Australian Government

BE COVIDSAFE

# Coronavirus (COVID-19) early aero-medical evacuation of covid-19 cases and contacts from remote communities

## Guidance for communities and organisations

## Purpose

This document highlights the need for early evacuation of cases for public health reasons and provides an initial framework for describing the situations in which an evacuation for public health reasons may occur, how these may be co-ordinated and key considerations for transport.

## Background

A case of COVID-19 in a remote Aboriginal and Torres Strait Islander community has the potential to rapidly cause an outbreak which may have high levels of mortality and morbidity. The Management Plan for Aboriginal and Torres Strait Islander Populations outlines the range of determinants and factors that can attribute to this quick spread.

Because of this, early isolation of suspect, probable and confirmed cases and quarantine of their contacts to prevent onwards transmission is an important component of the response. The decision to evacuate cases (with or without their close contacts) versus isolation and quarantining within the community will be informed by jurisdictional public health authorities and community preferences and facilities, noting that the risk to the community of quarantine/isolation breaking down is very high and that appropriate facilities, preferably single rooms with ensuite, are required for effective isolation and quarantine. In some communities where there is no laboratory capacity, suspect cases may need to be flown out to ensure timely testing for disease.

## Options for public health management of cases of COVID-19 in a remote Aboriginal and Torres Strait Islander communities

1. Isolate cases (in community or a regional centre) and quarantine extended community contacts (possibly the whole community) with or without wide spread testing.
2. Isolate cases and quarantine close contacts in usual or designated accommodation in the community.
3. Isolate cases and quarantine close contacts in designated accommodation in a regional centre.

The National Guidance for remote Aboriginal and Torres Strait Islander communities for COVID-19 outlines a number of considerations that should be taken into account when deciding whether to evacuate cases and their contacts. These include the likelihood that a suspect case will become a confirmed case on receipt of laboratory testing, available facilities for isolation and quarantine in the community and the community wishes. It should be noted that options 2 and 3 may not stop spread due to the likelihood that there are already multiple chains of transmission within the community by the time the first case presents for care, unless the case is clearly linked to a known index case or is from outside the community. In this scenario options 1 and 2 could be considered, depending on the extent of exposure of the case to other community members. However, moving people closer to hospital facilities is likely to increase the chance of a good outcome and relocating cases and contacts will take the load of overburdened and under resourced primary health care clinics during an outbreak given that cases and contacts will require frequent clinical review. Decisions about moving people closer to hospital facilities, when and how that will be done, must be made in collaboration with the individual and their family.

Ideally, by the time a case occurs in a remote community there will already be an operational plan in place (determined by the community, jurisdictional public health authorities and relevant health services) that outlines the steps to be taken including around evacuation.

## Aero-medical evacuations for public health reasons versus evacuation for clinical reasons

An evacuation may be needed for either public health or clinical reasons. The public health rationale for evacuation is to remove an infected, or possibly infected patient from the community to prevent onwards transmission.

**Evacuations for public health reasons may occur:**

- for individuals patient(s) suspected[1] as being a case (where there is no onsite laboratory capacity) who require testing for COVID-19
- for individuals who have had COVID-19 infection confirmed by laboratory testing, and who are clinically well but where the jurisdictional plan is to evacuate people with confirmed COVID-19
- where the community requests COVID-19 cases to be relocated
- close contacts[2] of suspect, probable and confirmed cases, who require quarantine and where the agreed community plan is to quarantine people out of community or where the community facilities have exceeded capacity or are not appropriate.

In some situations another option may be to use RFDS resources for rapid transport of the swab of a suspect case (whilst isolating the suspect case in appropriate accommodation in the community) to a site where this can be rapidly processed.

**Evacuations for clinical reasons may occur for:**

- individuals who are unwell and require care beyond what can be provided in the community
- the person is currently only mildly unwell but clinical indications are that the person has a high risk of developing a more severe illness due to comorbidity /age
- where the resident PHC team does not have capacity to provide daily monitoring and acute care/evacuation if the person becomes acutely unwell.

In some situations (e.g. for young people or those with communication difficulties) it may be necessary for cases and/or contacts who are being evacuated to be accompanied by an escort.

## Return of patients to community

Following isolation outside of community for non-hospitalised cases and contacts, individuals may require return transport to their communities, especially where aerial transport is the only feasible option.

For hospitalised patients, generally State and Territory agencies would provide return transport.

For Individuals isolated outside of community, return transport should be provide by existing State and Territory repatriation or return to community programs where

[1] The definition for probable and suspect cases are frequently adapted, but decision on whether an individual meets these criteria will usually involve a discussion between the treating clinician, relevant public health unit and affiliate

[2] Note that by definition contacts are asymptomatic

possible. The RFDS can provide repatriation services where existing services are not available or where there will be a significant delay to returning to community.

# Methods of evacuation

## Co-ordination and triage of evacuations

The decision to evacuate a suspect or confirmed case with or without their contacts, for either public health or clinical reasons should be made in discussion between the individual and their family as well as primary health, public health and other relevant staff and informed by relevant local and jurisdictional plans.

After a decision has been made to evacuate, either for clinical or public health indications the evacuation category should be discussed with local evacuation services and public health professional by the attending senior medical practitioner.

Low acuity evacuations can be used for individuals (relatively well patients and contacts) being evacuated for primarily public health reasons. Cases should be moved from remote communities as soon as possible, ideally with an escort, and if possible with take-off within 5 hours of request due to the public health urgency of these retrievals. This will still be dependent on a number of logistic limitations such as, but not limited to, aircraft availability (other clinical demand and competing high priority tasks) and aircraft ability to fly (weather, maintenance or unscheduled off line repairs; crew availability due to illness or CASA flight hours restrictions), as well as flight times and access to airstrips and ground transport for some remote communities.

The decision as to whether an escort is needed and who is an appropriate escort (including consideration of risk of transmission) will be made by clinic staff (including Aboriginal staff) in consultation with the patient and their family, senior medical officer and the public health unit where required and will be communicated to the retrieval agency for action.

Usual triaging and clinical criteria should be used to triage the evacuations of cases (confirmed, probable or suspect) where this is being done for **primarily clinical reasons**.

## Rationale and mode of evacuation of cases

If evacuation is being considered for clinical reasons then the retrieval organisation should follow their usual principles around triage, appropriate transport mode and clinical staff required to accompany the case, The Living Evidence Guidelines[3]

[3] Guidelines developed by the National COVID-19 Clinical Evidence Taskforce include evidence of markers of disease severity https://covid19evidence.net.au/

compiled by the National COVID-19 Clinical Evidence Taskforce may be a useful resource in doing this.

For mild cases where there are no concerns around deterioration in flight it may be appropriate to retrieve these patients using charter flights (or ground transport where feasible), particularly where this will mean that a patient is transported more quickly than waiting for a prolonged period for an aeromedical evacuation flight. However, this decision will need to be made carefully in consultation with senior staff from the retrieval and relevant health organisation, and in collaboration with the individual and the family.

The major rationale for evacuation of contacts is to prevent onwards disease transmission if they subsequently become positive (note that by definition contacts are well people who have been exposed to a case, if they develop symptoms they will become a case).

## Infection prevention and control principles in evacuating cases and contacts

Cases and their contacts should be managed according to the same infection prevention and control principles during transport. While it may be appropriate to send cases and contacts via charter flights (or ground transport) it will **not** be appropriate to send a case (whether suspect, probable or confirmed) via any kind of regular passenger transport due to the risk of transmission to others.

Cases and contacts can, where appropriate, be transported in the same aircraft. The decision on whether this is appropriate needs to made on a case by case basis and take into account the risk of additional transmission posed to contacts– this will include consideration of whether the case is coughing excessively, the amount of contact that has already occurred between the case and contacts and the length of the flight. At a minimum, cases (whether suspect, probable or confirmed) should and contacts should:

- wear surgical masks during transport
- be provided with brief education on cough/sneeze etiquette and asked not to have any physical contact and sit at least 1.5 metres apart where ever possible
- have access to alcohol based hand rub and tissues, and be encouraged to practise regular hand hygiene.

Appropriate infection prevention and control procedures should also be used for escorts accompanying cases and/or contacts.

Where charter flights are used to transport cases and contacts, aircraft should be used that:

- maximise the distance between the pilot and those being transported
- have the ability to isolate the cock pit (e.g using an aircraft blind)
- cases and contacts should not sit in the cockpit

Aeromedical crew (including pilots) should:

- wear appropriate PPE
- minimising close contact between cases and contacts and air crew
- isolate the cockpit (e.g. using an aircraft blind) where this is available; note that where an aircraft blind can be used pilots may be able to remove PPE after this is in place
- use appropriate settings for air circulation.

For further information on precautions required by aeromedical crew, including guidance on cleaning aircraft read our fact sheet – Coronavirus (COVID-19) information for aeromedical retrieval of patients.

## Other considerations

Aeromedical organisations should ensure that they have protocols for and agreements with other organisations (e.g. ambulance service) for ground transport of patients to receiving medical services and other organisations. This may include how patients are transported into receiving medical services or to their place of isolation in a way to minimise infection control risk to others.

All services should ensure they are working with families, community leaders (and state affiliates) to ensure culturally appropriate support is offered to the evacuee at the time and on arrival in their destination.