Attachment 1: Please note that these emails are timed as if being sent from a US time zone.

From: [redacted] <[redacted]>
Sent: Wednesday, April 15, 2020 1:50 AM
To: RACP Victoria <[redacted]>; [redacted] <[redacted]>;
'Andrew Wilson (DHHS)' <[redacted]>;
[redacted] <[redacted]>; [redacted]
[redacted] <[redacted]>; [redacted] <[redacted]>; [redacted]
<[redacted]>; [redacted] [redacted]>; [redacted]
<[redacted]>; [redacted] <[redacted]>; [redacted]
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<[redacted]>; [redacted] <[redacted]>; [redacted]
<[redacted]>; [redacted] <[redacted]>; [redacted]
<[redacted]>; [redacted] <[redacted]>; [redacted]
<[redacted]>; [redacted] <[redacted]>
Subject: Re: Meeting with Prof Andrew Wilson and Committee of Chairs of Victorian Medical Colleges

Dear All,

Please find attached a document that contains an operational approach to hotel quarantine. I think many of these principles will also apply to medihotels or step down residential or discharge programs that may be developed at a local Health Service level, so may be of use to some of you and worth being aware of.

The large numbers of returned travellers requiring quarantine in Vic have presented a huge learning opportunity for refinement of a safe, efficient and effective response for residents, staff and all of the stakeholders involved.

I think there are a number of outcomes:

The first is that there are significant differences from in home quarantine, including mental health, complex psychosocial issues, lack of medication supplies for chr medical conditions, food allergies and intolerances, access to health assessment, nursing and medical support for management of COVID19 symptoms and complications, fear and anxiety among limited hotel staff, PPE, security and waste management issues, drug and alcohol and smoking addiction and withdrawal, testing, communication, discharge criteria, transport and documentation etc etc.

The second is the absolute requirement for health staff involvement and support and escalation – nursing and medical – even in a cohort of pretty well/minimal symptomatic people who could "otherwise manage at home"

The third is the essential requirement for an operational approach. Fortunately there are both operational plans that been developed and applied successfully in very similar circumstances – eg management returned citizens from Wuhan – and expert advisory bodies like the https://www.nationaltraumacentre.nt.gov.au/ can provide advice and assistance. No need to develop de novo!

NCCTRC | National Critical Care and Trauma Response Centre
COVID-19. The National Critical Care and Trauma Response Centre (NCCTRC) is currently experiencing the impact of COVID-19 and in recognition of the evolving situation is suspending all education and training courses effective immediately.
www.nationaltraumacentre.nt.gov.au

I have distilled the basic components of the operational plans (attached) that have been developed by a collaboration of Australian experts in Disaster Medicine, who have very generously peovided multiple resources. Obviously at a Vic State/DHHS level the detail for each component is much more specific - the information is available but I haven't included it in the document so that it could be useful as a beginning template for other states or other residential circumstances, and the contact details will change for different geographic (regional vs rural vs metro) locations and depending onc urrent case definitions and testing criteria etc.

I understand there has been an enormous amount of effort from the Emergency Services and Health Minister through the Departments, The CHO and CMO and Safer Care Vic and the multidisciplinary staff involved at a direct residential care level (over 5000 returned travellers in residential quarantine) over the last few weeks in adjusting the approach to residential quarantine management, and that there has been much national scrutiny on the issue. I think it is very worthwhile making sure the huge quantity of work is acknowledged, and that the succesful outcomes and learnings are made available to assist other states and programs that may require a similar operational approach.

Very happy for feedback and refinement!

Regards,

[redacted]

Sent from Outlook

Attached to the above email was the following document:

Operational Approach to Hotel Quarantine – many principles likely to translate to MediHotels

NB Consider Operational Plans that have been utilised successfully including those developed by, and advice from https://www.nationaltraumacentre.nt.gov.au/

Consider Application of Hotel Zones:

Red zone:
confirmed Covid+ve Residents – will require SOP for Resident arrival, care in the Red zone and discharge criteria

Orange zone:
Quarantined Residents – monitored for development of symptoms for maximum incubation period.

Also applies to contacts of suspected cases. Should be managed with contact precautions if there is likely to be a delay in confirming or excluding COVID19 infection in the suspected case (eg delayed test).

Residents in the orange zone are required to maintain social distancing at all times to prevent contact from others who are quarantining as all residents may be infected with COVID-19 and not yet be symptomatic.

Green Zone: staff area
All other areas of the site that are not Red and Orange are Green and classed as COVID-19 free. Universal precautions and close attention to hand hygiene are applicable in this area. Cough etiquette, maintaining social distancing of 1.5 meters and staff to refrain from close greetings and hand shaking.
Consider PPE required for Zones – for staff and for patients. These need to match hospital care for nursing and support staff, eg:

Red Zone / Positive residents - Full Airborne transmission precautions (vs contact), including routine use of a P2/N95 mask, disposable gown, gloves, and eye protection for clinical staff. Support staff cleaning to wear full PPE as clinical. Meal drop requires a surgical mask and no gown meals dropped outside residents' rooms. No resident contact.
Orange Zone / Quarantine - Full Airborne transmission precautions for clinical direct patient contact. P2/N95 mask for CONTACT Nurse and a surgical mask for the clean nurse. Support staff cleaning P2 mask, Gloves and glasses, no gown. Meal delivery surgical mask, gloves.
All staff entering the red zone should practice hand hygiene on entry & exit.
Green Zone - Universal precautions including close attention to hand hygiene. Cough etiquette. No hand shaking, maintain social distancing.

PPE training and monitoring: Donning, Doffing + waste bags and Hand sanitiser at stations each floor

Staff clothing SOP:
eg: change to scrubs on arrival closed footwear, scrubs to be removed prior to leaving at end of shift

Develop PPE Infection control and Zone FAQs

Referral Pathway for Medical Transfer
eg Referral pathway for onsite healthcare staff when residents require escalation of care ED/Hospital admission
eg Ambulance Service to list Hotel as an "area of concern" in case of independent calls and may/will ask onsite healthcare staff to assess need for Ambulance attendance and transfer in case of low acuity calls

Develop minimum criteria for transfer to Hospital

Designate Hospitals for transfer Adult and Paediatric

Keep log of issues encountered on shift by staff:
eg:

no of symptomatic patients
Medical issues
requirements for prescription
Stores utilised and resupply requirements
Any operational issues
Other issues
eg – to be addressed early am and mid-afternoon for actioning

Designate Pharmacy/ies for supply of medications required for residents + process for prescription and transfer

Designate testing SOP re process for updated case definitions/testing criteria, equipment required, request authorisation, transfer to designated lab, re-stocking, results notification

Rubish Removal/clinical waste
eg biohazard bags in each room and doffing areas on each floor

Fire Evacuation SOP
eg as per Facilities plan – clinical staff wil be required to attend evacuation in PPE if required

Security/Evaluation SOP

Communications
eg Notification to residents bd re any changes to systems
eg utilise food drop times to remind residents of required actions (eg reminders to place their mask on before opening the door)
Translation into appropriate languages
Residents to have an emergency 24/7 contact number
Training and signage re PPE utilisation and donning and doffing requirements
Staff communication numbers for – nurse (eg 24/7), medical (off site, daily visit), Mental Health support service, Pathology Courier, Pharmacy, business centre, EM managers, PH manager, Health Department –other necc contact details as required, additional Hotel/s numbers

NB Phones in red/orange zones in ziplocked bags and decontaminated on doffing

Initial Health/medical screening on Arrival and Daily
eg over phone re medical history, medications, allergies and initial and daily COVID19 screening questions

SOP re if symptomatic – eg in-room assessment in PPE with temperatureas per medical screening tool
SOP re consideration/criteria for COVID19 testing
eg 24/7 onsite nurse + escalation to medical support +/- hospital transfer as appropriate

Role Onsite Nurse:
+/- Data collection and recording current residents,numers, names, room, details, ID
eg intial and subsequent COVID19 screening questions, initial medical assessment
Receive calls from reception re medical needs

Assess need for medical review via phone triage
In room assessment if required in PPE
Move patients Orange to Red if COVIDswab returned +ve
Request Medical support via phone or in-person, 000 for medical emergencies and transfer
Consider ensure appropriate supply regular medication for chronic medical conditions and escalation to medical support as per prescription requirements and fulfilment prescription/transfer from pharmacy as per SOP

Resident Satisfaction Survey eg weekly

COVID19 Test SOP: eg swab procedure including PPE, labelling, technique, correlating pt details, packaging, decontamination, doffing, waste disposition, communication, storage and transfer/transport test, restocking, security

Security SOP
eg: to accompany all in room assesments, PPE,
2 staff to assist residents to allocated rooms

Medical Assessments SOP
eg Red Zone with mild symptoms – medical review within 24/24 of arrival
Diagnostic equipment required eg thermometer, 02sats probe, pen – storage and decontamination requirements for these
Deteriorating patient pathway – eg; 000/Ambulance transfer eg unwell, SOB , hypoxic 02sats <95% considered for transfer

Resident Daily Care:
Red zone:
Daily health check symptoms with chart tick box (fever sore throat, cough, fatigue, SOB) HR reg/irreg, RR, Temp
Psychosocial conversation, identify any other medical concerns
24/7 phone line for emergencies for residents
Required to wear masks at all times
Orange Zone:
Daily Health check tick box (symptoms)
If symptoms – management symptoms + testing as per SOP
Identification sign – awaiting results – recorded/ process for receiving results
Recreational activities as enabled if not symptomatic – NB if possible facilitate sometime outside – supervised, appropriate PPE, rostered timeslots and traced, security, hand hygiene and decontamination
Psychosocial conversation and identify any other medical concerns eg afternoon telephone review

NB Discharge SOP
including timing of swabs, number of swabs, resolution symptoms/signs, transport arrangements and certification

NB After hours medical support contact details – will be required for nursing support 24/7
NB Medical support may be combination primary care/urgent/emergency care
24/7 Mental Health support/triage/assessment contact details

NB Advice and SOP re smoking/drug and alcohol addiction/withdrawal and exercise plan
NB Designate Office/administrative onsite space
NB identification needs complex families/psychosocial
NB SOP re food allergies and intolerances and alternatives
NB Develop Transfer Medically Unwell SOP, Medical screening form, Testing SOP

References:
WHO
https://www.who.int/emergencies/diseases/novel-coronavirus-2019
CDNA SoNG
https://www1.health.gov.au/internet/main/publishing.nsf/Content/cdna-song-novel-coronavirus.htm
National Critical Care and Trauma Response Centre: AUSMAT Operational Plan | Howard Springs February 2020.
Australian Health Sectors Emergency Response Plan for Novel Coronavirus (COVID-19)
https://www.health.gov.au/sites/default/files/documents/2020/02/australian-health-sector-emergency-response-plan-for-novel-coronavirus-covid-19_2.

The following email was also sent from [redacted] to Professor Andrew Wilson on that day:

From: [redacted]
Sent: Wednesday, April 15, 2020 7:09 AM
To: 'Andrew Wilson (DHHS)' <[redacted]>
Subject: Residential Quarantine

Dear Andrew,

Thank you so much for your time this afternoon on the Vic Faculty Chairs of Medical Colleges zoom call. I 'm not quite sure how you're doing it, and we appreciate the 24/7 access that many of the Departmental staff and SCV have provided. The extraordinary amount of work you're doing and that is being generated is so very much acknoweledged and appreciated by AMA Victoria and I know by so many across the medical profession, who will likely never get to tell you how grateful they are. As you highlighted this afternoon, I suspect the COVID19 related strategic and operational response is significantly more challenging in Vic than in the smaller more centralised states, who have a much higher Department of Health staffing ratio, and it makes the succesful response to date and the sesmic shifts that have taken place even more notable.

Re the issue of residential quarantine for returned travellers, we are aware that there has been an enormous amount of work down from the Emergency Services and Health Ministers' through the relevant Departments, our CHO and PHOS and yourself and SCV, and the multidisciplinary staff directly looking after the residents.

I am also aware that there's a fair bit of national scrutiny on Victoria on this issue currently, and I think that means a good opportunity for Victoria to promote it's experiences and learnings to assist other states, and also other programs where the principles will also be similar - eg medi hotels, step down discharge programs like resp rehab, other residential quarantine programs for vulnerable patients that might be set up by individual health services in Vic or elsewhere.

Based on some very generous resources shared by a collaboration of Australian Disaster Medicine experts, I have attached a very rough document that is a bit of a checklist of the prinicples - many of which have come out of the Vic experience to date, that might be of use for those developing or monitoring similar programs or the Vic programs going forward. I know you have had some preliminary conversations with Julian Rait on the issue of quarantine management and If you have any feedback or there are aspects that you think aren't useful even at this early stage it would be very much appreciated, but also completely understand if it's not anywhere near making it on to your radar.

Thank you again for the enormous amount of work that is being done by yourself and Safer Care Vic. I know as an Emergency Medicine Physician at Royal Melbourne Hospital that we all feel very fortunate to be working in Victoria at this time. Happy to help in any way that can be useful, particularly in communicating the work that the Department and SCV is doing, and in facilitating clinical representation and input.

[redacted] (board member AMA Victoria and of VDHP, and incoming Emergency Medicine Craft Group Rep to AMA Federal, FACEM RMH)
my phone number is [redacted]

Sent from Outlook

Attachment 2:

From: Nathan Pinskier [redacted] >
Date: Monday, 13 April 2020 at 2:17 pm
To: Prof Brett Sutton [redacted] >
Cc: [redacted] [redacted] >, Julian Rait [redacted] >
Subject: COVID-19 Hotel Dr arrangements

Hi Brett,

You might be aware that two weeks ago I was contacted by DHHS regarding the possibility of providing a medical workforce via Medical Deputising and other doctors to support the medical care of hotel quarantined overseas arrivals.

The doctor service commenced on Saturday 4 April at the Crown Hotel sites. What was initially a daytime onsite service involving one doctor and three hotels with overnight coverage being provided by the Doctor Doctor Medical Deputising Service has rapidly expanded into 24 coverage with now 6-8 doctors working daily and 1-2 overnight. It has become a sizable logistic operation which has involved onboarding new doctors on a daily basis.

The service is being coordinated by my medical administration arm Medi-Admin via Drs Nathan & [redacted]. We have been in regular communication with DHHS regarding the clinical requirements and the associated levels of resourcing and other support required. The DHHS team have all been very accommodating and supportive as best as possible however given the speed at which the service has been established there are a number of issues that require further consideration some of which are of a high priority.

These include (in no particular order):

1. The testing protocols and availability of results. Some COVID-19 tests are being sent to VDRL and some to Melbourne Pathology. The VDRL results are taking up to 5 days to arrive and are communicated to the doctors only if they ring up VDRL and are then sent to the hotel by fax. VDRL has refused to provide the results to the doctors over the phone. This is complete contrast to normal clinical communications practices for both urgent and routine results. This is placing individuals at risk. Test results should be provided in a timely manner and preferably be sent by a seamless electronic solution not fax with a direct call to the doctors and nurses for all COVID-19 positive results as son as they are available.

2. Mental Health Support services and escalation protocols. This has been identified by the doctors as a significant issue. [redacted] has personally briefed Martin Foley yesterday re this issue.

3. Availability of emergency medicines at each site via an imprest. There have apparently been a few cases of food related anaphylaxis.

4. Availability of oxygen and resuscitation equipment at each site.

5. The recording of clinical information. To date doctors have been recording clinical notes on paper as to have the nurses. This is clearly not ideal so we have addressed this for the doctors by requesting our IT providers to set up over the weekend a hosted version of Best Practice (this was approved by DHHS in conversation with Neville Board). BP has gone live today however the nurses who are provided by DHHS are still using paper. They also need to be added to the system so that they can access the doctors notes and instructions and also add clinical indication to the record. We are also installing the Melbourne Pathology secure messing software Fetch for pathology result downloads. I'm unclear whether this is available for VDRL. We are also aiming to setup access to MHR.

To support the electronic record data capture we will require some administrative support which includes provision of the names of all quarantined persons so they can be added to BP as required. We will also need to sort out the the process for the long term storage of both the paper and electronic clinical records.

6. The quarantine protocols and 14 day rule needs clarification. The doctors have advised that persons are being sent home from quarantine after 14 days irrespective of their COVID-19 status. Could you please clarify?

7. A private working area for the doctors is required at each hotel

8. Indemnity cover. Despite efforts to have this addressed it remains unresolved.
We require VMIA and/or Crown coverage for both the company and the doctors to be provided and confirmed immediately in writing with cover provided from the date of commencement of the service - Saturday April 4 2020.

9. PPE availability (I appreciate that this is an issue for all healthcare providers).

Please note that I have been in touch with Julian Rait (cc'd) this morning and he suggested that I contact you directly.

I would appreciate a call back today if possible to discuss the above.

In anticipation

Best

Nathan

Dr Nathan Pinskier MBBS, FRACGP, FAAPM, FAAQHC, Dip Prac Man, CPM
Director Medi7 (Medi-Admin) General Practices
President General Practice Deputising Association
Medical Director DrDr After Hours Deputising Service
Board Member Peninsula Health
Member RACGP Expert Committee ehealth
Strategic Clinical Advisor ADHA Secure Messaging
[redacted]

On 13 Apr 2020, at 3:33 pm, Brett Sutton (DHHS) <[redacted]> wrote:

Hi Nathan,

Thanks for raising these issues and reaching out. I appreciate that you and the service team have come to this role with no advance notice and have rapidly adjusted to the requirements of a large cohort of individuals requiring assessment and care.

As these issues are being raised with me for the first time, I'll require some time to check in with various individuals in DHHS to understand some more detail and what, if anything, might already be in train to address them. I'm sure you'll appreciate that some of the issues flagged are not in the direct control of DHHS but I am of course happy to explore solutions as soon as possible.

I'll call you tomorrow once I understand the issues in more detail – is 10am a possible time for a call?

Regards,
Brett

Adj Clin Prof Brett Sutton MBBS MPHTM FAFPHM FRSPH FACTM MFTM
Victorian Chief Health Officer
Victorian Chief Human Biosecurity Officer
Regulation, Health Protection & Emergency Management
Department of Health & Human Services | 14 / 50 Lonsdale St
ph. [redacted] e. [redacted]
health.vic.gov.au/public-health/chief-health-officer
twitter.com/VictorianCHO

Please note that I work from home on Thursdays and am contactable on the numbers above.

From: Nathan Pinskier <[redacted]>
Date: Tuesday, 14 April 2020 at 5:50 pm
To: Prof Brett Sutton [redacted]>, [redacted]"
<[redacted]>
Cc: [redacted] <[redacted]>, Julian Rait <[redacted]>
Subject: Re: COVID-19 Hotel Dr arrangements

Dear Brett and Annaliese,

Thanks for calling us today to discuss the various issues documented in my email yesterday.
As per our discussions I note the following:

1. COVID-19 Testing: To streamline the process and turnaround time it is preferable that all COVID-19 test specimens including those ordered and undertaken by the duty nurses be sent to Melbourne Pathology. DHHS will advise the nurses of such.

In the event that tests are sent to VIDRL the protocol for releasing results to the doctors needs to be changed so that results are provided by phone call as they become available and also electronically (if possible).

2. Clinical Care Pathways and escalation protocols:
You advised that there are a number of teams on the ground at each hotel providing different care services and that DHHS is working to coordinate and streamline their various activities. DHHS is also establishing a central database to coordinate and track activities and actions. I understand that the doctors will be provided access to this database.

In addition, clinical care pathways and escalation protocols need to be confirmed both for general care and mental health issues. Furthermore it would be of advantage if the doctors can be provided with direct priority access to senior hospital duty doctors where required.

3. Availability of emergency medicines at each site via an imprest:
Given the number of quarantined persons at each hotel, it is unworkable to expect the doctors to continue to personally supply emergency medicines, of which they are only supplied a limited quantity each month via the doctors bag. Yesterday we established a locked imprest at each hotel containing a small number of medicines which have been supplied by the DOH contracted city pharmacy. This list requires review to ensure it's appropriateness. A daily monitoring and handover process will be established.

4. Medical Equipment:

Essential medical and medical resuscitation equipment needs to be available at each hotel. At a minimum, this includes a pulse oximeter, bag and masks and AED (if not already present). It needs to be confirmed as to how these will be provisioned.

5. Recording of Medical Notes:
Best Practice is now fully operational and being used by the doctors. As discussed we will now need to provide some administrative support in order to scan into BP the doctors paper records created over the past 10 days. Do we need to have the funding for this resourcing confirmed by [redacted] or are we good to proceed?

6. The Quarantine protocols and departure protocols:
You advised that DoH is working on refining the hotel quarantine and departure protocols. We are looking forward to receiving the update so that we can circulate it to all the doctors.

7. A private working area for the doctors is required at each hotel:
Please advise as to how this is best progressed?

8. Indemnity cover:
As discussed this remains unresolved. This is a unique situation whereby the doctors are providing a service to DHHS under legislation enacted by National Cabinet. In discussions with Avant, it remains unclear as to whether the doctors are covered by their existing medical defence indemnity insurance. Our company entity appears not to be covered by its existing policies. This is a risk we cannot continue to be exposed to. We therefore repeat our requirement that VMIA and/or the Crown provide coverage for **both the company and the doctors immediately** with confirmation of such in writing and cover provided from the date of commencement of the service - Saturday April 4 2020. As a further point, I note that all the primary care pop up COVID clinics established by the Commonwealth have been provided with Crown indemnity. We require equal consideration and identical indemnity arrangements.

As a final matter not raised in the teleconference.
Parking Tickets:
I understand that several of the doctors have received parking fines Incurred outside the hotels. We would appreciate that consideration be given to waiving these fines as they were incurred as the direct consequence of the provision of medical services. The same process should apply as per the waiving fines incurred by health professionals parking outside hospitals announced by the Premier over the long weekend.

Thanks for your ongoing consideration

Best

Nathan

Dr Nathan Pinskier MBBS, FRACGP, FAAPM, FAAQHC, Dip Prac Man, CPM
Director Medi7 (Medi-Admin) General Practices
President General Practice Deputising Association
Medical Director DrDr After Hours Deputising Service
Board Member Peninsula Health
Member RACGP Expert Committee ehealth
Strategic Clinical Advisor ADHA Secure Messaging
[redacted]