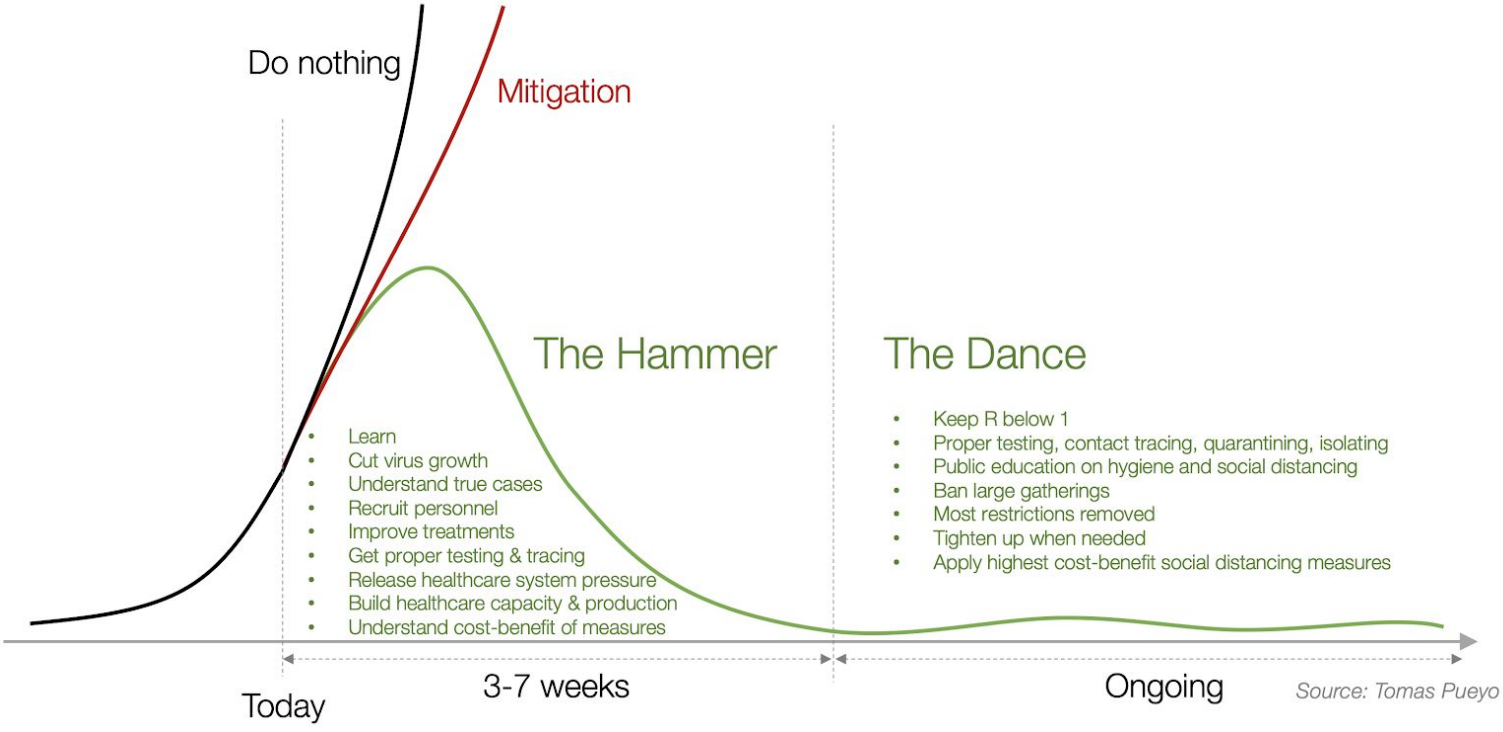


Chart 13: Suppression vs. Mitigation vs. Do Nothing — early on



Note Wuhan went into lockdown at 400 cases

Who to *QUARANTINE* at home (no symptoms)

For 14 days after last potential exposure:

1. Returned travellers from overseas (all countries and cruises from 16th March)

2. Close contacts of confirmed COVID-19 cases
3. Healthcare workers (returning from anny overseas country)

They are doing us an enormous favour, bearing an incredible burden, heroes, need to acknowledge
No logic in testing this group while they do **not** have symptoms

Who to TEST and ISOLATE (symptomatic)

1. Suspected cases
2. Also test: HCWs with fever (>37.5c) AND acute respiratory illness

If you test they **MUST ISOLATE** until result back, and if already in **quarantine must continue** to wait out 14 days irrespective of test result

Testing criteria

A moving feast. Keep tracking the NSW criteria at following, currently:
https://www.health.nsw.gov.au/Infectious/diseases/Pages/coronavirus-update.aspx

1. Travellers from overseas with onset of respiratory symptoms or fever within 14 days of return
2. Close contacts of confirmed COVID-19 cases with respiratory symptoms or fever within 14 days of last contact
3. Healthcare workers with recent onset of respiratory symptoms AND fever irrespective of travel history. Healthcare workers who have fever OR respiratory symptoms should be assessed for testing on a case by case basis
4. Patients admitted to hospital with acute respiratory illness or unexplained fever
5. Patients with acute respiratory illness or fever in high risk settings such as hospitals, aged care facilities, residential care facilities, boarding schools, cruise ships
6. Patients with acute respiratory illness or fever presenting with reported links to settings where COVID-19 outbreaks have occurred
7. Patients with unexplained respiratory symptoms or fever in Aboriginal rural and remote communities.

People without symptoms should not be tested.

Use HealthPathways - now expanded across several sub-pages, includes FAQs on medications
GPs can use the PHN Triage Flowchart tool
https://hne.communityhealthpathways.org/files/Resources/COVID-GPTRIAGE5-BRANDED200320.pdf

Testing Options (https://hne.communityhealthpathways.org/722376.htm)

- GP practices who have set up to do testing with phone triage
- Private pathology collection centre
- COVID testing centres (CTCs), mild criteria
    - JHH, CMN, Maitland
    - Belmont drive-through (call ahead 4923 2211)
- ED if seriously unwell
- PNH-led collection centres

Patients who do not meet criteria may be turned away from CTCs

Requesting Testing

Samples: ONE swab only, oropharyngeal (first) and deep nasopharyngeal

- ~75% sensitive in early illness, reliant on quality of collection

Request: COVID-19 testing

- ONLY consider adding other respiratory pathogens if will change management eg. HCWs or aged-care residents where considering Tamiflu

PHU is NOT in favour of a private path lab offering self-swabbing - not yet validated

Goals of management of confirmed cases & outbreaks

- Limit forward transmission
- Supportive treatment (still no practical treatment options)
- Vigilance for, and treatment of complications
    - GPs will be monitoring the mild cases managed at home
    - Be aware of deterioration at 7-10 day mark

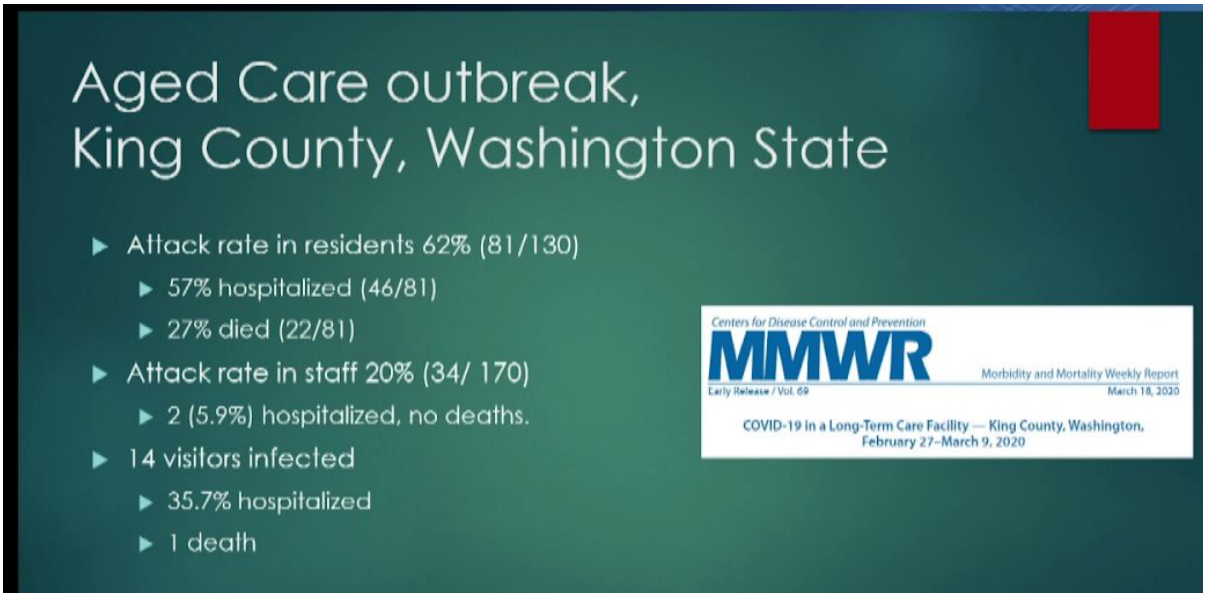
Home management of mild cases

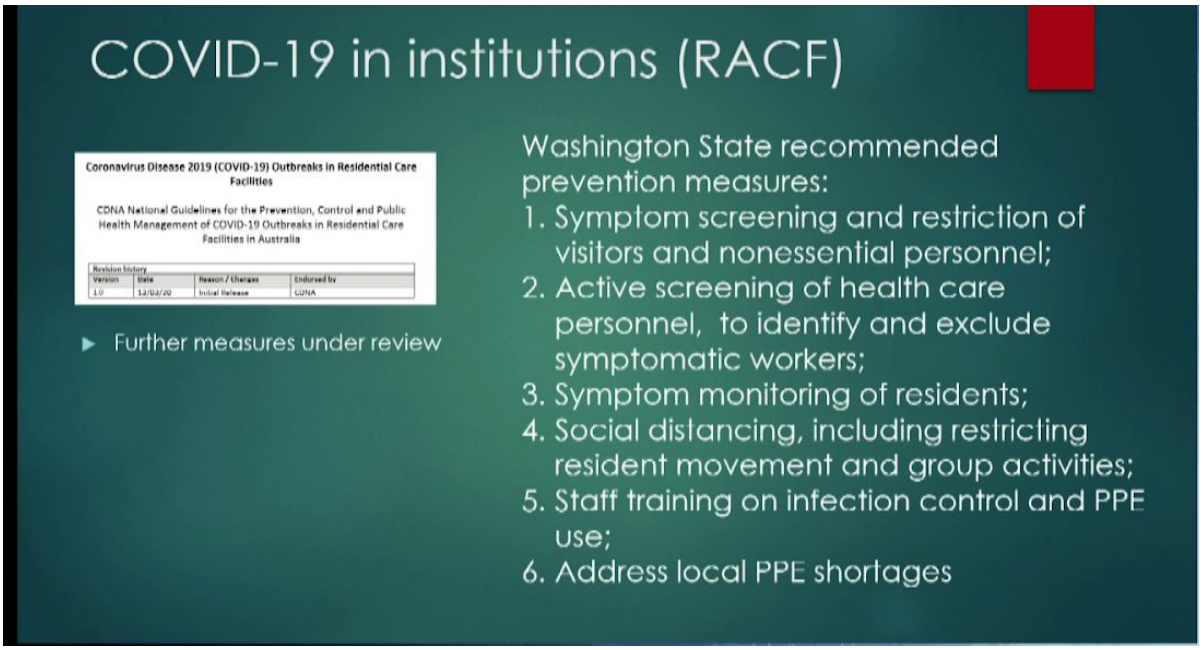
- Strictly remain at home, except for medical review, until cleared
- Daily review by phone (clinicians / PHU, HITH may come online soon)
- Separate from others (separate bedroom and bathroom, surgical mask on case and carer when in shared space)
- Increased repeated cleaning of surfaces - at least daily using a fresh clean cloth with detergent (wash hands after cleaning)
- Carer - also quarantined (14 days post non-infectiousness of case), self-monitor for symptoms

Guidelines for Release from isolation - confirmed cases including HCWs

https://www.health.gov.au/news/australian-health-protection-principal-committee-ahppc-coronavirus-covid-19-statement-on-21-march-2020

Don't let it get into Aged Care Facilities





COVID-19 in HCW

- Test all with fever AND respiratory symptoms (consider testing if isolated fever or respiratory symptoms on case-by-case)
- If tested, maintain strict quarantine whilst awaiting test results (getting faster now Pathology North doing local testing)
- Close contact in healthcare setting defined as >15min face to face WITHOUT PPE, >2hrs without PPE in same space = quarantine for 14 days
- Fever clinics still sending specimens to Sydney 3-4 day turnaround, only inpatient testing being done at JHH
- JHH is setting up a priority parallel flow for HCW testing

Infection control

Mildly unwell patient

- Standard, Contact & Droplet precautions
    - Surgical mask, goggles, gloves, (?gown)
    - Wipe contact surfaces, no need to ‘rest’ the room

Moderate to severely unwell patient (coughing +)

- Standard, Contact and Airborne precautions
- Refer to Emergency

Surgical masks:

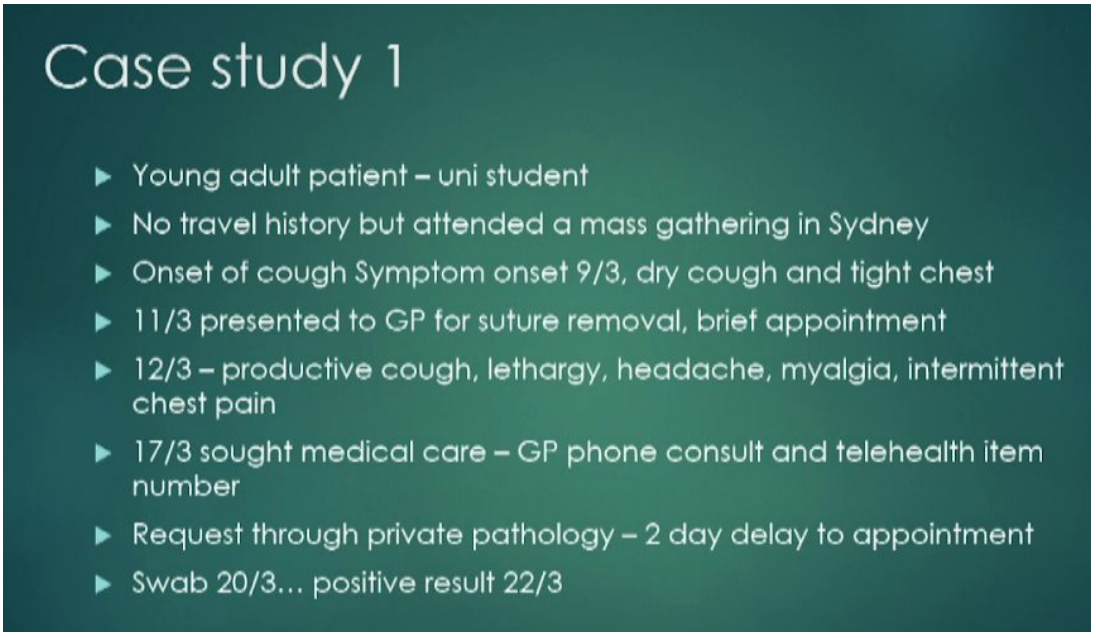
Standard level 2 Surgical mask with ear loops is adequate outside a hospital setting

- unless performing aerosol-generating procedure
- don’t reuse, even if drying them out
- Maximum *60 minute use*, discard earlier if becomes moist = ineffective
- Care++ with removal, don’t touch the front
- Hand hygiene after disposal

Conservation of PPE

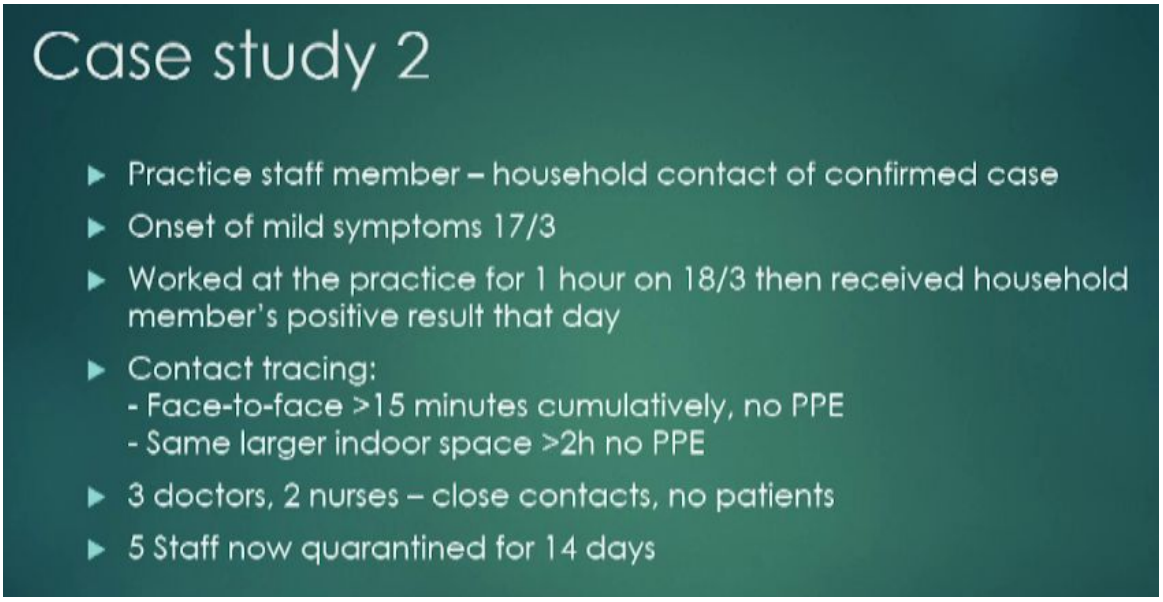
- P2 & N95 masks can be worn continuously over *an entire shift* if not taken off
    - Will get quite uncomfortable but still work if moist
- May need to get creative with supplies and alternatives
- Hopefully Wuhan will start exporting masks again
- Antiseptic and alcohol wipes are made in US & UK, exports have ceased
- Plenty of gloves, with more hand gel arriving soon
- Gowns ok to wear multiple patients if not grossly contaminated
- DO NOT YET need to routinely consult in full PPE - may be unhelpful barrier

Case study 1



- Private pathology centres are still fulfilling any request regardless of criteria, but they are running several days delay to collect specimens.
- This case was potentially infectious in the community from the 08-22/3 and did NOT meet criteria for testing
- The brief consult with the GP on the 11/3 was determined as casual contact
- Close-proximity gatherings for a prolonged period of time appear to be main transmission
- 10-15% across NSW are unknown source
- China household transmission was ~5-10%, not enough local data yet
- Close contacts who quarantine should be regarded as **heroes** due to profound impact within only 2 generations

Case Study 2



(Based on a recent case)

- STAY HOME if symptomatic HCW - give permission for staff to enforce this culturally
    - Isolated rhinorrhoea = err on side of caution, may develop further
- Had to contact trace practice staff, patients, practice manager was on the phone for an entire day (consider surge staff capacity), PHU was busy all weekend with this case
- 5 staff from this small practice deemed close contacts and quarantined
- Risk assessment is a graduated approach, PHU helps with these assessments
- It is only a matter of time before your practice has a positive staff result

Q&As

- No data on using antivirals for *prophylaxis*
- Hydroxychloroquine in Australia is in short supply, please don't use
    - RCTs are underway for multiple antiviral combos
- No association of Croup or Asthma with COVID-19 in children
- GP Practices should consider all creative measures for cohorting patients to avoid mixing high-risk with low-risk, eg vaccination days, URTI clinics
- If a home contact of a HCW has an URTI but HCW is healthy there is no need to self-isolate, especially if child as not implicated in transmission chain
- COVID-19 only considered infectious for <48hrs before symptoms
- Expert opinion is unlikely to get repeat infection with COVID-19, at least this wave
- Over 1800 COVID-19 papers now published
- No evidence for how long any post-infection immunity would last
- Work on district isolation facilities for confirmed cases is in progress
- HCW returning home after shift:
    - assume clothes contaminated, change, shower, wash clothes in hot water
    - Hospitals moving toward higher use of scrubs that stay on site
    - Bare below elbows
- Spirometry - depends on the machine & mouthpieces being used
    - See national asthma council guides on the topic

- Don’t believe pregnant women are at particular risk, but recommending they do not care for confirmed cases
- Cruise ships are the worst