COVID + Learning Network Webinar Questions

OFFICIAL

Paediatric COVID-19 Positive Care Pathways

Questions and Answers

Q1: How will health link as a service work regionally or is this for Metro only? Are intake assessments available to regional areas? A: The Department of Health's COVID + Pathways team is currently working on this and is partnering with PricewaterhouseCoopers (PwC) to ensure there is assessment undertaken in regional areas. The pathway revision team also has representation from Bendigo, Shepparton Health and Latrobe Regional Hospital (LRH). We are looking to engage more regional areas and will continue to work with regional services to standardise work processes.

Q2: Can you please share the current intake Assessment/ risk stratification for those Health Service Providers that aren't in the current rollout to enable standardisation?
A: At the moment this work is in draft and has been shared to the Metropolitan PHN CEO Forum. Next week's COVID+ Pathway Learning Network webinar will include more detail on this process.

Q3: Will the COVID + Pathways come at the expense of much other care and resources? There is a concern that services will be inundated people requiring delayed care in the not-too-distant future. What will be the plan for COVID normal? A: The work being done now in terms of bringing a system of care should be able to be translated with some ease to the person who has chronic disease. If we could provide a standardised pathway then we can duplicate the roadmap and apply it across the state. COVID is an opportunity to try and look at a new way of delivering care and look at some issues and difficulties that have been around for a long time in the health care system. Standardising the process across the state is important. Additionally, SCV have set up a platform to look at data for non-covid patients to identify any safety issues or signals to be acted upon.

Q4: At which stage is health direct is involved- is this immediately post positive notification text with question links or does it require the case to be allocated first to a region? A: It is important for health services, entities and organisations to have their hands on the clinical governance for COVID positive patients. HealthDirect, when they are successfully resourced and allowed to enable scalability for the intake, triage and assessment process they can help to standardise this process with partnered health services along with their own workflow. This work seeks to help the Directors of organisations to have and apply a clinically validated assessment tool.
We have been using a workforce of registered nurses, but under a supervisory model, we could also use other professions including medical and nursing students.

Q5: Are we looking at the use of remote monitoring platforms more widely? This is currently being used in Barwon South West - is this a model we are looking at for scalability? A: Yes, remote monitoring is extensively used in the medium acuity pathway and self-assessment reporting occurs through the COVID monitor app back to the HSP's.

Q6: By remote monitoring are you talking about phone support to find out readings, or a platform + app that captures the data and alerts clinicians etc? A: The COVID monitor app enables COVID positive pathway clients to enter symptoms daily and if there is a decline in symptoms this will be captured by the monitoring HSP who then reaches out to the C+P client. In summary, remote monitoring uses a combination of modes depending on symptoms/risk.

Q7: Regarding outpatient oxygen therapy for recovering patients - who augments the dose (l/min), how are patients assessed (as inpatient they get 4 hourly nursing observations), do they come under the HITH model (usually maximal BD contacts)? A: Work is currently underway in this space, once further information is available it will be made available to health services and clinicians.

Q8: What is the data sharing solution for patients in the pathways so that we can efficiently see what each part is doing for the patient, and their journey? A: A data cell with a dashboard of where a person is within the healthcare system at any given time is currently under development and will be shared as soon as it is ready.

Q9: Our ability to be flexible has in some part been facilitated but the industrial concessions of unions in a time of crisis. How might we move forward with workforce to ensure flexibility is retained but worker rights are protected? A: It is important to acknowledge the work that is being done in relation to COVID and the positive pathways as there are many valuable takeaways and learnings that require clear intentions moving forward. SCV will look to explore workforce implications as a future COVID+ Learning Network webinar topic.

Q10: Given that whole households are becoming infected, do families get both adult and paediatric advice for the household on initial contact? Many adult services being asked to give paediatric advice for families who have had no contact/information regarding this. A: Monash Children's Hospital (MCH) COVID + Pathways currently has around 1300 children from the SEPHU catchment in our pathway. We work closely with our adult colleagues to try and care for family units, but with paediatrics specific input as needed.

Q11: What is the youngest age you are recommending to use home oximetry on? A: MCH is only using oximetry on a case-by-case basis. They try to provide care for children who have respiratory symptoms from the age of 12 years and older (The experience from Sydney found that the treatment was not very useful for 12-years-old and under children). We have also been using this service as part of a bronchiolitis trial for infants. They are not routinely recommending oximetry yet and advice tends to be ad-hoc in younger cases depending on their presentation.

Q12: If a child is assessed as being in a medium risk category, is it recommended they receive paediatric input via telehealth? A: Yes, it is recommended that they would at least receive an initial assessment or a review if worsening symptoms.

Q13: What is the communication plan to reframe how mild disease is going to be self-managed?A: Work is currently underway to include communications to the general public and clinicians in regard to the COVID + Pathways. Once this is ready it will be made available to clinicians and health services

Q14: Is there a family information sheet for post COVID illness potential complications?A: Royal Children Hospital (RCH)'s Wallaby Ward homepage has a lot of information, including a family fac sheet, panel discussion for parents. There's also information, Facebook webinars, podcasts and resources on the Monash Health website.

Some of the links shared:
https://www.rch.org.au/wallaby/COVID-19_resources/
https://monashhealth.org/health-professionals/covid-19/covid-19-positive-care-pathways/

Q15: A lot of the decision making in the pathway relies on oximetry. When you are not using oximetry in a significant proportion of children, how are you making those decision as to which part of the pathway they should go into?A: We purposely left the oxygen saturation out of the pathway because a lot of the assessments are done via telehealth. While the oxygen saturation can be helpful, we want to rely more on the work of breathing as an assessment tool as well.

Q16: What would the GP engagement look like for managing children and young people with COVID as opposed to adults? A: We have been working with PHNs and we are aware of the burden of care on them, mainly from their adult services but also the paediatrics COVID. In the vast majority of children, this is a mild viral illness, so the burden of care is not heavy on GPs. There is work being done to help with GP colleagues to better manage this.

Q17: The online apps for people to self-manage and self-assess could be very helpful. What is your view on this and how do you use those yourself at RCH?A: We have started using the apps. The remote symptom monitoring tool was pushed out twice daily to the families to do a check-in and then it flags with the staff if any critical symptoms so the staff could facilitate an earlier review. But this does rely on family engagement so for families who parents are very unwell or who's from culturally/linguistically diverse background, the apps might not be as effective. But they serve as an extra tool to allow us to redirect our attention to where it is most needed.

Q18: How do we align Paediatrics pathway with the adult pathway and having clarity for families about consistency? How do you practically manage the family group?A: We have not started those relationship formally and this is something we need to work with the adult partners in more detail. Family admissions/paediatrics guidance at Box Hill hospital under the work done by Andy Lovett as well as management have been a great model of care.

Q19: The whole system could potentially be overwhelmed with the increasing number of children who will be diagnosed once the schools are opened up again. Presumably, there will be very little hands-on management of those from the acutes and most of them will need to go to another system. What is the thing that you need to sort out if the system cannot cope with all of these children within the low-risk

group?A: The vast majority of the children will not need intensive monitoring and will be able to have check-in and families will be able to reach out accordingly. We hope that with the vaccination rate goes up for the adolescence cohort, we are not going to see the high number of children diagnosed positive to COVID as we expected. We expect to see increased demand in services for children with medical complexities who are exposed to COVID-19.

Comments and feedback:

- The North-East Vic/South NSW have put lots of time and resources into developing their regional pathway. Engagement is essential to make sure that this is factored into the new pathway rather than overriding all this work.
- The consideration of regional GPs in areas such as Horsham and Ararat including streamlined support and consideration of risk stratification in those areas is also critical as they may be assisting in the management of moderate risk patients.
- It should not be an expectation that GPs can just take on extra loads. If we do this there is a risk that patients can't get into a GP and will end up in ED. GP's in the primary care space are being slammed with new patients and long hours. Some are still providing vaccinations and conducting COVID-19 testing. We need to have structures in place in case the GP has no capacity. For example, the health service can manage low risk patients as well.
- Suggestion to train up medical and other health students to do the low-risk work rather than overburden GPs.
- It is critical that paediatric and adult models of care are aligned, particularly if there is a family of COVID + patients.
- In western Victoria we've asked GPs regarding their appetite/preparedness to take on COVID low risk care for people without a regular GP. There is quite low interest at the moment and there may be challenges in getting primary care to take these patients on.
- SCV should develop curated clinician information for the clinical networks primary care to take these patients on. Some resources should also sit within Health Pathways for GPs to distribute to patients.