Australasian College for Emergency Medicine

Minutes

25 September 2020

COVID-19 Emergency Medicine Community of Practice (EMCoP)

Chair: Dr Simon Judkins and A/Prof Julia Morphet
Date: 25 September 2020
Time: 1530-1700
Location: Virtual Zoom via PC, phone or tablet

1. Welcome

1.1 Acknowledgement of Country

S Judkins acknowledged the Wurundjeri people of the Kulin nation as the Traditional Custodians of the lands upon which the meeting was held. He also acknowledged the Traditional Custodians of the lands upon which Australian emergency departments (EDs) are located. He paid his respects to Elders past, present and future; for they hold the memories, traditions, culture and hopes of Aboriginal and Torres Strait Islander peoples of Australia. In recognition that ACEM is a bi-national College, he acknowledged Māori as tangata whenua and Treaty of Waitangi partners in Aotearoa New Zealand.

1.2 Welcome

1. S Judkins welcomes everyone to the third CoP meeting and reports that there are now 300 EMCoP members. The latest issues and logs are up on the website and the link attached for discussion for the meeting.
2. S Judkins requests for continued contact for thoughts, ideas, and ideas requests for information to guide the next speakers and presentations.
3. S Judkins thanks the partners for the support in putting the meetings together
    - Ambulance Victoria (AV)
    - Safer Care Victoria (SCV)
    - College for Emergency Nursing Australasia (CENA)
    - Department of Health and Human Services (DHHS)

2. Standing agenda

S Judkins hands it over to J Morphet to lead the Standing Agenda

2.1 CENA – Jo Morey

J Morphet hands it over to J Morey to start standing agenda items. The messages being heard from the fortnightly Nurse Manager Meetings held by CENA are still essentially the same.

- How will the return of elective surgery impact health services and access block which is complicated by the growing mental health presentations and representations in the ED.
- The department is unsettled due to the sheer volume of mental health patients and occupational violence and aggression (OVA) risk.
- There is still a level of anxiousness around mental health patients and how elective surgery may impact them
- There is also a sense that COVID is beginning to settle but still managing the volume overload times with the changes to screening and/or PPE wind back.

2.2 Ambulance Victoria Update – David Llewelyn, Clinical Support Officer, COVID Support, Ambulance Victoria

J Morphet hands it over to D Llewelyn to provide an update from AV

- AV adopted a dynamic approach with their COVID management because of the state-wide involvement with significant rural assets and metropolitan area they service.
- AV have had to adopt some flexibility with some of the facilities that AV serve such as the aged care facilities. These have been dropped off for full PPE requirements and maintained

at the metropolitan area. This is the same modelling around prisons and hotspots as they become more prominent that AV had to react accordingly.

- AV PPE requirements with the nursing homes and the metropolitan area is still under review and still currently applying as if COVID positive. These will be dropped as COVID numbers reduce.
- Referral services continue to grow in numbers ~ 800 cases a day.
- Mask fit test continues to go towards a respiratory protection model. An evaluation is being undertaken shortly and will review their position again with mask fitting as they have yet to adopt it internally.
- PPE is still a big issue across the board and any changes in the space will be fought with anxiety and comfort. It will need to be evaluated as movement towards warmer months. There are still ongoing issues with alternative PPE.
- Staff welfare heat strategy has been discussed
    - Lighter uniform
    - Breathable gowns and garments
    - Refreshments, cooling, and rehydration strategies for staff
        - Feedback from staff about management in heading towards the warmer months
- AV remains with 25 staff in COVID positive and down 20 staff a day who are being impacted while waiting for COVID results
- With staff that are susceptible to immune compromising illness, around 170 staff have been moved to alternative duties to keep them isolated. Another 50 staff with partners who are pregnant have applied for non-patient exposure positions so that they can attend the birth of their children and has become an unintended consequence of the lockdown.
- D Llewelyn is asked how AV is maintaining rural coverage
    - As far as normal business goes. There is no change. There is increased resourcing to expand coverage of the early surging aged care facility patient transport movements. Rural coverage has maintained without issue. There is a decrease in workload but with an increase in duration of case. AV have still maintained business as usual (BAU) and have not had any significant direct impacts on response capability
- M Stewart comments that their teams are wearing scrubs instead of uniforms under their gowns to deal with heat. D Llewelyn responds that they are looking at many options and have sanctioned usage of shorts for staff.
- S Judkins asked if PPE changes will be aligned with hospital and ED protocols
    - All work is under DHHS governance and therefore garments and PPE are approved by them. A lot of what AV does is aligned with agencies and stakeholders as there is no point coming into other facilities with non-similar garments or protection. They liaise with purchasing departments and PPE agencies who determine the level of protection used by AV.
    - There is conflict sometimes between protocols but can be changed at the front door. The only current discussions held is for how staff feel regarding their comfort and protection. No other considerations for change.

2.3 ACEM Victoria Faculty Update – Dr Mya Cubitt, Victorian Faculty Chair

J Morphet welcomes M Cubit to provide an update on behalf of the Victorian faculty

- ED staff are very exhausted and there is no break for staff to take much needed leave.
- There is escalating tension with exhausted workforce and reintroduction of elective surgery.
- Further debriefing and learning together about things that have gone well and not gone well to take forward in the next few months
- Mya Cubit asks DHHS, SCV, DoH, or where relevant - what strategies do we have in place i to monitor and mitigate patient and staff risk while exhaustion escalates, and we return to normal services. How will we manage staff exhaustion and the need for pause and debrief?
- We need mitigation strategies to reduce the risk for the harm we might bring to patients if we don't address this issue, debrief, and rest.

- There is ongoing lack of immediate solutions on the mental health crisis. It remains an unmitigated disaster and really adding to workforce burnout. Causing problems with responsiveness and ongoing access block
- M Cubitt asks when a conversation about immediate/interim solutions will happen and how we as a community can feed into immediate solutions (eg. funding for security guard resources)
- The rolling back strategies for the lockdown community isolation rely on a decrease on overall community burden of COVID-19. There are concerns that without currently successful or clear strategies to manage high risk areas such as aged care or healthcare worker infection, we may have trouble of getting <5 [cases]. There is concern that perhaps we haven't addressed those high-risk areas that then impact on everybody's ability to wind back their lockdown. M Cubitt asks where decisions are being made regarding how we address specific populations in isolation and if we cannot improve our ability to protect those specific populations, how will it impact on community wide lockdown.
- M Cubitt invites anyone who can enter those conversations or make suggestions or things they have heard in relation to the above.

2.4 Urgent Care Centres Update – Dr Tim Baker, Director, Centre for Rural Emergency Medicine

J Morphet invites T Baker to provide an update on Urgent Care Centres
The situation in rural Victoria has gotten better and people are starting to have a bit of normalcy in their daily lives. Very few cases now in rural Victoria.

- Paediatric mental health presentations are happening at urgent care centres.
- Urgent care centres have no security and almost all inpatient paediatric mental health beds are a long way from urgent care centres and are usually in the city
- Staff are in a holding pattern to see what will happen to the changes in PPE and in the way of doing things as they are in a slightly lower COVID prevalence area

2.5 ECCN Update – Dr Peter Cameron, Clinical Lead, Emergency Care Clinical Network, Safer Care Victoria

J Morphet invites P Cameron to update on the Emergency Care Clinical Network.
The numbers are coming down and ECCN is starting to think about the next six months beyond the pandemic itself.

- There is retrospective look at lessons learnt and how current structures have worked, how clusters operate, governance models going forward, and how decisions are made.
- There are issues around clarity of governance and decision-making. Therefore, there are great opportunities to learn/improve from it.
- The emergency part has been able to influence and improve things significantly through the clinical leadership group.
- Thunderstorm Asthma
    - Advice is going into the public health representatives to ensure that EDs have a plan for Thunderstorm Asthma.
    - ECCN is better prepared for it in terms of monitoring it and the way it works. The issue is that it is a bit trickier with COVID in the background and ECCN is currently waiting for advice from public health.
    - If the current community prevalence is very low for COVID, it would be senseless to prevent asthmatics from getting emergency treatment on the off chance they have COVID. Basic advice for this is to make sure there are stocks of puffers, spaces, etc. so they can be handed out quickly and have space for rapid expansion if necessary.
    - If current community prevalence remains low, then it would be relatively straightforward to manage.
- The PPE transitions
    - Fit test is a misdirection of energy and are concerned that we are focusing on the wrong issues.
    - N95's worn incorrectly is more dangerous than wearing a surgical mask and good hygiene behaviour.
- Elective Surgery

    - Talk of ward closures due to the need to reengineer wards to account for air flow and air exchanges. Closed wards with an increase in elective surgery will cause chaos. P Cameron has tried to push this agenda forward and has been reassured this will not happen.
- Mental Health
    - There is a plan and its slow and will take time. The numbers indicate that it is not as straight forward as some might think.
    - There is a significant increase in young presentations but no increase in older presentations. Suicide has remained the same or decreased. There is a significant increase in calls to health lines and a decrease in face to face presentations.
    - Less recreational drugs are used in dance parties, however, more people seeking help, feeling anxious and depressed with personality problems.
        - It will be interesting to tease this information out and see where our focus and attention should be.
    - Code Grey and Code Blacks have been increasing at most EDs. This is an issue we need to look at the security arrangements at EDs.
    - M Robb asks – Can FACEMs have input into the Safe Care Victoria Review and provide feedback. P Cameron replies yes, and any feedback sent to him or L Hewitt and they will make sure something happens.

3. Focused Discussions

3.1 Planned Return to Elective Surgery – Prof David Watters, Former President of the Royal Australasian College of Surgeons, Chair of COVID-19 Perioperative Expert Working Group

S Judkins introduces our first guest speaker Prof David Watters. As hospitals get busier and particularly with elective surgery being reintroduced, beds have come at a premium and the aim is that people do not suffer in the ED due to lack of beds.

- Principles for resuming elective surgery should be based around safety and quality. These principles are safe, effective, person-centred, timely, equitable, and efficient
- D Watters emphasises person-centred. The perioperative expert working group recognises that person-centred rather than practitioner-centred as this is not about getting people back to BAU but about treating the right patients, at the right time, and with the resources available.
- The Government elective surgery roadmap is in two paces.
    - Regional Victoria: From 28 Sep 2020, on 85% usual activity, and where community cases are at <5 per day on a 14-day rolling average. We are currently well below those numbers and all elective surgery according to the D Watter's guidance should be prioritised by clinical need or urgency, those who have previously been cancelled during the pandemic addressing long waiting patients whose conditions may have changed, and taking into account individual circumstances. DHHS has decided to monitor it by activity caps as previously at 75% or 85% and later 100%. This is probably not the ideal way to govern it and may be the only practical way in which to govern it.
    - Metro Melbourne: Looking at a 13-day rolling average <30-50, there is a slightly different road map. From 28 Sep 2020 up to 75% of usual activity. This timeline may change but is prioritised in order of by clinical need/urgency, previously cancelled surgery, long waiting times, and individual characteristics.
    - Working at 75% and 85% wont even address any of the backlog and we need to consider what that [backlog] is?
    - There are 30,000 less procedures this year than last year in March.
    - The number of people waiting for surgery was already rising between Jan 2019 and Jan 2020 and now 10,000 more patients than that. This means that the backlog of patients is 40,000 plus. This data comes from the Elective Surgery Information System (ESIS) and it does not even include colonoscopy and gastroscopy. It also does not include patients from private and operating in private hospitals if they are not in the ESIS waiting list in public hospitals.

    - We think that 2/3 of elective surgery is done in private, then the backlog of patients waiting for surgery who would otherwise have had it would be 100,000 plus.
    - Looking at the categories comparing Aug 2020 to Mar 2020:
        - Category 1 has been kept up with as it has not changed much
        - Category 2 and three has increased on the waiting list
        - All specialties have gone up in number of patients waiting for surgery by 40% - 50%.
        - Cardiothoracic surgeries is the lowest riser as they would have been Category 1 or 2
        - The largest procedures with increasing patients waiting are tonsillectomy and cataracts. It shows not that these patients do not need surgery, but the fairness and good sense of the specialist's concerns have up-categorised their patients by and large. This represents that most operations would be Category 3.
        - When we look at patients removed from the waiting list, those that presented as an emergency patient has not changed much and possibly gone down recently. Those that are not contactable have gone down. Patients who have died has not changed much and patients who have failed to arrive for treatment has slightly gone down.
        - The flow of patients into elective surgery has an impact on beds in the hospital. The perioperative expert working group has tried to look at what options health services must reintroduce Category 2b patients during the aftermath of the pandemic, and when bed and ICU capacity may be compromised. They have advocated for health services to look at ready to go short notice patients (cataracts or minor surgery type procedures) and have some guarantee that these patients will be out in 2 – 4 days. If you are approaching a bed crisis for any reason (including COVID) you would still have beds available soon after doing them. The longer stay patients would be done when you get into the low risk ring zone which is what regional Victoria is currently in.
        - Individual hospital's overwhelmed (emergency surgery only or emergencies diverted) such as Frankston and Category One & 2a is allowed at all hospitals but and most metropolitan Melbourne has been in.
- In terms of governance of elective surgery, we are still stuck with the health department looking at activity caps and any guidance and advice provided by D Watters will be guidance advice rather than being enforceable. This will result in some people gaming the system. The pandemic has shown that 90% of people do the right thing while 10% still don't.
- D Watters happy to take questions but reminds that if we are at 40,000 elective surgeries backlogged now come the end of November, we are probably 50,000 patients behind the public system.
- S Judkins requests for questions and for people to unmute to ask them
- S Judkins asks about unrelated elective surgery question. S Judkins starts by saying one of the lessons learnt from the pandemic is that we can be flexible about the things we do. One of the issues getting raised in EDs is when ED patients presenting are not valuing or evaluating their care when there could be other direct admissions into surgical wards without the ED needing to be involved. They could be referred to by their GP directly to an acute surgical (hot clinic for example). One of our FACEMs mentioned that patients often get referred to the ED by our GP colleagues but many of the cases can be referred directly to the surgical team for review. A lot of our post operative surgical patients come to the ED and we become a holding bay until the surgeons see them.
    - S Judkins asks if there are conversations about streamlining some of the care and trying to ensure that we get the right patient to the right practitioners at the right time and trying to avoid unnecessary presentations to EDs.
    - D Watters answers that these discussions are yet to happen but everything said is very sensible and is happy to have that discussion as there are discussions about health service reform. They have been focusing greater on outpatient referrals from primary care. D Watters agrees in the concept of a hot clinic for a clearly surgical condition would be appropriate to reduce the unnecessary ED presentations. Usually

<5% of ED presentations are surgical but nonetheless those patients have a prolonged journey through the ED and would be better to go to a hot clinic if they don't require resuscitation.
    - S Judkins responds that it is not a huge workload but clearly better for patients to not present to the ED especially during COVID times due to a priority to reduce waiting lists and overcrowded rooms. To not go back, we need to start having those conversations now so we can start to put those processes in place. We have been so focused on managing the pandemic but there are certain opportunities to take advantage of to ensure we don't go back to the old system which had several issues.
    - D Watters responds. This epitomises the end of the first wave where everyone was so exhausted and were happy to get back to normal and there was no planning to make things better in the second wave. Many of the discussions during the first wave had to be restarted in the second wave. We need to set time aside to improve our health system and not just say 'we are too exhausted or lets go back to normal' as the old normal was not the best.
    - Question from attendee. How much public work is being done in private? D Watters responds that we are hoping that the private sector has reserved capacity to do public cases as it will be needed. It will require contracts and agreements between public and private and will be a question of whether it will be organised at a state level or cluster level. This is to be decided and no clear way forward yet.
    - P Cameron asks about the ward closures due reengineering and if it is being factored into the recommencement of surgery.
    - D Watters responds that he heard from the grapevine that it is assumed it has to happen. Many of the wards need to be tested and some of them will fail. It is a question of how quickly we can reengineer our hospitals. There is a plan for "Blitz" which in D Watters view will not be available before November 2020. Some of it will involve operating and doing cases when it would have otherwise experienced Christmas slowdowns. This impacts very tired healthcare workers but will be one of the ways to use spare capacity. If wards are to be closed for reengineering, it will have an impact on elective surgery.
    - S Judkins thanks D Watters for his time and requests for constant communication between the two colleges.

3.2 Managing infection risk in high risk environments: next 3 – 6 months – Professor Paul Johnson, Deputy Director Department of Infectious Diseases, Austin Health

S Judkins introduced Professor Paul Johnson. He starts by stating that there has never been a COVID pandemic before and so it happening anywhere at this point is just guessing. Our first wave emerged during winter. Mostly elderly patients and those with genetic dispositions had the most deaths. If you have a big enough outbreak, you will have a large age range. Anxiety has returned in autumn.

- Summer reduces COVID prevalence
    - People are outside, better spaced, UV kills the virus, and less time spent together gathered inside.
    - When there were 750+ cases a day, there was so much pressure and workload
    - There would be five close contacts but will have to consider around 15-20 people to find out among the close contacts
    - There is a focus on R. R = 3 for COVID – 19. This means that this virus (SARS COVID 2) biology interacting with the biology of humans doing normal stuff before you interfere in anyway.
    - The reproductive time for this is three to five days
    - If contact tracing and quarantining resources was fast enough, you could get a handle of this
    - COVID-19 has this annoying trait where it is just able to be caught if you are super-fast, however, any gaps or slow down will let it get away from you.
    - 1 turns into 3 which turns into 27 and by 2 weeks you would have 81 cases/day, and by 4 weeks you would have 6561 cases/day.
    - Covid19data.com.au – a voluntary website using public data and provide excellent data visualisation of things

- A pandemic is a new transmissible agent (virus or bacteria) that matters (causes a certain amount of damage) for which there is no immunity and has the ability to spread.
- It is not so much a uniform spread throughout Victoria but a great big stack of expanding outbreaks in particularly high-risk places such as workplaces, schools, aged care, health care.
- The epidemic curve starts expanding and comes into a peak and starts to come down. At its peak, 20% of the entire population have got the virus. It means 1/5 are sick on that particular day. If mortality is just 1%, 25,000,000 Australians would mean 50,000 people dying on that peak day. It shows how disruptive that is even if 99% survive.
- A pandemic stops because in this enclosed system, it runs out of susceptible people and no longer available to it. There are now a number of people resistant to it because they have antibodies and now recovered. Once at a certain point, there is no way the virus can continue with the R = 4 as it runs out of susceptibles. This number is the fabled immunity. With COVID you need around 60-70% to be naturally immune to stop this process.
- However, in the UK with 46,000 deaths, they only have 8% seropositive. Which would mean another 55 – 60% to reach herd immunity. And then what happens like measles prevaccination, older people die, and new people are born without immunity and then you get endemic measles every year until a vaccination comes along (other way of gaining herd immunity).
- How do we change R
    - R_0 = r (transmissibility) * $\bar{c}$ (average rate of contacts between cases and susceptible people * d (duration of infectiousness) [when you change these terms it becomes R effective]
- Transmissibility is the probability that when a susceptible person comes into contact with an infected person, viral transfer will occur. C is the average number of contacts between people who are susceptible and those carrying the virus. D is the duration of infectiousness.
- We can all together work on altering these. In transmissibility we can wash hands, social distance, or wear a mask. In C we can stay home (cutting contact), in d we can find and isolate all cases. Hopefully this gets R effective to below 1. Hand hygiene, social distancing, wear mask, get tested.
- We are all able to kill the virus unless it kills us. However, if a single new case arrives, the biology of the virus and humans is the same and we are back to the same case unless our herd immunity is at 60%.
- The next thing we can do is perhaps keep our cities more open if we can quickly find the case, quarantine the contacts, and stop the expansion. If we can combine this with wearing masks, then we can keep R lower even if not below 1. If we find cases incredibly quickly and get hold of their contacts, and put them in quarantine, so when they become sick, they are unable to transmit it. This is what England has done all summer and has already manifestly failed.
- With new CCOM (Case Contact and Outbreak Management) functions, we would be able to achieve this. But, as we open up again, unless there is good luck there is no virus in Australia, it will happen again.
- One interesting thing happening in France where all of this is happening again, is that the mortality for people in ICU, in the first wave their mortality is 35 – 40%. Now, it is lower at 25 – 30%. The highest mortality in Australia is at 11%, part of this is due to two evidence-based interventions, a) Remdesivir to reduce viral replication in people who are in the ward sick before they get into ICU and b) steroids. The really mortal part of COVID-19 is the acute late inflammatory reaction that causes an acute respiratory distress syndrome (ARDS) like pneumonia rather than the virus itself. Why this happens some and not to others is unknown, but it is clear that the older you are, the more likely this is to happen. There are some sub groups (diabetes, hypertension, etc) with risk factors and even blood groups (some protective and some not) which act as predictors.

- One other thing that could be happening that we are hoping for is that the virus most likely to spread successfully is the one that is easily detected which could be the least pathogenic one. We just don't know it and cannot take the risk.
- A Varma asks about having seasonal variation, and that it seems to be worse in winter. Should we start planning already for a third wave as it might be worse than our second wave.
- P Johnson responds that the idea of waves was indelibly burned out of our tribal memory by 1918. There were three distinct Spanish flue waves that didn't necessarily follow the seasons. But this idea comes, causes chaos, goes away, and comes back is part of these things but is not clear. As seen in Europe the worst season is the coldest months. Yes, if it is still around, unless we have got a vaccine, we will have more trouble next season that we are at the moment. However, in France, Merce, it seems like it really got going in the summer months and so doesn't strictly obey these rules. If we look at R – if we want to increase it, we put people close together in tighter spaces where they have to shout and talk to be heard. Which is why in summer seasons, R is lower as people are more likely to be farther apart. There is one study in Brazil that shows a 4% reduction in the risk of transmission by median average daily temperature up until 25 degrees. Whether that is picking up that people are getting together when they are cold or be inside rather than outside, no one knows.
- N Ballenden asks about the ability to contain health worker infections in high risk settings like aged care and hospitals and are there specific strategies? What does that specific strategy look like?
- P Johnson responds that the investigation into significant size outbreaks in Royal Melbourne and other places, it seems that the PPE equipment works if it is perfectly used and people are not tired and for force of infection (*force of infection = number of new infections/(number of susceptible persons * average duration of exposure)*) which means the number of patients in your hospital excluding COVID is reasonable. But what seems to have gone wrong at the Royal Melbourne and Austin is that people weren't getting infected in the wards with the patients, but when they were tired and chatting in the lunchroom without PPE on. Some of the transmission between health workers happened at that place in Austin. In the Royal Melbourne it did have direct transmission between patients and health workers that could not be explained and still not clear. It could have been due to the large volume of people and the relatively old ventilation system. They improved the use of mask and PPE and they spread their patients out which seems to have reduced pressure of infection. Since that intervention, they have been able to stop it. In aged care, there are new cases of health worker infections. It is not clear why that is, but it seems that it is still simple PPE failure rather than mysterious effects. Working hours in PPE and getting it right all time is ultimately what the issue is and being tired and not following protocol at all times.
- M Cubitt follows up and wonders if one of the reasons the cases went down as it did was due to the community prevalence and therefore the prevalence in the hospital. There is still a sense of doubt as to how these outbreaks are occurring particularly in the aged care sector. If one of the postulated reasons is tired health care workers, everyone is much more tired now. There is concern that we haven't solved this problem and may prevent us from the opening up strategies. The other question is regarding difficulty in proving the efficacy of COVID without COVID in the community. What is the plan for developing the vaccine? Will there be human challenge trials in Victoria or rely on other countries to do that for us.
- P Johnson responds that there is now plenty of COVID in Europe and running out of cases will not be a problem where it was expected to be a problem. One of the candidate programs (Oxford) is a live attenuated virus and which we have a role in. We will be manufacturing locally and will know if its efficacious relatively soon due to the increase in cases. Vaccine viral challenge where you deliberately expose a volunteer to the virus is definitely been planned but is probably not necessary now due to the new wave in Europe. As distant from the area of the new wave in Europe, P Johnson elects to not delve deeper to not get any comments that might be wrong.

With respect to the health workers, the virus is in the community, and where they have gotten COVID from (e.g. hospital, tram, etc), P Johnson is working on a regional response worked closely with Darwin Health. Quite a few healthcare workers were infected and diagnosed in Dulong and so turn up in Dulong statistics. These cases did originate in Dulong as there was no transmission recorded in Dulong at the time they became infected. There are undoubtedly transmissions that occurred specifically at work even though people were wearing PPE and it is not completely clear why. It is most likely one of the multifactorial cases namely tiredness, force of infection, poor ventilation, and other factors unknown. As to how we can control it, China have managed to stop transmission in their healthcare workforce after the peak but before the end of the Wuhan outbreak.

- S Judkins mentions P Johnsons role at the metro hubs and regional contact tracing hubs and asks P Johnson what is happening there.
- P Johnson responds that he seconded at the DHHS to set up the regional response which was to set up six regional public health units but are all currently dedicated to COVID in the five big health regions (Barwon South West, Ballarat Grampians, Bendigo Loddon Mallee, two in Hume, one in Latrobe Regional Health in Gippsland) all based on their regional health services and they have taken on in those places all the COVID things that could happen (e.g. contact tracing, care for patients, quarantine of close contacts, outbreaks in schools, etc). Everything COVID is done in the region and the speed and locality has helped them react quickly alongside the relatively low cases. It has been regarded as successful and with an element of luck. The Premier liked the model and wants to replicate it and high speed local public health units are being implemented. One on the north east, one on the south east, and one on the west. There will still be two to three more. The model from the regions are based on health services but are not confined to health services (e.g. the Northeast one will be led by Austin and will involve local government areas, GPs, community health centres, etc). Monash has an advanced integrated hospital with its community, probably better than the other two examples. There is a model to follow but within a few more years, it is expected that public health will be divided into five or six sub-departments within Melbourne. Instead of it all being done in DHHS central, it will be done by region with support from the centre. Three are supposed to start implementing in the next week.
- P Cameron asks what P Johnson's thoughts are on the Swedish model and how much evidence is there behind their restrictions.
- P Johnson responds that they have a shotgun approach and doing everything. However, it is unknown which intervention worked. He believed that the masks were very effective. Using the example in Victoria, it peaked around 14 days after the introduction of masks which was very similar to the time of introduction of stage four. In other regions, there was never stage four but masks were introduced. Masks are effective particularly because the only way to deal with asymptomatic carriers. They do depend on the population to wear masks. We wear our masks to protect each other as it helps pick up the virus when talking. As we take restrictions away, if we keep the masks, and some of the restrictions, alongside good case contact and isolation, we could see a similar situation to NSW of five to ten [cases] a day but still functioning as a normal society. With respect to the Swedish model, it looked good for a while but the economic analysis suggests that the damage done to their economy is similar, but the number of deaths is higher than their Scandinavian counterparts and they are yet to reach herd immunity. It is incredibly difficult to know and if we let it loose again, our hospitals will be overwhelmed. There is hope for a Stage Two plus masks level.

3.3 Contact Tracing – Professor Euan Wallace, Deputy Secretary – Case Contact and Outbreak management (CCOM) COVID-19 Public Health command DHHS

S Judkins introduced Professor Euan Wallace. They have done contact tracing for the last nine weeks. The branch within the division is essentially about case contact tracing and outbreak management. This will be about case and contact tracing.

- There has been a massive surge in the workforce (1123 now vs 57 before)

- At peak there 600-700 new cases a day, each worth 3 – 5 close contacts on average, so 3,500 close contacts, and required interview.
- Upon arrival to the division, there had already been work done on process improvement. It was work that commenced after the first wave. But the second wave came much sooner before implementation was allowed. E Wallace picked up several improvements already in flight and accelerated them with other bits of the department such as the business and intelligence unit, etc.
- The interviews for close and new cases had about a 30-40% no pickup rate when first started. Every 10 phone calls, three to four of them had no response. This is because of unknown ID when first called. They introduced SMS alert for contacts to receive a text regarding the DoH calling soon. Increased pick up rates to about 90%. About 10-15% of new cases do not pick up. A very large number of new cases had either an incorrect or incomplete phone number or address. They put in place data sharing protocols in government (e.g. if phone number is wrong, it just gets imported automatically). With the 10-15% of those who don't pick up, Operation Vestige will send the army (authorised personnel, army or navy) who will then correct the details or invite them to phone in. It is now 100% of new cases being interviewed within 24 hours of notification.
- In second wave, each new case is associated with 3 – 4 new contacts on average. These close contacts now get a notification for a case interview. In addition, there are random compliance checks by Victoria Police to ensure isolation and quarantining.
- Virtual wards for health and wellbeing shared with DoH is set-up. A number of health services then become health providers as 10-20% of these cases become ill or symptomatic.
- In terms of the process itself, there is now a fully digitalised process. Lots of ill-informed media and federal politicians regarding gold standard in case and contact processing in other jurisdictions. Constant contact with Queensland and NSW who have the ongoing workloads. Victoria is the only jurisdiction that is digitalised end to end. Details will be entered in Test Tracker on an iPad. The QR code will go to sample in a laboratory and will go to CCOM. If positive, the QR code is picked up and the details are already in the system. Patient receives an SMS and phone call interview. Data is entered in real time into the system. As soon as close contacts are entered and before the end of the interview, those close contacts will have been already informed via SMS.
- There are daily reports to national cabinet but also to own cabinet.
- There are three core metrics
    - These are based on the 22 September data and captured in the Sitrep for that date
    - They report daily the number of new cases that are yet to be contacted (Metric One) and have yet to have an interview completed (Metric Two). Every day for the last couple of weeks, this would be zero.
    - Metric Three is that of their close contacts (avg of 3 -4 for each new case) how many have been notified and made sure they are quarantining within 48 hours of receiving notification.
    - E Wallace presents a slide that captures an hour by hour the number of cases which have had an interview completed.
        - The national rate of within 24 hours has now been changed to within 4 hours
    - This displays the performance and process improvements enabled by the digital end to end solutions put in place over the last nine weeks.
    - M Cubitt asks if there have been any adjustments made within the last couple four weeks as her overall experience is similar to other parts of health care. It seems like the tasks are divided up into siloed teams each with their own responsibility but perhaps not the information sharing portals that make it efficient. They didn't seem to be communicated to each other well. Are there any changes to that as information sharing has been a problem across health care generally?
    - E Wallace responds that there have been some changes and some are not yet complete. The system they have been using PHESS (Public Health Event Surveillance System) which is the epidemiological surveillance system for public health in Victoria. It is not enabled to allow sharing of systems and various contributors to the overarching care type of a person who tested positive. Various bits and pieces of the process have not been linked as PHESS does not allow them. While not yet fully

functional, it has been replaced by a more modern customer relationship management system. It is a platform that Western Australia (WA), South Australia (SA), and New Zealand have put in place as a response to COVID. They went out to the market to see what systems allow shared information. Using the experience from WA and SA they selected Salesforce with a future intent that the jurisdictions can talk to each other. As for the individual who tests positive for COVID or close contact, all of the contributors to their management will be talking through Salesforce and can see their different contributions until hopefully the experiences will be much better in the future.

- M Cubitt comments that she feels the workforce was a bit frustrated due to repetition of steps
- P Barnett asks what the current delay is from testing until notification.
- E Wallace responds that the gold standard to the performance measurement their getting to is 48h from test to closure. This means notification and quarantine of the close contact, test, sample, result, interview, close contacts identified, isolated, and quarantined. Currently sitting at 43h.
- A question is asked regarding how privacy and patient confidentiality is being maintained within the system with all the data sharing going on?
- E Wallace responds that all the data is going into the DoH. So, the team is not sharing data with anyone. They are having things share with them. They also have a data sharing protocol with the Commonwealth so they can access MBS data. But coming into the DoH and Commonwealth, there is very tight privacy regulation and all the platforms are on secure systems and have very rigorous privacy protocols. In terms of sharing the data with a health service, at interview they ask a question around “are you willing for us to share” which has recently changed to a default to optioning out. When the health provider calls, there is another question asking if they are willing to share information.
- The information sharing is more provided to CCOM rather than out by CCOM.

4. Issues and Actions

4.1 Summary of Issues and action and discussion emerging issues

J Morphet notes that there is a plan in the next CoP meeting to discuss workforce specifically and the mental health challenge needs to be escalated again.

5. Meeting close

- For any out of session questions, issues or suggestions for future meetings, email EMCommunityofPractice@acem.org.au or contact Natalie Wright 0439 363 713 or Jo Tyler 0417 300 690.
- The next meeting will be Friday 09 October 2020, 3.30-5pm, and all are welcome. To register for the EMCoP please go to the ACEM website.
- S Judkins thanked everyone for their participation and hard work