COVID + Learning Network Webinar Questions

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COVID + Pathways Experience and Learnings from the ED – Hear from Barwon Health

Questions and Answers

Q: Can you explain more about the proprietary platform?

A: The proprietary platform uses the Tunstall integrated care platform for the COVID+ pathways has been built upon previous care models for Heart Failure and COPD.

Q: Are you doing any Sotrovimab or Budesonide treatments in the community?

A: Barwon Health are running Sotrovimab 3-4 times a day through out-patient clinics.

Q: Considering this platform and workforce implications what are the workforce benefits and how will this platform assist with future care delivery post COVID?

A: It would be great to see this platform move into virtual rounds for district nursing. Adapting to this type of care delivery is a huge change process for staff to support and appreciate that care won't be any less by delivering it in a different way. Barwon Health currently have huge capacity for this change and it's a matter of taking staff along the journey.

Q: Are these patients in your HITH program or another funded program? Are you doing video telehealth or telephone only for the daily calls?

A: Patients are in a Community Health program rather than HITH. Calls are mostly phone, but we are able to do video where required or requested in particular for the psychology consults. Some people are able to enter data onto apps however verbal information tends to give good information about certain symptoms such as shortness of breath. Those who can use the technology are far less time challenged and very proactive.

Q: How are you engaging with GPs and do they have access to data through telemonitoring?

A: The platform used is the same setting as health failure and COPD. GPs are notified that a patient is on a pathway and they will receive admission and discharge notes.

Barwon Health will invite GPs to have access to patient's data however only a few like to do that.

Q: Do you think a text message linked to a portal for people to lodge their symptoms would be good enough for tech literate people instead of daily calls?

A: In non-COVID monitoring we're looking at building confidence in staff that the monitoring provides 'equivalence' in the level of care and then also patients start to drive the kinds of care they are comfortable with.

Q: Is information Bluetooth enabled?

A: Yes, they have both and this tends to be a supply and demand issue. The platform has the ability to pull directly from devices while some people are entering their own data manually. Bluetooth for less tech savvy and where we provide tablet and connectivity. For patients using the phone app they can choose to Bluetooth the devices if they have the tech knowledge. Most don't with the app!

Q: What is the proportion of people that don't engage? What innovative things are you doing to try to engage those people? Door knocks etc?

A: Approximately 10% do not engage and often those that don't engage don't have GP's. A lot of time is spent on people who aren't engaging and sometimes it is enough for HITH nurses on the ground to go out and eyeball someone. You can also negotiate with patients and ask for their preferences e.g. No calls before 2pm.

A positive household model is used for big families. The family is asked to appoint a key contact to work as a liaison within the household. There is often a higher risk level for someone who lives alone as opposed to with 3-4 others.

Q: Is there a link between engagement and vaccination rate?

A: There is a disproportionate amount in the monitoring program.

Q: Are there any specific interventions for pregnant women and the indigenous community?

A: Obstetricians and gynaecology teams have access to the remote patient monitoring and are able to have oversight of patients.

In regard to indigenous engagement, we will ask permission to share their details with a local AHLOs/ACCHO's and work with them to support engagement. At the moment there is about a 50/50 level of engagement and 1:2 strike rate otherwise we will use our own liaison team.

Q: Do you have any problems accessing and supporting disabled people in supported accommodation under NDIS?

A: Patients have a phone app for reporting all their data which includes secure messaging so they can provide clinicians with info – this could be used for tech savy people to self-report that they're OK rather than a phone call.

Q: Do you have Allied Health clinical support for these patients to support their care and recovery and identify potential transitions into needing ongoing care and support with long COVID?

A: Barwon Health are looking at Rehab@Home options for ongoing care.

During wave 2 last year, St Vincent's implemented a 'follow' up call 1 week post conclusion of isolation period to identify people with enduring symptoms and then link them into community health/ambulatory rehabilitation services. It was appreciated ++ by consumers and we identified many who needed

ongoing/multi-disciplinary COVID-specific rehab. The sheer volume of cases for us more recently has meant we can't prioritise this at present, but it was a great element of the model and is an ongoing gap.

Q: Was the follow up call done as part of the home monitoring program?

A: Yes, it was done by our nursing/allied health clinicians as part of our COVID + Community pathway

Q: Is the Rehab@Home going to be a multidisciplinary service with allied health, nursing and medical?

A: It is still in development, but yes we are aiming for a M-D approach which is equivalent to rehab wards - with a mix of remote and in-person service delivery.

Q: What about the asylum seekers in custody who test positive? How are they supported?

A: The department of health has worked with their medical team to provide an equivalent medical support to the virtual home support programs and they have onsite 24h nursing.

Q: Do you mean Commonwealth Dept of Health medical team?

A: they have internal contracted medical teams that look after them

Q: Can you expand on the additional MBS item number GPs?

A: As per the Ministers announcement a new, temporary MBS item for $25 will be available to help general practices cover the extra cost of treating COVID-positive or suspected COVID positive patients face-to-face and ensuring COVID-safe infection controls

Q: What about long COVID and rehabilitation plans?

A: The number of admissions is coming down and there are now a number of controls in place. It is time to put long COVID and rehabilitation front and centre. Suggestion to bring something back to this webinar platform.

Comments

- Our funding models need to better support innovation – many of the constraints are funding related
- Mental health has been a significant issue in terms of anxiety in isolation and the ability to comply with isolation and safety of staff in terms of outreach when vulnerable clients are non-contactable
- Peer or consumer workforce may be useful to understand different perspectives/cultural consultants
- We need to re assess the constraints on exchange of health information between Public Health/notifiable disease info and health services, who support patients. Also GPs. These are more legal than technical