Update for GPs from GP Dr Joanne Wood

Read the updated COVID-19 Assessment & Management section of Health pathways for a detailed guide to both telehealth and targeted examination techniques

Review the (Beta!) Health Pathways section: COVID-19 Ongoing Assessment and Management to see the plan for GP & community management of COVID-19

These must be 'living' GP-led documents

Use the round blue *Send Feedback* button (floating bottom-right of screen) if you identify an unanswered question or solution. GP Feedback is critical, HNE is relying on the amazing collection of GP brains out there to develop and refine these guidelines for GP use.

Key Points of Ongoing Management plan:

All COVID-19 positive patients will be allocated to a stream by PHU:

1. Community management by GP (expected review every 2-3 days, with telehealth at day 10 to clear from isolation). If patient is deteriorating, consider accessing home support from COVID19 HiTH or referral to ED
2. Community care by COVID-19 Hospital in the Home (patients will be provided with pulse oximeter and thermometer)
3. Inpatient Hospital care

Expand "Management Options" in Management section on Pathways for full details

GP-monitored patients

- Should have a focus on patient education, not on frequency of GP contact.
- Patients need to know what to look out for in monitoring themselves:
    - What triggers a telehealth appt with GP
    - What triggers a trip to ED
- Flag patients with risk factors and potential difficulties in maintaining isolation (see Medical Risk Factors list on Pathway)
- If numbers escalate it will be critical for GPs to have planned ahead and identified areas and patients they need to invest increased time in preparation for
- Bulk of GP work will be in clearing people from isolation - more specific guidelines are in development
- Community case follow-up is a work in progress, the previous SMS daily contact system is currently down.

Hospital in the Home service (HiTH)

- HNE District-wide service with single point of access for PHU & GPs
- Team of senior doctors has been assembled on a roster to manage these patients
- Will largely be over the telephone or video where available
- Will provide pulse oximeters & thermometer for home monitoring of O2 sats and HR
- Health Pathways has been updated to reflect changes to HitH
- Risk stratification: will have a call centre for GPs to refer patients of particular concern for close monitoring by HiTH
- Expecting ¼ - ⅓ of patients to have to go to hospital at some point, will have streamlined pathway in place to avoid ED and proceed to designated facilities
- Any COVID-19 discharged inpatient will go home on HiTH
- HiTH expects to clear some patients themselves, but most will be handed back to their GP

Updates

Commonwealth-funded Community Respiratory Clinics:

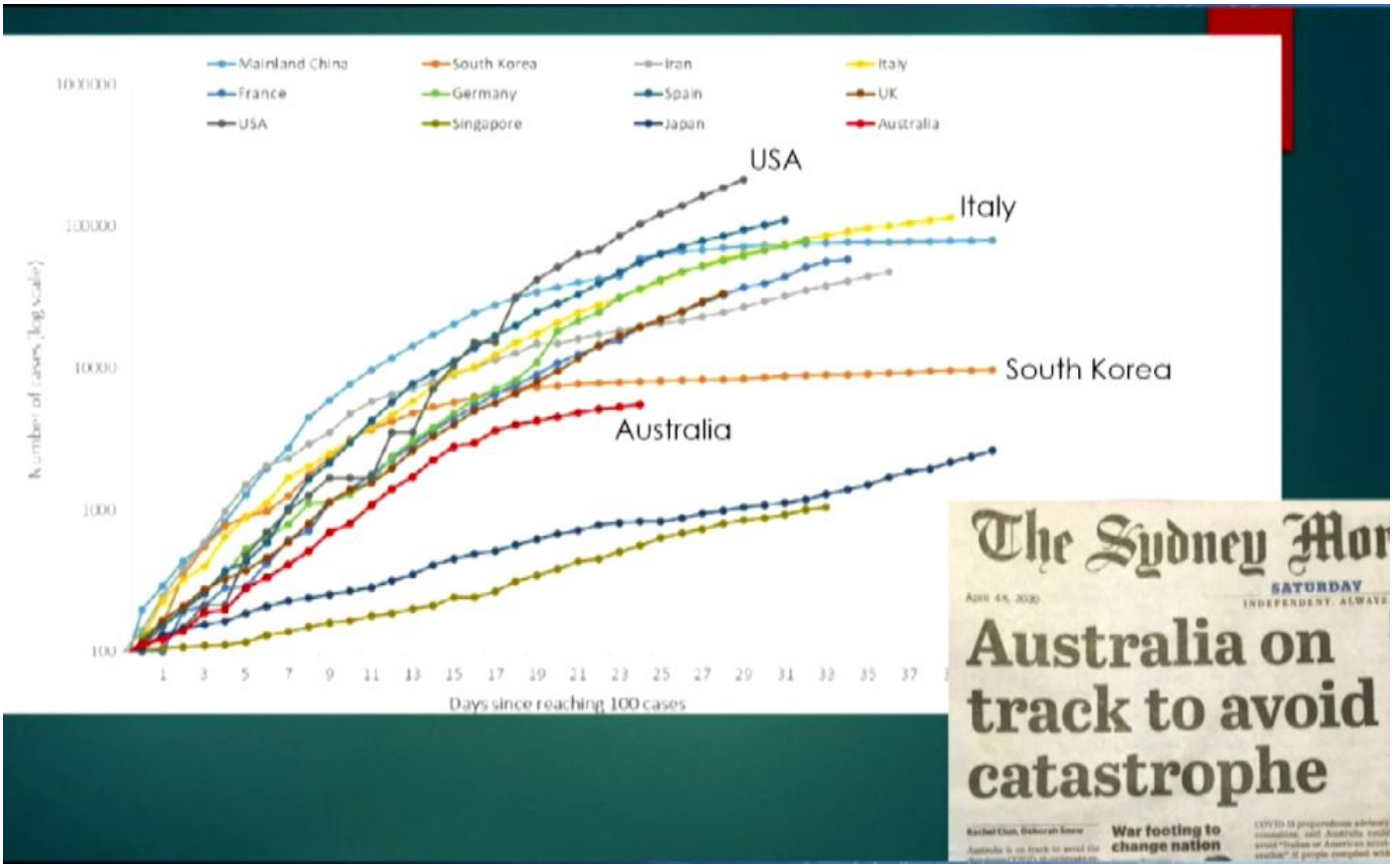
- Raymond Terrace clinic to open Thursday this week
- Toronto is awaiting approval to commence, Tamworth & Erina similar
- Monitor Health Pathways for news

Ordering process for masks via:

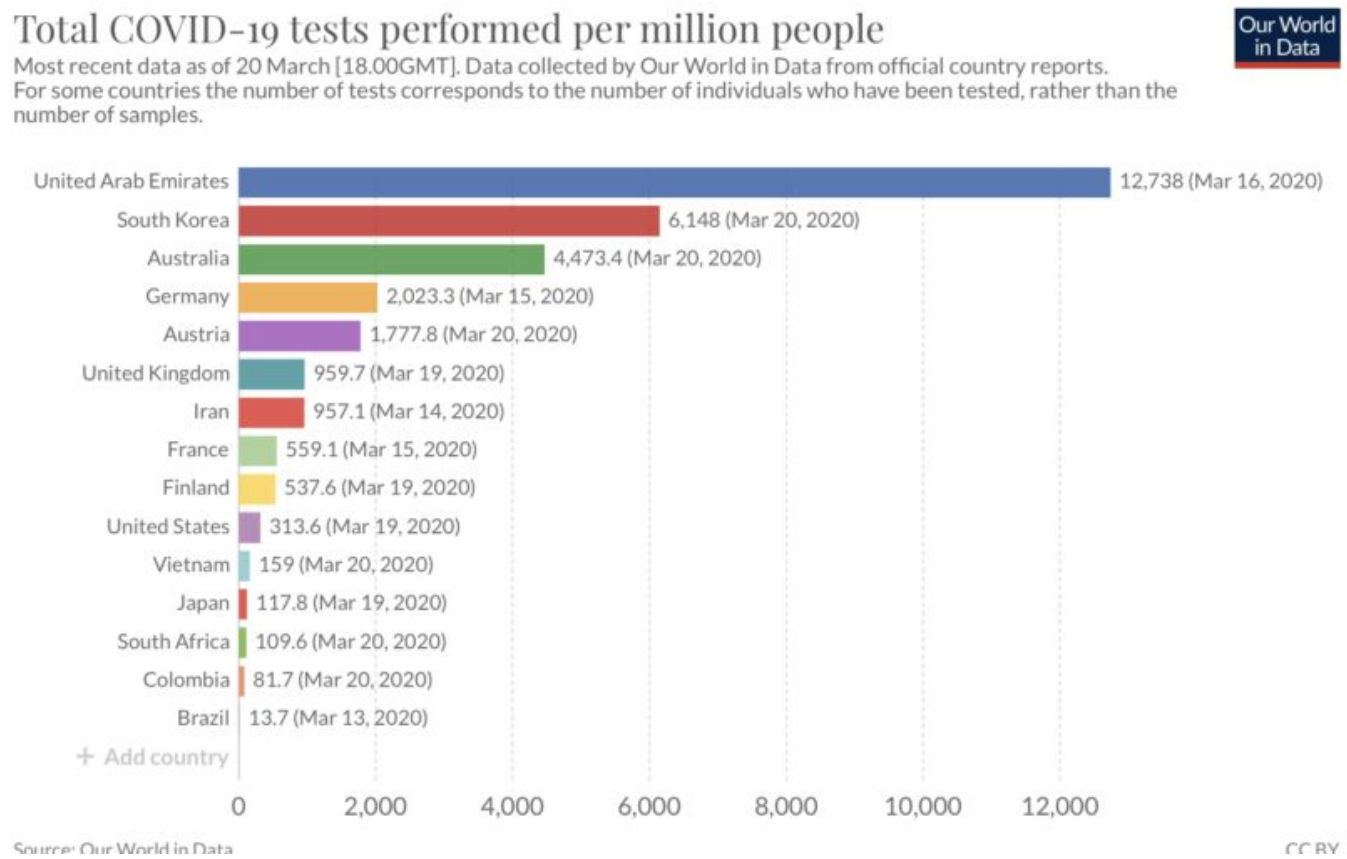
https://peoplebank.hneccphn.com.au/mask-requests/survey_tools/surgical-mask-request-form
- from today will get email confirmation for requests & ?dispatch
- can supply two boxes each request
- have access to ~1.5/52 worth of masks currently from National Stockpile

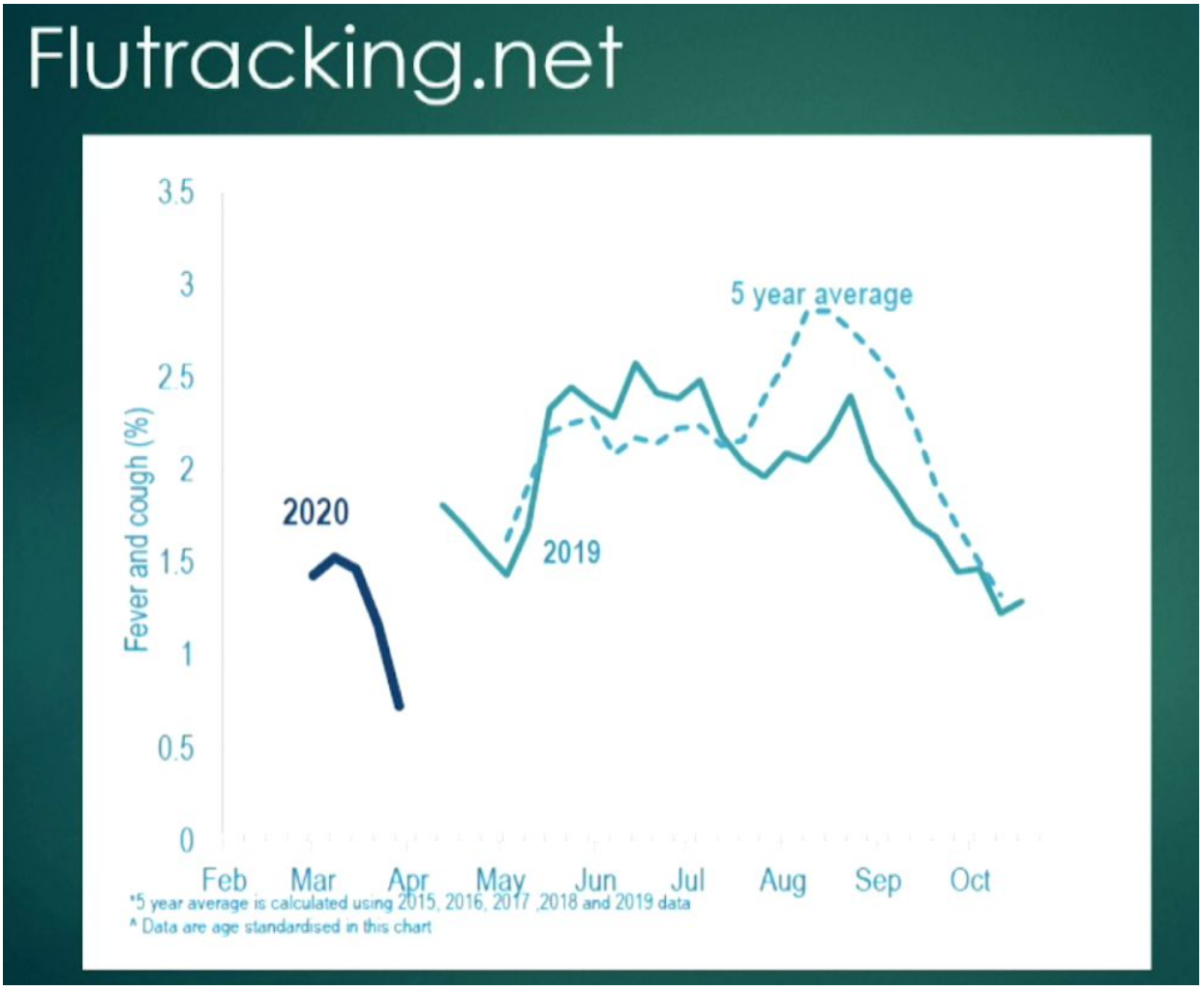
Epidemiology Update

International: >1million cases, now 5 countries ahead of China



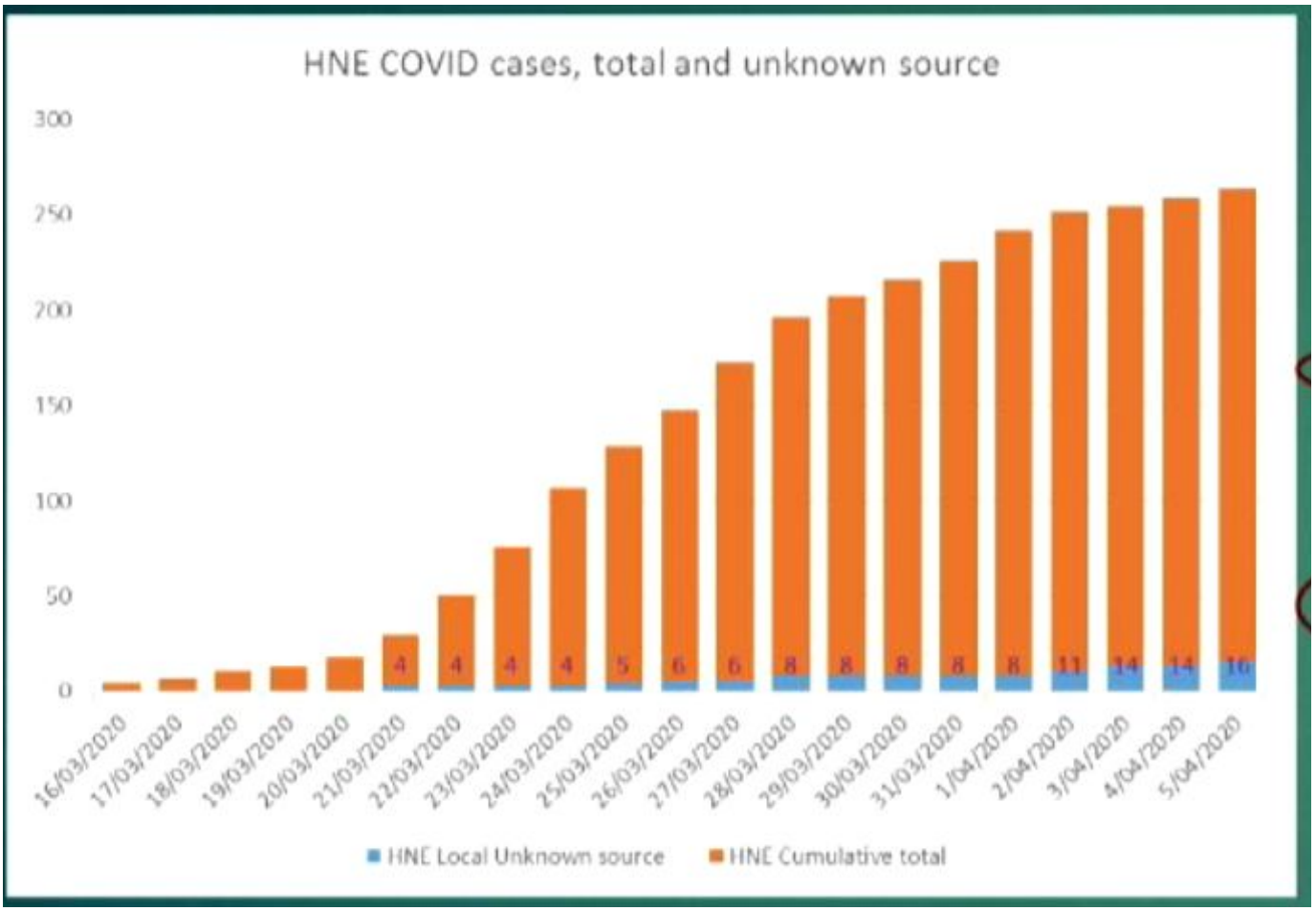
Note logarithmic axis: straight rise = horrifying. We are cautiously optimistic.





Social distancing efforts are having a superb impact. Data from Flu-tracking project shows a short, sharp drop in flu-like symptoms after introduction of distancing measures.

HNE Epidemiology Update



Satisfying drop in rate of accumulated cases. Blue represents unrecognised source, can assume it represents community spread (16 of 250 cases)

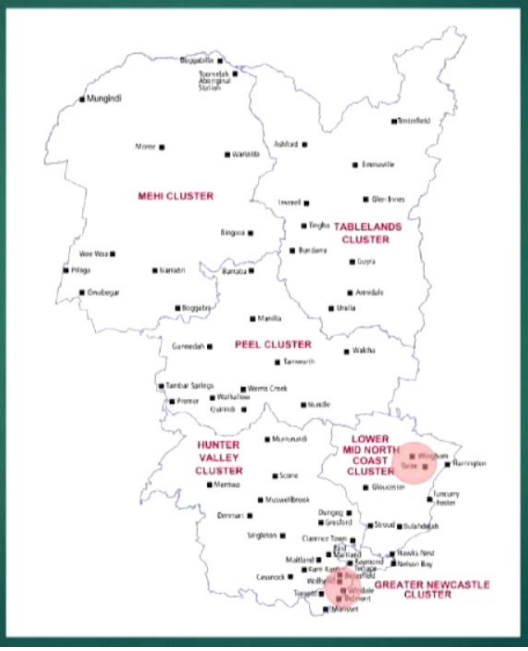
Appendix 1: Demographic details of confirmed cases in Hunter New England Local Health District (n=248), as at 5 April 2020 18:30

Cases				
Age	Female	Male	Total	Percent
0-9	0	0	0	0.0%
10-19	8	4	12	4.8%
20-29	27	18	45	18.1%
30-39	15	14	29	11.%
40-49	6	8	14	5.6%
50-59	22	16	38	15.%
60-69	30	19	49	19.8%
70-79	24	22	46	18.5%
80-89	9	6	15	6.8%
90-100	0	0	0	0.0%
Total	141	107	248	100.0%
Median age (range)		56.0 (11 –87)		

Key age group is 20-29 - critical for epidemiology going forward to restrict their movement
The 60-69 age group is largely from cruise ships

Hunter New England

Local Government Area	Cases
Lake Macquarie (C)	52
Newcastle (C)	48
Cessnock (C)	31
Port Stephens (A)	25
Great Lakes (A)	23
Greater Taree (C)	17
Maitland (C)	16
Tamworth Regional (A)	12
Dungog (A)	6
Tenterfield (A)	3
Inverell (A)	3
Singleton (A)	2
Glen Innes Severn (A)	2
Muswellbrook (A)	1
Gloucester (A)	1
Gunnedah (A)	1
Upper Hunter Shire (A)	1
Uralla (A)	1
Armidale Dumaresq (A)	1
Liverpool Plains (A)	1



Increased testing promoted at sites with clusters of cases with unknown source:

- Taree
- Eastern Lake Macquarie: Valentine, Belmont, Mt Hutton, Windale, Croudace Bay

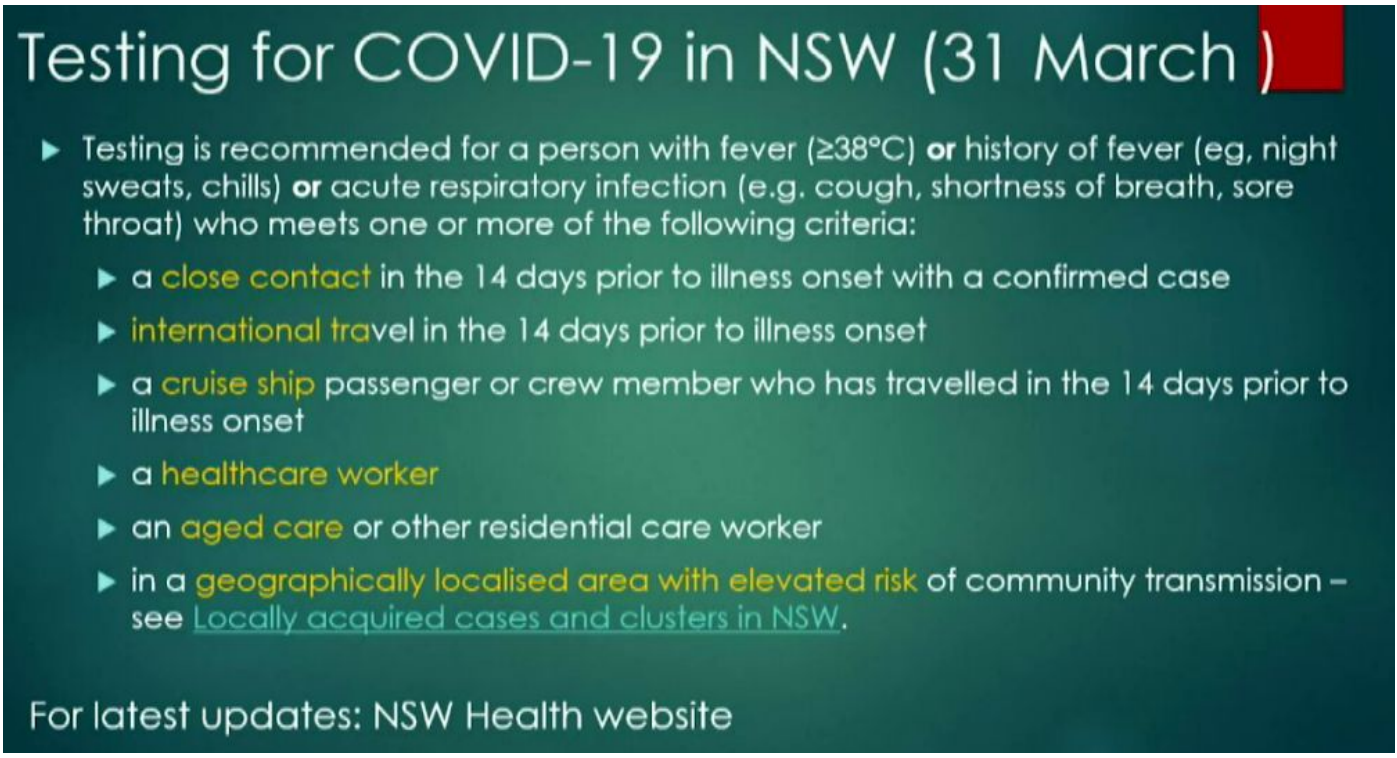
No patient transmission in ACFs to date

Cases across HNE, note two clusters of suspected local transmission

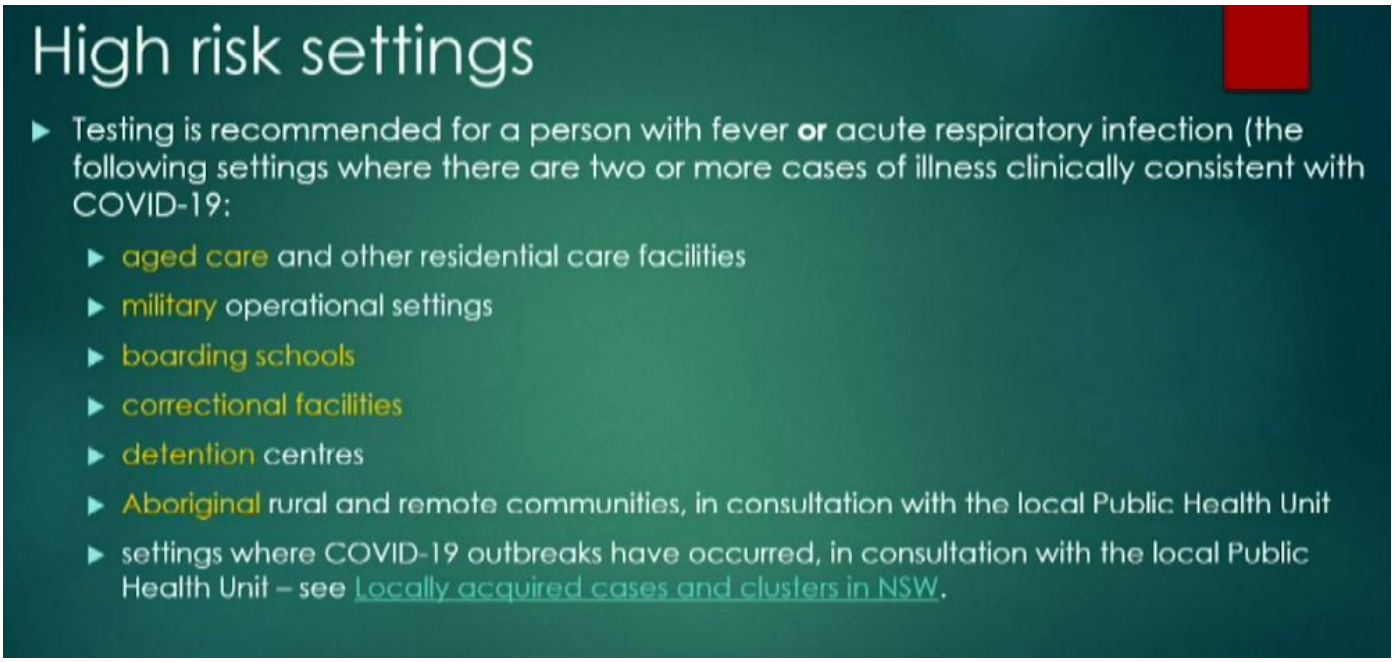
Testing Update

Belmont testing centre fully booked for last few days, you must call ahead to book
Additional testing in both hotspots/clusters didn't detect any additional cases which is reassuring
A few ACFs affected but no evidence of local transmission between patients

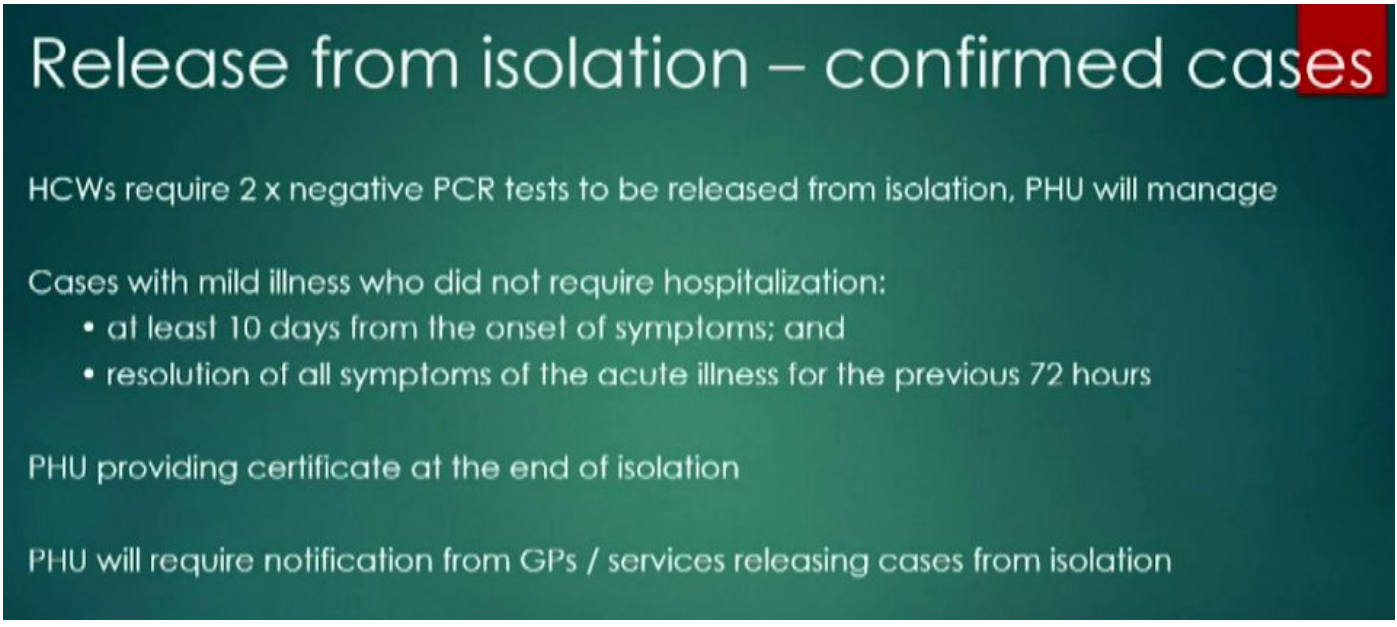
Current Testing Recommendations



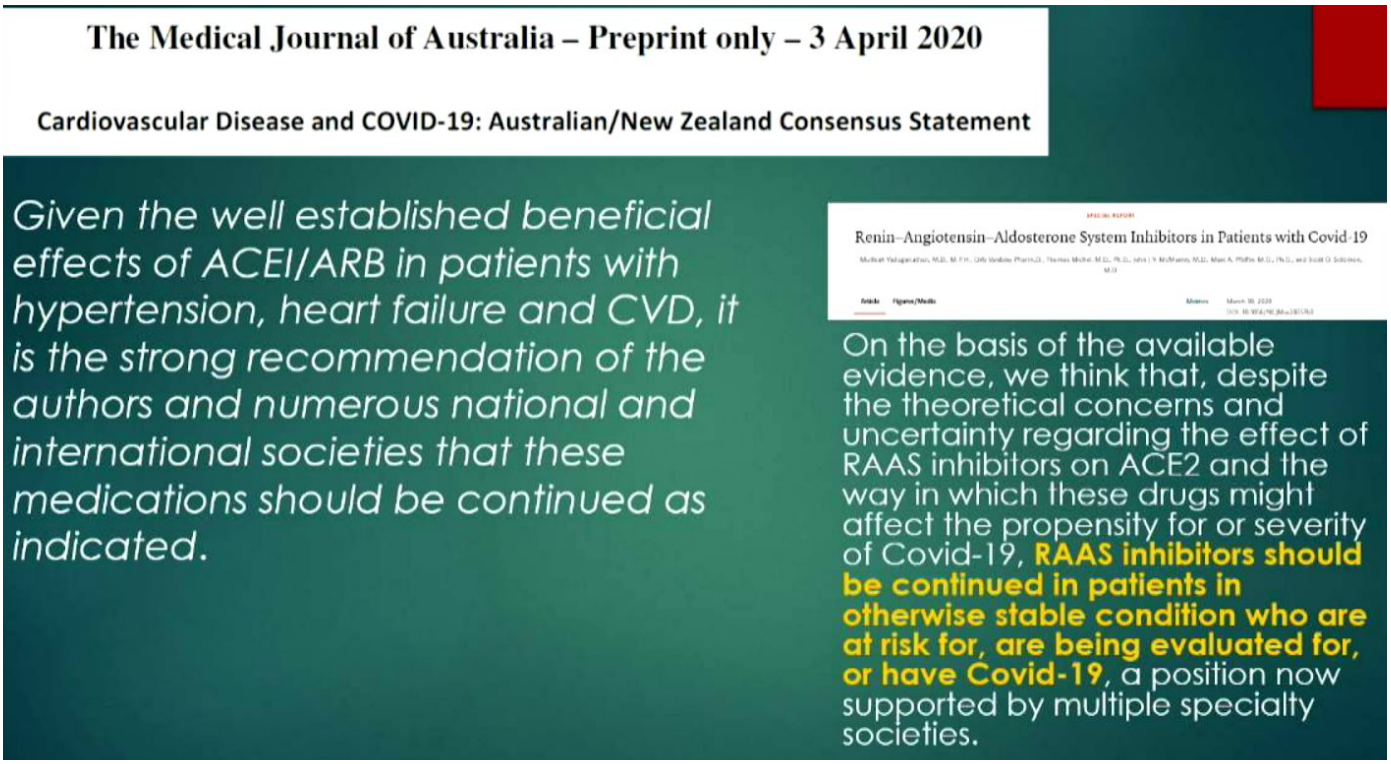
NSW Health Website is the Source of Truth for testing criteria



Expanded testing criteria
Deliberate strategy to broaden testing where risk or prior probability is high
Test = isolate until result is available
Testing remains one swab, oropharyngeal first and nasopharyngeal
Almost no testing of other viral respiratory pathogens being conducted to preserve reagents
PCR takeaway: beware of inconclusive or indeterminate results, both false positives and negatives



Police are conducting home spot-checks on isolating patients known to NSW Health.
Release from isolation: GPs expected to perform a critical role in near future, expect more detailed guidelines shortly
HCWs in isolation will continue to be managed by Public Health as they are more complex



Hypertension a risk factor for progression, binding site for ACEI is DIFFERENT to SARS-COV-2 binding site

Aged Care Facilities

ACFs 2 major studies describe ~⅓ of ACF residents dying after horizontal transmission
PHN's guidelines for ACFs may have their own dedicated webinar in future
Separate Aged Care Emergency (ACE) section on Pathways aimed at staff in ACFs

- https://hne.communityhealthpathways.org/90820.htm has link with user/pwd

Main GP contacts for Aged Care have been Jennifer Briggs & Charles Robinson

Infection Control

- Advice has not changed: droplet & contact precautions are key, no evidence of aerosol/airborne spread, evidence is that either a P2/N95 OR a surgical mask provides necessary protection in a GP context.
- Variant advice from ED & Anaesthetic colleges is causing some anxiety and tension
- From ID perspective have NOT reached point where generalised mask-wearing in public is advised.
- Risk-assessed use of PPE still key, any high-risk examination should involve PPE *regardless of patient symptoms*
- Reception staff do NOT require masking if adequate triage arrangements in place to distinguish potential respiratory infections and control in-practice exposure
- Advice for clinicians to get used to wearing PPE now in expectation that in coming weeks it may become mandatory
- Practice incorporating PPE into your workflow so when it becomes critical you get it right

- Donning and doffing should ideally utilise a buddy, it's hard to do right, even for HCWs who utilise it daily

Q&As

PPE for Flu-clinics:

For asymptomatic patients: standard precautions, No mask required, minimise face-to-face positioning, some success with drive-through flu clinics and outdoor clinics

Copies of results to usual GP for patients tested through hospital clinics?

Unfortunately AUSLAB pathology currently requires manually adding regular GP details if copy requested, quite a lot of extra work at ED & lab level to make it happen, only happening reliably at drive-through clinics so far.
NSW Pathology today went live with COVID results being sms'd to patients

Antibody testing?

RACP statement on Ab tests: not worthwhile in acute presentations day 1-5, no role in diagnosis, no reliable response before day 12
No approved Point of Care tests yet
Serology available but quite restricted even within PHU & hospitals, direct request with reasoning to Westmead lab required

Schools?

Studies in process on transmissions in schools
Good data suggesting children are NOT the index cases in identified clusters, still no major role for young children in transmission chains
Fundamentally different to influenza
Much more sensible to close universities based on evidence

Cloth vs Surgical masks?

Vast range of community-made masks out there, vacuum cleaner bags, cotton etc
Inferior to standard masks, don't recommend using them in Health settings if proper masks available
May be a useful role in community setting in containing coughs/sneezes, not entirely successful at containing aerosols in cough
Cotton loses efficacy as soon as wet
Significant role in stopping wearer touching their face

Local cluster: more info?

The fact they're boosting testing from a cluster of 3 is a testament to the sensitivity of monitoring
GPs are asked to identify candidates with symptoms in those regions for testing
At this stage looking at 2 week boost period dependent on number of new cases identified
No further information available

ACFs:

Oxygen supply plans & Palliative care planning is being set up for ACFs to access
Aim is to manage as many as possible within ACFs
Risk assessments have been conducted at all HNE ACFs, identifying ACFs with less RN cover, education videos created
Test early with a high level of suspicion, even a single case should trigger outbreak measures in that ACF with universal PPE precautions etc.
Highly aware of cognitively impaired patients in ACFs as likely to have atypical presentation and will not observe distancing or hygiene precautions

Asymptomatic spread?

Difficult to know the significance given different testing in different countries the data comes from
Clearly asymptomatic patients can transmit but significance in transmission chains is still uncertain.
PHU consider 24hr period before symptoms in their tracing
NO strong signals as yet indicating this period is a key part of transmission chains
Data out of China also did NOT suggest this is a key period in transmission
Ruby Princess Cruise ship data ~18% of positive cases remained asymptomatic
In assessing recovery - PCR testing is highly sensitive and does not require a viable virus for detection, data from other viruses suggests viability stops long before PCR positivity stops

Are N95 masks single use if used for aerosol-generating procedures?

Depends on which aerosol-generating procedure. N95/P2 masks can be safely used for sessions depending on perspiration levels, up to 2hrs, then disposed
Plans afoot for processing and re-sterilising masks have paused at all but Calvary Mater as supplies currently adequate and “Yuck Factor” high. JHH will have the capacity to sterilise and reuse masks soon just in case.

Do you need a mask if you’re wearing a full-face shield?

It is essentially advanced eye protection, ideally you need a mask underneath.
Again, no evidence of droplet nuclei / aerosol major role. Glasses should be adequate, side protection or wrap-around even better.
No tricks to prevent glasses fogging up, visors are the best way around that

Can we keep used masks in a ziploc bag and cycle through them with the same user?

Not recommended.

1. May go mouldy in the bag
2. Risk of contaminating other surfaces you may not be aware of
3. Need to do vapor-disinfection if you want to re-use

Risk factors?

See list on Health Pathways
COPD doesn’t seem to be an independent risk factor

Age still single most important risk factor with large increase from 60yo up
Advise patients to be particularly vigilant on days 7 to 12 of illness due to risk of rapid deterioration. Deterioration at up to 3 weeks in elderly patients.
A rapidly evolving space developing assessment tools to determine who needs elevated levels of care, none yet validated

Advanced Care Directives

Planning is important for GPs, now is a good time to avoid futile care down the track, ask them early.
Rockwood Clinical Frailty Scale (Canadian): simple, good objective measure, 6+ much less likely to survive Critical Care & ICU, given that mortality once on a ventilator at best ranges from 50-95%
https://www.bgs.org.uk/sites/default/files/content/attachment/2018-07-05/rockwood_cfs.pdf

Redflags for deterioration?

See list on Health Pathways. Hypoxia assessment is key, a hypoxic COVID-19 patient may not be otherwise symptomatic
GET AN SpO2 BASELINE for your patients when well where possible

Should the whole family isolate until the result returns when a member is tested?

No, the tested member should isolate from the rest of the family, but the rest do not have to. But always exceptions e.g. family member is a HCW, then case by case.
If they come back positive then they isolate until cleared and the close contacts go into quarantine. E.g. for a carer of a confirmed case their quarantine does not effectively START until the case is no longer infectious.

Our practice has had two positive cases, will PHU assess our staff risk and notify us?

PHU definitely does this as a routine for all close contacts identified, if any questions the practice will be contacted to clarify.

How many staff in Public Health now?

Many. Buildings-full.

How are GP referral criteria being assessed at testing clinics?

At Belmont clinic they take patient's word for it and swab. Haven't got the time or interest to investigate. Can't speak for other sites.

Do we have enough EN/RNs at ACFs?

No. Many do not even have 24/24 RN cover. Current Aged Care Emergency (ACE) program aimed at capacity building for ACFs, establishing "phone-a-friend" plans to a doctor or ED nurse, 20% reduction in transfers since this program started. An RN working in an ACF is paid at a lower rate than at a hospital, problematic disincentive.

If we have a COVID-19 positive ACF resident, what happens?

PHU should already know and will act. If you're unsure if anyone is aware - make the call to check, both ACF & PHU.

Public & GPs have the right to know daily suburb locations and numbers?

Public health has decided not to openly publish suburb data due to stigmatisation. PHU already has horrifying stories of community stigmatisation and outright abuse just from the 250 current cases. Cluster data of 3+ is smallest planned public releases currently.
HiTH is facing this as an issue with their traditional model of visitation which requires donning/doffing outside the patient's door...

Plan for palliative care in the community for COVID-19 patients?

Standard consult model with boosted telehealth presence predicted to be adequate

COVID-PCR sensitivity?

Published sensitivity data 75-80% but feeling is this may be down as testing later-presenting cases
Expert-opinion is samples taken in first 5 days are likely to be much more sensitive, but no data out yet.
Sample quality essential, deep nasal + oropharyngeal, watch the 40s NEJM video
https://www.youtube.com/watch?v=DVJNWefmHjE

Criteria for admission from HiTH to Hospital?

Check red-flag symptom list in Health Pathway.

So is COVID-19 airborne or not? 3hr figures from studies quoted.

No data on relevance to transmission. Possibly viral-load effect on why airborne transmission does not appear to be significant. WHO is confident not considered airborne.
Droplets on surfaces DO remain viable for indirect contact transmission.
For home isolation must ensure any surfaces in common/shared-spaces are cleaned frequently

If someone is not a high-risk contact e.g HCW with URTI but COVID-19 NEGATIVE how long to isolate?

Expected to stay at home while they have symptoms. If Influenza-positive there's a minimum 5-day exclusion. Even passing on a mild cold in current circumstances can lead to significant anxiety/morbidity. "Soldiering-on" is not an option currently.
Suggest starting every day with a safety meeting to check in on all staff, providing support, making decision at start of day to send someone home. For GPs suggest calling a colleague for their advice. There are formal phone-lines in place for this for hospital staff, many calls already!

Immunity: Any data? Can you be re-infected?

Known immunity for other coronavirus strains, reasonable to conclude some immunity immediately after recovery, antibodies seem to be important in coronaviruses which is great. Duration not clear. Unknown effect from immune-modulating drugs at this point.