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Webinar 4 July 2020

Medicine post COVID-19

Collated Q&As and comments during webinar

Dr Mya Cubitt: Question was "what is BAU"?

Dr Mya Cubitt: Business as usual

nick: Andrew there are jurisdictions that have well developed quality and safety divisions like Safer Care Victoria, but this led to discordance in advice particularly on widespread mask use in ED. What do you see as the role of federal DoH , and the Commission, compared to jurisdictional clinical governance organs during a pandemic?

Janice Cheng: Discordant/varied advice is indeed quite an issue, especially considering many senior clinicians work across many different public/private health networks. How was/is this managed?

nick: @janice the government funded the COVIDEvidence taskforce which is building on the national living evidence taskforce through Cochrane. This will be something to take forward as we look to rapidly developed national guidance across a range of issues. So far Stroke and COVID have a national living guidelines group.

Bennett Sheridan: https://covid19evidence.net.au/

Janice Cheng: Thank you for that link. I believe the focus of the National Clinical Evidence Taskforce is on clinical care though. Is there a group looking at the logistics of dealing with COVID (e.g. screening leading up to elective surgery, desolation processes etc)? There is quite a bit of variability across health networks. Whilst I understand there has to be some degree of variation to accomodate the different contexts in which the different networks operate, it does make it difficult for clinicians who work across many different networks to keep abreast of.

Prof Andrew Wilson: really support Nicks comments on the responsibility we all hold when speaking in public forums. People listen to us and confidence in the system and its leaders is really important now more than ever.

nick: @janice that is a really good point and something that I've personally been struggling with. I think largely the systems issues like patient flow, elective surgery screening, and design of EDs and ICUs perhaps the best way I have seen is through Communities of Practice. This is because, whilst frustrating on one level that we have to work it out at individual institutions, on another level it's important to have those local discussions. I agree though we lack broad guidance on that

Prof Andrew Wilson: As Nick said, a key is that people talk to the groups affected (esp if it is divergent) before they speak publically since they often don't have all the context and limited understanding of the impacts. Leaders and systems need time to consider response etc.

Dr Mya Cubitt: Agree Andrew. Our ACEM COVID19 Guideline makes the point of asking clinicians to direct messages to the appropriate channels. Which of course means (we) clinicians in leadership

positions need to ensure we're careful in giving clinicians a clear and transparent understanding of where and how they can do that. A challenge to all of us at every level.

nick: @belinda I think the only successful way is to keep ourselves open as leaders to hear alternative views. My biggest concern has been loud social media voices that are very influential amongst junior docs.

nick: @all Would really welcome craft group/college/individual feedback on Telehealth as we are looking at the future structure. Please email nick.coatsworth@health.gov.au

Prof Andrew Wilson: agree mya - its an ongoing challenge! most people do the right thing - i think the craft groups, ama etc have overall been pretty good. Its isolated people from the academic sector with no official role that cause most of the problems (but seem the "go to" people at the moment...)

Marcia Bonazzi: Sorry from Marcia again. I have questions about the mask use.I have been following advice from all the private hospital I work. St Vincents, FPH and Epworth Freemasons . The hospitals have support us and educated us. Epworth has been fantastic with PPE training and zoom and emails with advice and support. We were advised to use masks and protection mainly on 2nd stage of labour because the risks is higher with the pushing. Everybody has support and done that however was always on our mind that in labour wards is difficult to keep social distance as you understand why. I was just wondering what will be the guidelines from now on with the hot spots. My main rooms are in Fitzroy but i travel once a fortnight to Essendon and Reservoir for consulting. I have been advised by my insurance to avoid these spots from now on so my patients can come to Fitzroy. In my rooms I have insert protection for my staff on reception and myself and my staff are using masks. we have enough hand sanitiser at the moment and all patien01:35:54

Nisha Khot: Is there an explanation for why different healthcare organisations have chosen different methods of staff and visitor screening?

Rob Millar: There are areas of practice which have been sidelined by COVID preparedness, e.g. paediatrics, but impacted significantly by displacement of services, lack of screening services etc. How do we re-engage these important services while maintaining COVID vigilance and the learnings from our experience?

Marcia Bonazzi: all patients are offered mask and telehealth and phone consultation. Phone consultations are fine but i am not having many patients accepting telehealth despite being offered. I understand that the mask use is debatable but on my last clinic at a public hospital when I was listening the fetal heart a patient felt very hot and blow air very close to me. Any advice to me?

nick: @nisha there are national guidelines on staff and visitor screening but will be large local variation in implementation; we are currently working on a paper on implementation barriers to screening checks

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Dr Mya Cubitt: Posting from the Q&A panel - “The UK has started asking elective patients to self isolate for 2 weeks prior to surgery and then have a negative covid swab prior to surgery. Have we considered this approach in Australia given the risk to patients having surgery if covid positive?”

nick: Something to consider from Andrew’s and Chris’ talk - as health administrators our focus on Business Continuity in disaster of any sort - infectious, cyber, bushfire. Importance of ongoing engagement of disaster planners and BCP directors with clinicians, and the difference between a plan one paper’ and a shared understanding of those plans!1

nick: *a plan on paper*

Dr Mya Cubitt: From the Q&A panel; Thank you for arranging this webinar, some great insights!

Given the discussion has been predominantly from a public hospital/ health service perspective in Victoria, can we see a future collaborative health service better integrate general practice? eg mass testing in postcode specific areas seems to treat GPs as an afterthought rather than as primary care.

Having a better integration with general practice would reduce low value care demands on hospitals (especially emergency departments)

nick: Great point! For me the best results have come from cross disciplinary collaboration. The funding model won’t change to relying on C’wealth or States to improve GP/hospital collaboration cannot be relied on. College collaboration, collaboration within Primary health networks and EDs, even local practices and EDs?

Janice Cheng: A lot of work has been done between hospital networks and their corresponding PHNs. So it’ll be interesting to hear from the panelists whether the collaborative focus is likely to shift from streamlining outpatient/admission/discharge collaboration to home/digital/collaborative care post COVID..

Janice Cheng: If there is time, I would love to also love to hear from the panelists regarding the concept of low value care please. Towards the beginning of the pandemic, Duckett specifically suggested procedures such as knee arthroscopies for OA etc are low value. Is there a clinician guided group looking into everything from definition metrics, scope (e.g. everything from appropriateness of investigations, prescription rationalisation, to procedures evaluation etc)?

nick: good point John - it does highlight the importance of early collaboration between the colleges and infection control particularly when they are developing guidelines. Now we have the Infection Control Expert Group that is happy to review any College guidelines. Hasn’t always been able to harmonise but certainly helped escape is;lay in the critical care and ED craft groups

nick: *certainly helped collaboration in*

Cameron Knott: Regional pathology services are limited and continue to delay testing for regional centres (5d turnaround, rather than 4-6 hours in some places

nick: yes. important to note that in the latest CDNA Series of national guidelines that patients who are tested but do not meet suspected case criteria would not need to isolate pending a result particularly if symptoms resolved. does not apply to hotspots

Kate Stewart: I agree Cameron - no time to talk about the dire state of pathology in regional and rural Victoria in 3 minutes but it is a huge problem. Essentially, all regional pathology is being provided currently by 2 private pathology companies, except Shepparton.

Cameron Knott: PPE burn in regions happens more at the end of dubious supply chains at times.

Nisha Khot: There has been a lot of confusion about the need to isolate if one has a test when one is asymptomatic.

nick: definitely don't isolate an asymptomatic pt waiting for test unless they are a known contact (in which case pub health will be managing it)

Nisha Khot: @nick Thanks for this re: asymptomatic patients. Would this be true of asymptomatic patients in hot spots?

nick: yes, but don't assume risk Ax has been adequate and recheck. If family or workplace outbreak then assume contact and isolate. Vic DHHS will have specific advice on what they are telling the patients who are asymptomatic and would need to follow that.