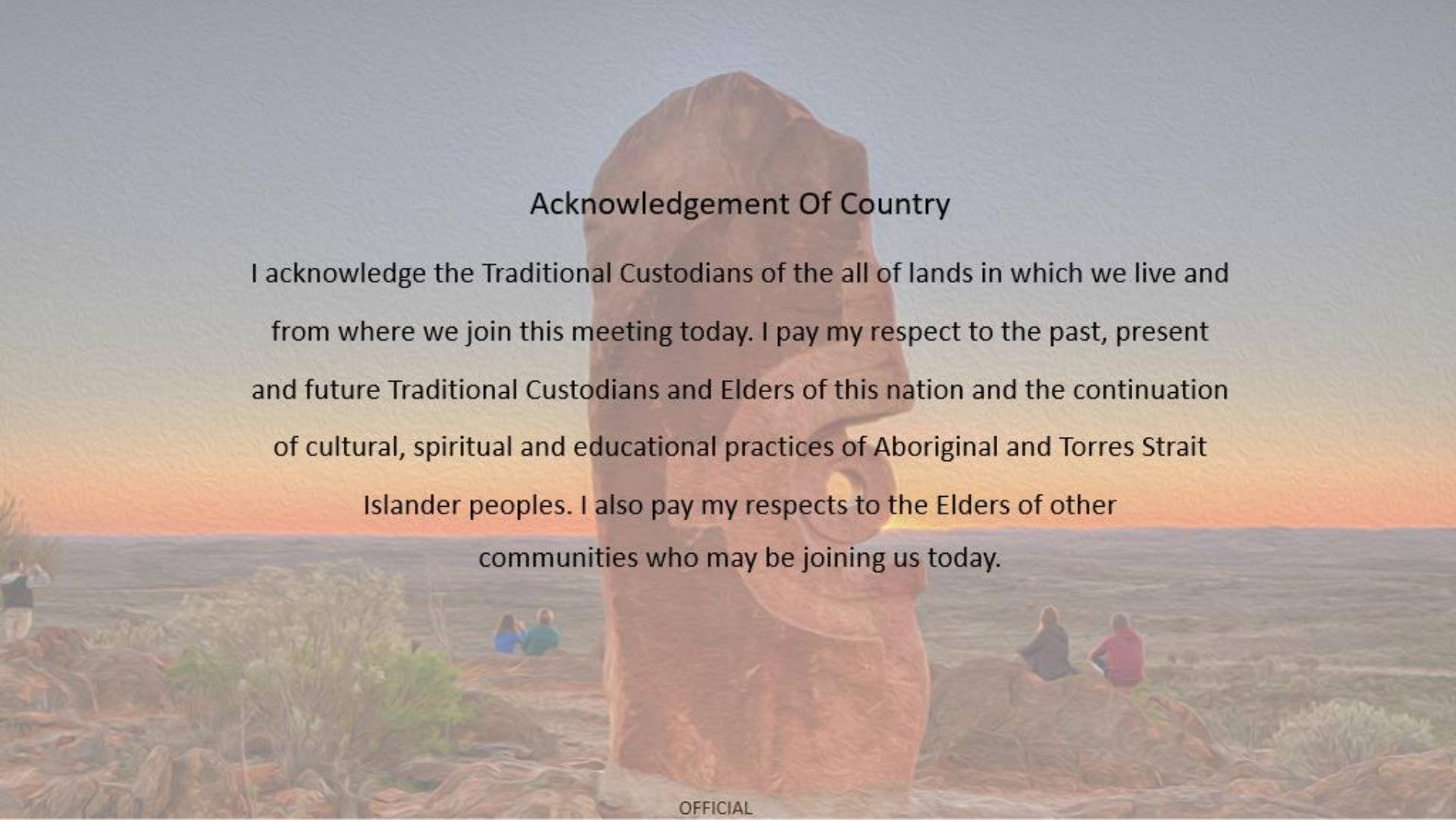
Safer Care Victoria

29 September 2021

Experiences and learnings in delivering the COVID + Pathway

Webinar 1: COVID + Pathway Learning Network webinar series

VICTORIA State Government



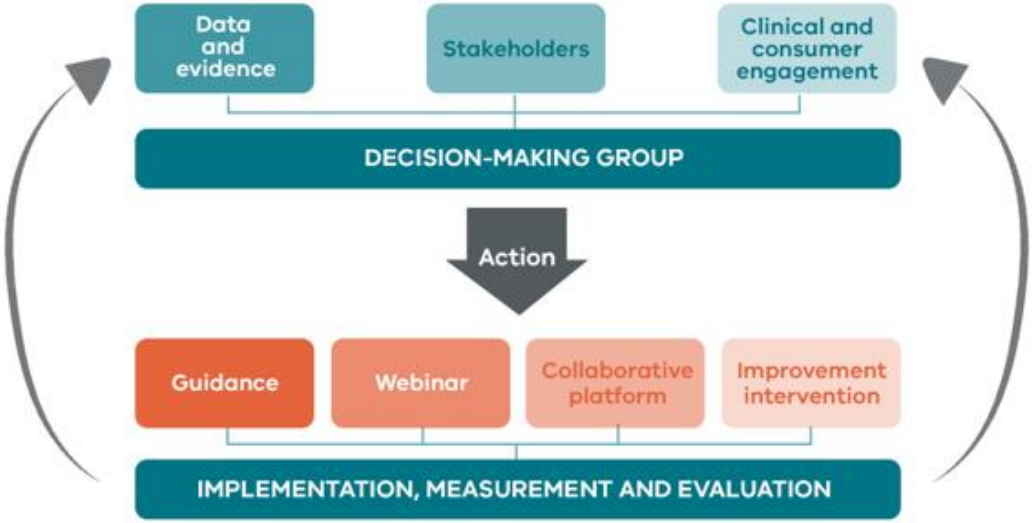
Acknowledgement Of Country

I acknowledge the Traditional Custodians of the all of lands in which we live and from where we join this meeting today. I pay my respect to the past, present and future Traditional Custodians and Elders of this nation and the continuation of cultural, spiritual and educational practices of Aboriginal and Torres Strait Islander peoples. I also pay my respects to the Elders of other communities who may be joining us today.

Webinar series purpose

- Showcase local clinicians who will share their experiences delivering the COVID + Pathways model
- Provide a forum for sharing and collaboration to support the delivery of best practice

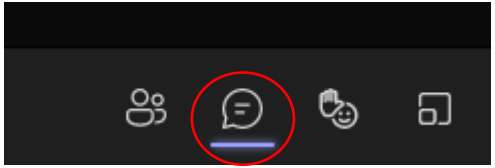
COVID + Pathway Learning Network



Before we start

Questions

Throughout the webinar you can ask questions by typing you question into the chat.



There will also be a dedicated time for questions and discussions.

The presenters will do their best to answer your questions at the end of the presentation.

Overview

Topic	Presenter
COVID + Pathway update	Shannon Wight, Executive Lead COVID + Pathways Program & Executive Director Clinical Operations, Eastern Health
Experiences and learnings in delivering the COVID +Pathway – The North West Melbourne experience	Dr Nicole Allard, coHealth GP, public health and pathway lead Dr Alistair Miller, Respiratory and Sleep Physician and Clinical Lead - West Metro COVID care pathway, The Royal Melbourne Hospital
Questions	All

COVID + Pathways update

Shannon Wight– Executive Lead, COVID + Pathways Program

& Executive Director Clinical Operations, Eastern Health

COVID+ Pathways (C+P) how it's changed

Pre delta - C+P program – as it was

- Devolved Health Service Partnership (HSP) model – collaboration between health services and local community and primary care providers
- Had capacity for 100% clinical and social assessment intake of all C+P clients across each HSP
- Capacity to meet medium acuity complex care remote monitoring/HITH
- Simplified reporting processes just on client numbers in the pathways
- High care patients streamed to appropriate COVID allocated health service
- Public health able to provide clearance across low, medium and high pathways

COVID+ Pathways (C+P) how it's changed

Delta C+P program - what it's becoming

- **Visibility:** Need for standardised statewide definitions and models of care across all metro and regional services
- **Workforce**: Centralised transparency on HSP ability to deal with surge capacity and how to support when needed
- **Risk:** Need to clinically risk stratify all C+ clients into appropriate care pathways where capacity is limited for intake assessments
- **Bed demand:** Scale up medium acuity for community C+ clients and enable supported discharge from hospital to free up beds
- **Intel:** Complex data integrations to enable timely access to C+ intel for pathways, hospitals and LPHUs
- **People**: ongoing consistent and informative messaging to the Victorian community on how to self care with COVID.

C+P priorities

Key priority	Solution to date	Further work underway
Capacity for intake assessments at Metro HSPs	HSPs rediverting own staff, utilising agencies with regional support where available – this is short term solution.	Determine approach for which C+ people do not enter into a monitored pathway (low/ medium/high) instead are allocated to self care and GP engagement. This significantly reduces resource load. Public messaging is key.
Predicted numbers of patients to be managed through the medium acuity/HITH monitoring services	Building surge capacity through PHN and community health partners as community numbers continue to increase whilst also supporting patient centred decision making. Clinical risk stratification over which C+ patients are suitable for supported discharge onto medium pathway	Funding of COVID care navigators at hospitals coordinating early discharge plus expanding discharge protocol established for C+ patients (adults, paeds and maternity) to medium pathway as numbers escalate. And equipment resourcing
Health Service Partnerships devolved governance model	Standardisation across the program. This covers pathway entry, triage/prioritisation processes and case management.	Standardised regional model currently in development.

C+P priorities

Key priority	Solution to date	Further work underway
Clinical oversight across state-wide C+P standardisation approach	C+P Clinical Advisory Group (CP-CAG) established to address C+P risk stratification for DELTA strain.	Clinically determine and endorse proportion of C+P people that do not enter into a monitored pathway (low/ medium/high) instead receive text message referencing self-care and GP if needed – this also distributes capacity pressures
AV interactions - increasing numbers of COVID+ patients and services making 000 calls	Ambulance Emergency Ops Centre (AEOC) coordinating clinician lead calls from pathways program to steaming hospitals and providing community clinicians access to real time sight on streaming hospitals capacity – determining best choice for patient admission options.	Determine approach as finite resourcing and saturation of C+P people in the community will significantly increase 000 calls.

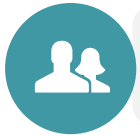
Example: key changes to the medium risk pathway

In response to the predicted surge in cases, the C+P **medium risk pathway** has been optimised to establish several mitigating actions to decompress some of the current pressures which include actions to:

- Optimise and expand community services that are currently helping manage demand – including community health organisations, General Practitioners, Hospital in the Home (HITH) services, and established COVID-19 remote monitoring services.
- Standardised approach across the C+P program which covers pathways entry, triage and risk prioritisations
- Extend current community capacity to assess and, where necessary, monitor medium severity patients with COVID-19 in the community using physiological equipment including pulse oximetry.
- Established criteria for **supported hospital discharge** model with home oxygen therapy for C+patients.
- Preferred use of telehealth rather than phone for assessment of medium severity patients.

C+P – call to action

HSP clinical, operational leads and the department **meet daily** to discuss, review and escalate issues and collaborate on approaches



Ongoing work underway to scale up HITH capacity through Better@Home learnings and UK models

Ongoing capacity building at metro HSPs utilising internal and external levers to increase pathway intake numbers in the hundreds on a daily basis – massive resourcing exercise

Bi-weekly C+P CAG meeting with clinical, sector and consumer focus to ensure right care and right timing – on the right pathway

Family Finding service established to support parents in planning alternate care arrangements for their children in the event they require hospitalisation with COVID-19.

Questions

Please type your question in the chat

Experiences and learnings in delivering the COVID +Pathway – The North West Melbourne experience

Presentation 29 September 2021

Dr. Nicole Allard General Practitioner and clinical and public health lead at cohealth

The Royal Melbourne Hospital

cohealth care for all

phn NORTH WESTERN MELBOURNE An Australian Government Initiative

Western Health

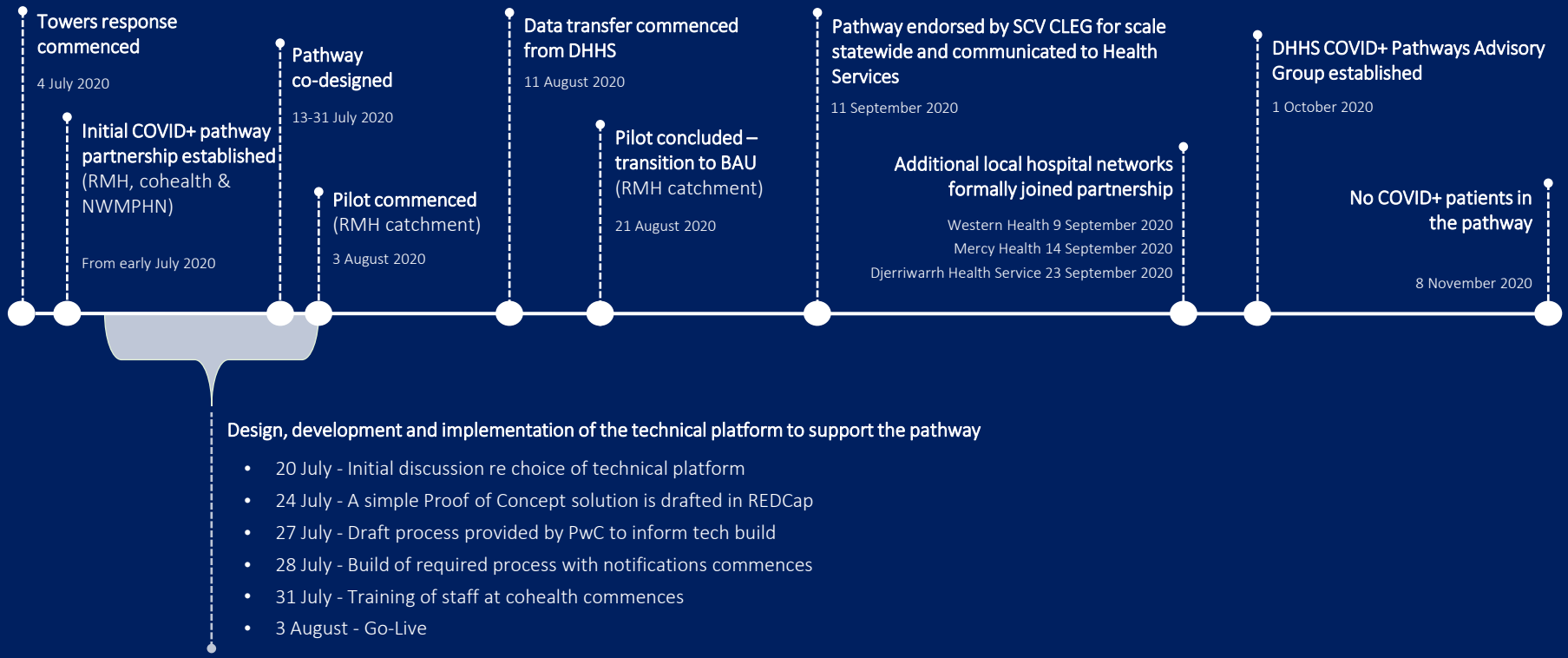
Mercy Health Care first

VICTORIA State Government | Health and Human Services

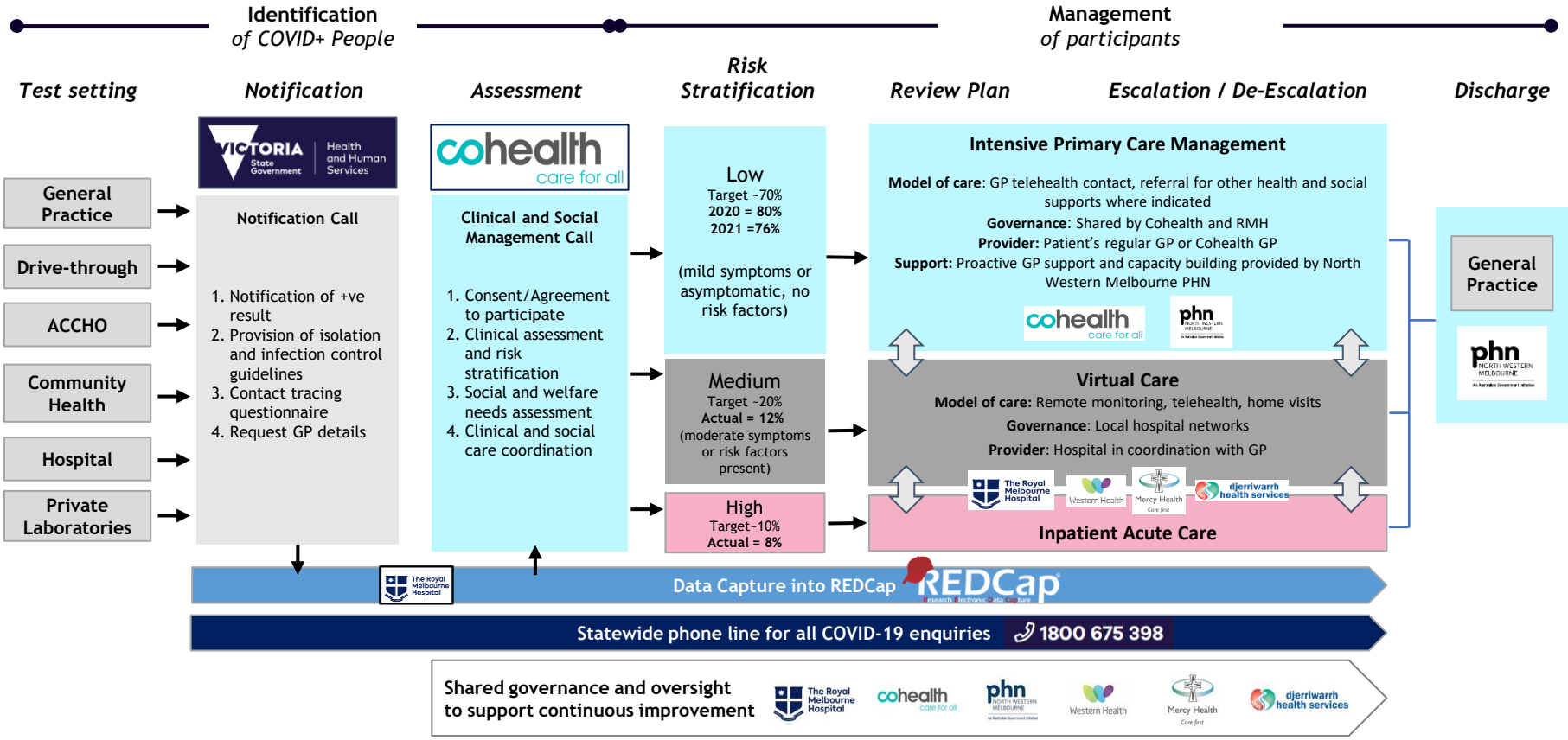
none to declare

Conflicts of interest

2020 Timeline of events



The North Western Melbourne COVID+ Pathway



Management: Low risk group review schedule

Review Schedule		Review Frequency & Delivery							
		Days* 1-4	Personnel	Medium	Additional Services	Days* 5-14 or resolution	Personnel	Medium	Additional Services
Care Pathway	Regular GP	Inital contact	Regular GP	Phone/ video health	Nil	Second Daily	Regular GP	Phone	Nil
	Wraparound	*As required, based on social needs assessment*				*As required, based on social needs assessment*			

*Days since symptom onset, or since date of test if asymptomatic

Frequency may vary based on:
- Clinician discretion
- Patient's health literacy
- Service capacity

Source: adapted from Metro North COVID-19 Virtual Ward - Model of Care, 11 June 2020, discussions with RMH clinicians Prof Ben Cowie, Dr George Braitberg, Dr Martin Dutch and Cohealth GP Dr Nicole Allard

Management: Medium risk group review schedule

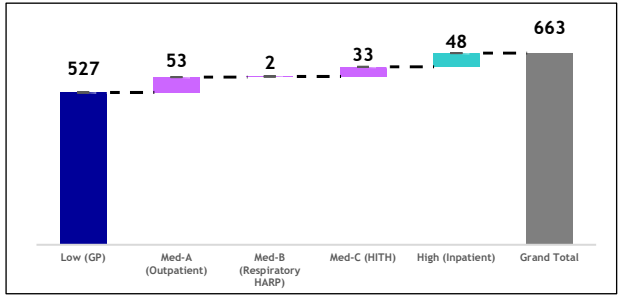
Review Schedule		Review Frequency & Delivery							
		Days* 1-4	Personnel	Medium	Equipment	Days* 5-14	Personnel	Medium	Equipment
Care Pathway	Telehealth	Second Daily	Medical	Telehealth	Nil	Daily	Medical	Telehealth	Nil
	Telehealth + Monitoring	Second Daily	Medical/ HARP Staff	Telehealth	Remote Monitoring	Daily	Medical/ HARP Staff	Telehealth	Remote Monitoring
	HITH	Daily	Medical/ HITH Staff	Telehealth + HITH visits	Remote Monitoring	Daily	Medical/ HITH Staff	Telehealth + HITH visits	Remote Monitoring
	High Risk	Inpatient							

*Days since symptom onset, or since date of test if asymptomatic

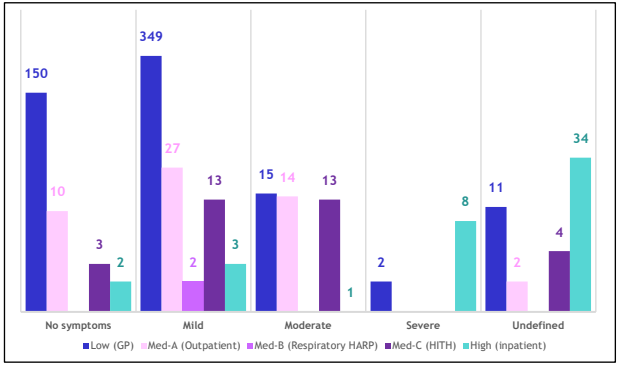
Reference:
Metro North (Queensland) COVID-19 Virtual Ward - Model of Care, 11 June 2020
Discussions with RMH clinicians Prof Ben Cowie, Dr George Braitberg, Dr Martin Dutch and Cohealth GP Dr Nicole Allard

7) Assessment outcomes - Participants referred into clinical pathways

Participants by Initial Clinical Care Pathway
As at 15 Dec 2020, # participants



Participants by Symptom Severity and Initial Pathway
As at 15 Dec 2020, # participants



663 participants were referred initially into one of three clinical pathways which provided care and timely escalations aligned to patients' clinical needs

HIGH

48 (8%) participants were referred directly to ED or inpatient care.

- **45 (97%)** were already in inpatient care prior to notification to cohealth Assessment centre.
- 2 of high risk participants assessed by the assessment centre needed an ambulance to be called to ensure immediate care

MEDIUM

88 (13.3%) participants were referred to the medium risk pathway following initial assessment

- 33 to Med-C (HITH), 2 to Med-B (Respiratory HARP) and 53 to Med-A (Outpatient telehealth)
- **61% (54) remained in their initial clinical pathway** with the escalations / de-escalations within Med A-C and to high and low pathways occurring throughout the course of care
- **Common triggers of escalation within Med pathways** include progression of symptoms requiring further intervention/investigation (e.g. blood tests, imaging), needing in-person assessments or respiratory physician involvement/advice
- **Additional clinical support** provided by HARP team, primarily dietetics, physiotherapy and social work

LOW

527 (79.5 %) participants were referred into low risk pathway with GP oversight through remote monitoring following their initial assessment

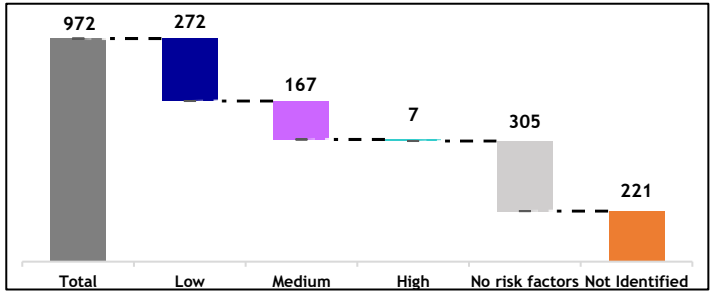
- **349 (66%) participants were identified as experiencing mild symptoms, 15 (3%) were identified as experiencing moderate symptoms and 150 (28%) were asymptomatic whilst symptoms of 11 (2%) were not recorded. 2 participants were identified as severe**
- **189 (36%) participants had no usual GP** and were provided access to GPs through new GP referrals.
- **75% of clients were cared for by GPs external to cohealth**. Referrals to cohealth GPs occurred for existing cohealth clients, those ineligible for Medicare or those living in high rise towers.

1) Day 0 refers to date of symptom onset or date test taken, if asymptomatic. Source: REDCap data extract 3 D[illegible] Miller (Clinical Lead Virtual Ward), Brigitte Cleveland (RMH), Clare Jennings (Cohealth)

54% of pathway participants had social risk factors

5) Assessment outcomes - COVID+ people with social risk factors and needs

Total Social Risk Assessments[1]



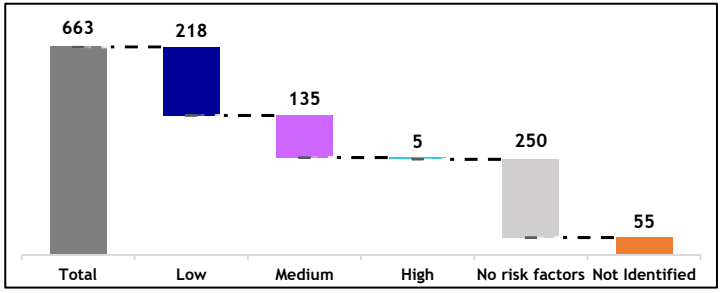
High: homelessness, insecure / unsafe accommodation, AOD withdrawal risk / treatment
Med: Crowded housing/risk of eviction, poor health literacy, language barrier, AOD dependency, pregnancy with no antenatal care, mental health concerns, memory / behavioural problems, no regular GP, financial concerns,
Low: Material requirements to facilitate isolation (food, basic supplies)

- **446 (45%) of people assessed were identified having social risk factors.** Of these, 272 (28%) were classed as low risk, 167 people (20%) as medium risk, and 7 (1%) were high risk requiring immediate intervention
- **31% of people assessed (305) were identified as having no risk factors**

67

- **67 people referred into Hotel Quarantine** due to insecure housing or inability to isolate at home.

Social Risk Assessment for Participants[2] on the pathway



- 358 (54%) of participants assessed were identified as having social risk factors: 218 (33%) were low, 135 (20%) were medium, and 4 (1%) were high requiring immediate intervention.
- 250 (38%) of participants assessed were identified to not have any social risk factors at time of assessment.

Ineligible for Medicare - Unable to access GP care

153

- **153 (23%) participants were ineligible for Medicare**
- 145 (95%) were suitable for low stream and were referred to cohealth GPs (funded by DHHS to provide covid care and support)
- 107 (70%) were international students

"Patient working in aged care continued to work despite having COVID-19 - support provided by working with employer to allow patient to stop going to work without fear of losing her job"

"Intl. students in shared housing with COVID who are at risk of homelessness if housemates informed - referral made to ensure they got to Hotel Quarantine"

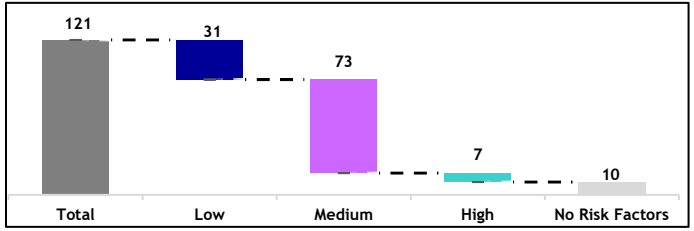
"Patient using heroin was linked with a GP to start an opioid substitution therapy, enabling patient to stay at home"

1) Includes social Risk assessments for all participants as well as those that were already in care or referred to care with other health services or hotel quarantine; hence, total should be greater than total patients referred to a clinical pathways. Clients in aged or custodial care, had already completed their isolation or were uncontactable were not assessment for isolation needs, 2) Social Risk assessment were conducted for all participants streamed to Low and Medium Care Pathways but were rarely undertaken for inpatient participants as priority was clinical care.

12.4% of people assessed required additional supports to enable self-isolation

6) Assessment outcomes - COVID+ people with social risk factors and needs

People requiring supports by social risk assessment



- **972 people were assessed for social and welfare risks**
- **121 (12.4%)** identified they needed additional services to isolate
- 5% were assess with high-risk factors, 60% with medium-risk factors, 25% with low-risk factors whilst 8 % had no risk factors.

Providing advice enabled self-management

- Many people were able to manage their **social and welfare needs** themselves or with help from friends and family **once the Assessment Centre provided information and advice about how to access support.**
- As REDCap only captured when people needed additional support or services, this is often not reflected in the data captured.

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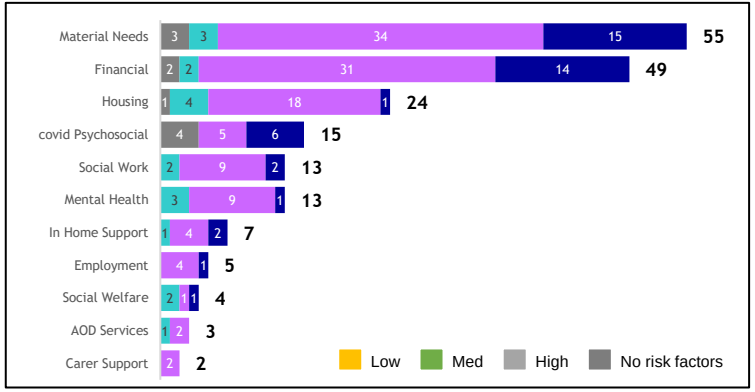
Care Coordination and Support

- **54 people referred to cohealth's Care Navigation team** for care coordination and case management during self-isolation

Additional services required by type[1]



- **Majority of supports required were for material needs, financial assistance and housing needs**

Govt financial support also enabled self-management

23%

- **23% of people assessed (215)** identified that they have or would be accessing government financial supports
- 19.4% of people assessed (189) have or will be applying for the **$1500 pandemic payment**
- 3.6% of people assessed (35) are already being supported via **job keeper or job seeker**

"Overall, it was a good experience getting healthcare, hotel accommodation and financial support from the program. The facilities that included in the program made me feel even more comfortable and It has boosted my confidence to fight against the illness mentally as well as physically."

"cohealth and my GP were amazing throughout the whole process my only down fall was support from my own work company where I got covid - I'm grateful for these guys that got me through it"

1) Not all assessed patients have additional service requirements indicated, and a patient may have multiple service requirements indicated; hence total additional services required does not equate to total assessed patients. Source: RedCap data extract 3 Dec 2020, Kim Webber (Cohealth) for patient scenarios provided on 25 Aug 2020, Clare Jennings (Cohealth)

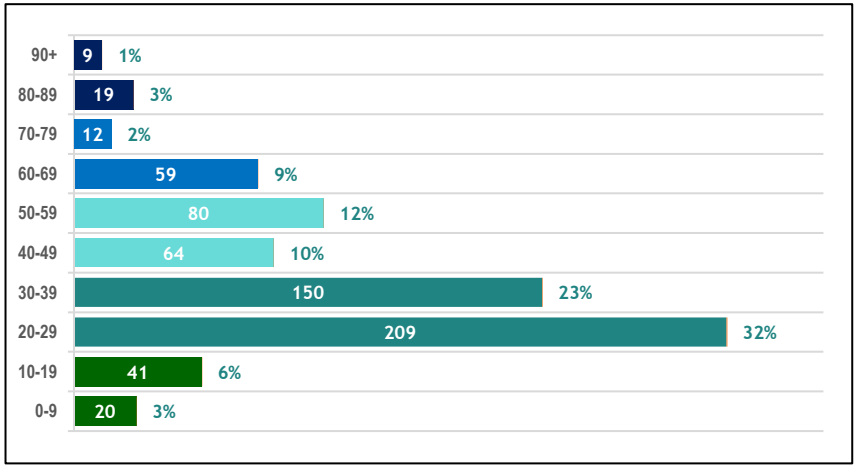
Patient Demographics

Age

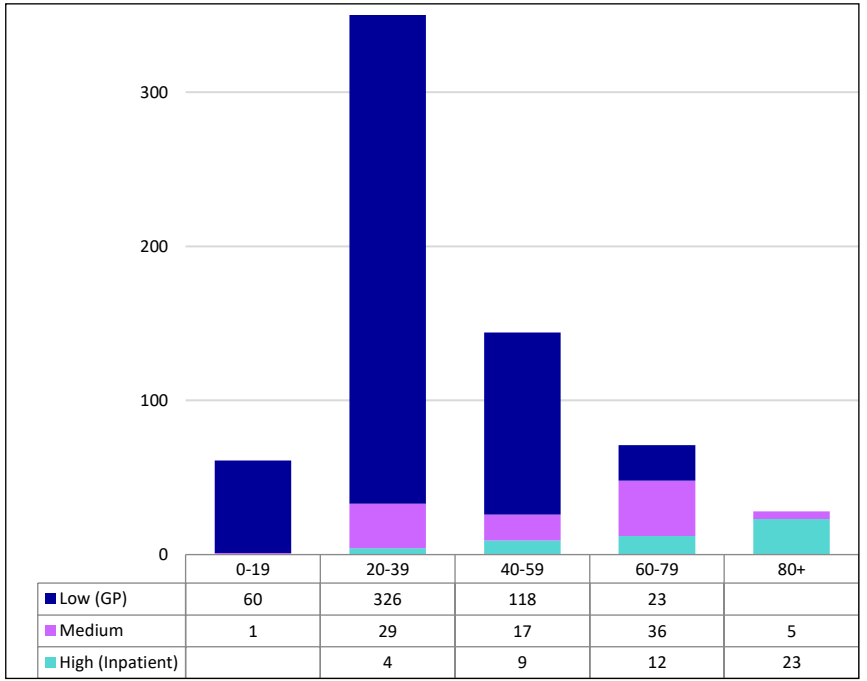
85 % of participants (564) were under the age of 60

- 55% of participants (359) were aged between 20 and 39 years
- 22% of participants (144) were aged between 40 and 59 years
- 9% of participants (61) were under the age of 20

Participants by Age Group



Participants by Age Group and Initial Pathway

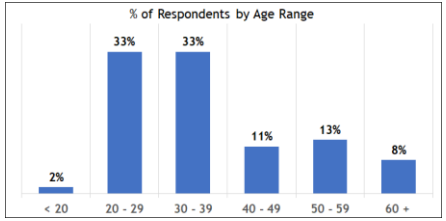


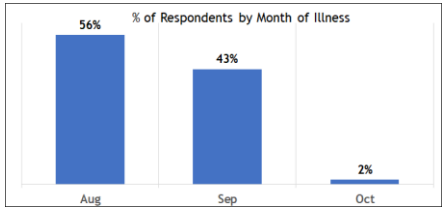
	0-19	20-39	40-59	60-79	80+
Low (GP)	60	326	118	23	
Medium	1	29	17	36	5
High (Inpatient)		4	9	12	23

1) Source: Extract and analysis of cohealth clinical data 31 January 2021

Low Risk Pathway Experience Survey Results

Experience Respondents





- 420 Low-risk pathway experience survey invitation sent via SMS
- 64 (15%) responded
- 4 told us they also received care via health service telehealth at home
- 1 told us they also received care via the hotel quarantine program

What did we learn

Assessment	• **94%** agreed their healthcare needs were assessed at initial contact • **86%** reported they felt completely comfortable to ask questions or raise issues during their initial assessment. A further **13%** felt comfortable to do so to some extent
Healthcare	• **89%** rated the **healthcare they received as good or very good** • **35%** received care from a **GP they had not previously seen** (referred to by the program) • **95%** identified they **knew who to contact for support and medical advice if their condition deteriorated**

Social Supports	• **43% reported they needed additional supports to help them self-isolate**
	  • Material Needs (Food and Other Supplies) were needed by 41% of those that required additional supports
	  • Financial Supports were needed by 38% of those that required additional supports
	• **81%** reported it was easy to get the supports they needed, whilst 16% said it was not needed
	• **81%** rated the care they received to self-isolate (other than health care) as good or very good

Checks in	• **76%** received daily or second daily check-ups whilst in self-isolation • **71%** felt the level of contact was appropriate whilst **14% felt it was too much and 3% not enough** • **8% responded they got so many calls from so many different groups they were unable to comment**
Isolation and Infection Control	• **78%** agreed the program helped them reduce their **physical contacts with others whilst COVID+** • **87%** agreed the program helped them **understand how to prevent transmission within their household**

Source: Client Experience Survey RMH REDCap Extract 3 Feb 2021

Positive Participant Feedback

"Health care team was very supportive and helpful. I appreciate for all the help and support that they gave me and family through this hard time. Keep up the amazing work. Thank you."

"you've been doing a great job"

"Very good. Well managed. Organised. Friendly staff"

"Thank you kindly for all the support. We are amazed"

"cohealth, RMH: Covid ward staff, Telehealth, Hospital @ home, HARP, Ambulance Victoria, St. John's Ambulance Services and our GP were all exemplary in their care."

"Very grateful for the care received"

" Dr Catherine was absolutely amazing. She was very understanding and explained in detail, so I felt more at ease."

"The health workers were so helpful while i was looking after my 5 kids and feeling sick myself"

" Please keep up to the good work"

Participant suggested improvements and criticisms

"include psychology or counselling appointments for people who have to isolate for a considerable amount of time"

"would like more information about being cleared and if and when I should have any further tests"

"asking unnecessary questions"

"a lot of support, but it seemed disjointed (late August), with calls from cohealth, my GP, DHHS nurse, Vic Pol. When you're sick, so many calls can be draining"

"improve on the quality of information delivered as at times different people were telling myself and family members different information"

"Too many people involved. Had to keep repeating my story to many people... appeared to be no linkages with each dept or person spoken to. "

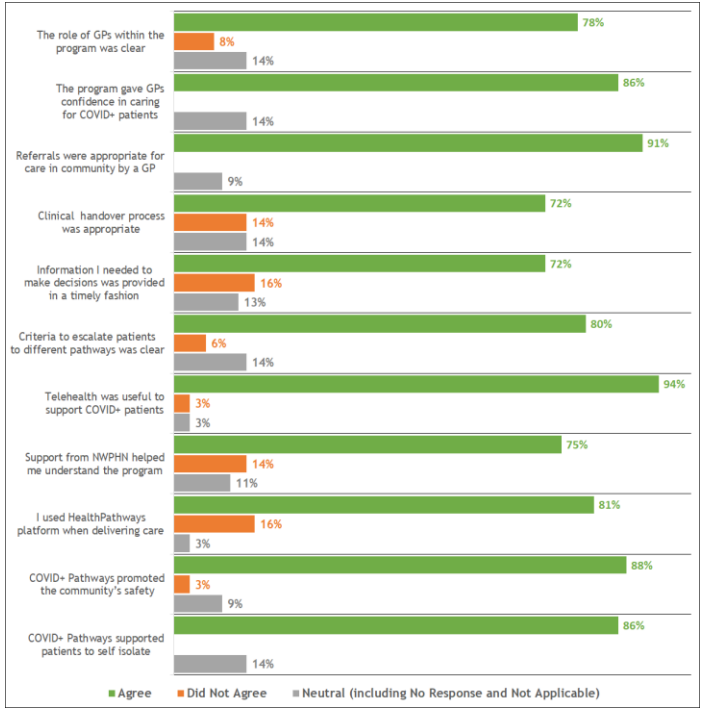
" I got multiple calls from different groups and I received different information from them all. It was very confusing."

" communication between DHHS and cohealth to improve the clearance of COVID 19 and help patient to be effectively out of isolation."

Source: REDCAP Client Experience Survey

We invited GPs involved in the Low-Risk Pathway to share their experiences

GP Experience Survey Results



Who did we hear from and what did they tell us

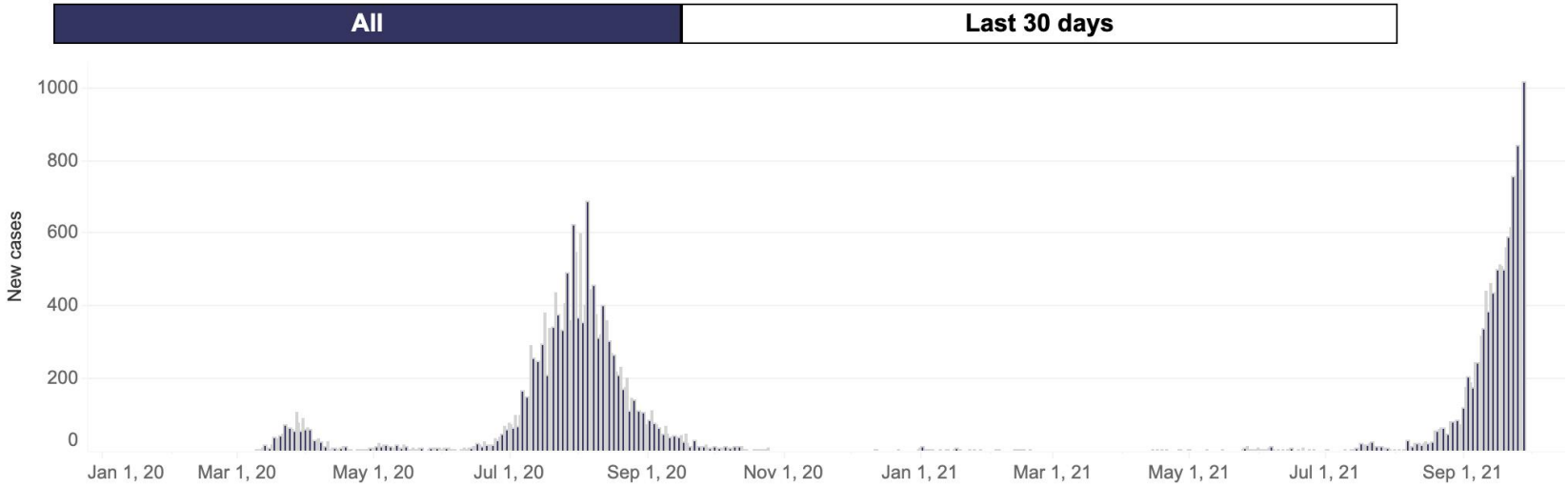
Who did we hear from	• 292 GPs sent survey via email - 22 % (64) responded • 91% of these GPs were in private practice • 60% cared for a single COVID+ patient whilst 7% cared for 10 or more patients • 100% completed REDCap reviews of their patients
Referrals to GPs	• **78%** agreed the patients referred to them were appropriate for being cared for in the community by a GP in the community • **72%** agreed that **clinical handover was appropriate** whilst **14% did not** • **72%** agreed they got the information they needed to make decisions in a timely manner whilst 13% disagreed
Caring for COVID+ Patients	• **86%** agreed that the program gave them confidence in caring for a COVID+ patient in the community. No GP expressed a negative response • **94%** agreed that **telehealth was a useful mechanism** to support COVID+ patients • **80%** agreed the criteria to escalated clients to higher risk pathways was clear
Caring for Community	• **86%** agreed the program helped to support patients to self-isolate • **88%** agreed the program promoted the community's safety
Support for GPs	• **78%** agreed that they understood their role as a GP within the program. • **75%** agreed the support provided by NWPHN helped them understand the program care

Themes	Strengths *"What worked well"*	Challenges *"What didn't work well"*	Opportunities *"What to do differently"*
Governance & Decision Rights	• **Coordination and shared governance** • **Being able to build relationships with partners** • **Right people with the right skills** in leadership • **Daily meetings** with cohealth/PHN • **PwC's facilitative role** in connecting clinical-technical-operational activity	• **The regulatory/legislative framework** served as a barrier for timely data transfer (privacy bureaucracy vs 'do no harm' model) • **Direct representation from Public Health Unit** would have reduced inefficiencies • **Greater clarity was needed between care and compliance functions**	• **Ensure greater clarity of governance structure** • **Implement joint clinical governance decision-making** (clinical, tech, ops) • **Integrate representation of decision-makers** (e.g. Dept. tech/data lead, Public Health) • **Confirm the funding model at scale,** incl. patients with no Medicare • **Leveraging the partnership** to respond to outcomes and connect with communities to support vaccination.
Clinical Pathways	• **Integrated models of care** for improved population and public health outcomes • **Continuity of care** by linking with usual GP • **Patient-centred model** as patients were supported to be cared for at home • **Clear and consistently agreed** clinical pathways across the primary and acute interface • **Well-received education sessions/materials** incl. webinars and HealthPathways	• No specific funding to provide care to **patients with no Medicare and no regular/usual GP** • **Lack of access to shared clinical dataset** for all partner health services eg GPs (note associated opportunities under workforce and technology & data)	• **Identify further opportunities to deliver integrated care** through different models of care with primary and tertiary partners • **Emphasise public health role of model** to stop spread through clinical and social support • **Provide a single source of information** for patients incl. mental health supports • **Give consideration for med/high risk patients** on discharge plan with no usual GP • **Ensure clear documentation for GP referral** • **Develop a standalone HITH service** if patient volumes can be known
Workforce	• **Ability to quickly ramp-up** capacity and capability • **Having assessment centre staff** with experience in mental health, family violence, etc. • **Improved confidence of GPs** to accept patients with this novel virus • **Having technical expertise** across teams • Increased opportunity to **discuss challenging cases** • **Increased collegiality and networking**	• **Managing workforce engagement** (e.g. managing GP interest unaware of upstream data flow issue and changes to department processes)	• **Agree clear roles and responsibilities** upfront • **Continue to upskill GPs** through training / education • **Undertake early preparation** to assist with rapid deployment incl. at-scale workforce • **Utilise a fit for purpose shared care digital platform** to provide value for all clinicians to enable integrated care and increased compliance with data collection

Themes	Strengths *"What worked well"*	Challenges *"What didn't work well"*	Opportunities *"What to do differently"*
Operations & Processes	• **Willingness to collaborate** from trusted and existing partnerships (e.g. RMH clinical lead support in GP education) • **Ability to trial and test processes live** • **Ability to notify GPs** via RedCap • **Having a single point of contact** within each organisation	• **Lack of consistency** in following mapped out processes • **Lack of clear and consistent communication** (e.g., discussions in different working groups) • **Lack of refinement of tail-end processes** (e.g., discharge process) • **Inability to test processes at scale** • **Lack of a standalone HITH service** (competing demands from usual services, difficulty allocating capacity without patient volume) • **GPs working part-time / lack of email access**	• **Identify further opportunities to automate** • **Undertake evaluation** to improve processes and workflows ensuring a continuous improvement approach • **Increase consumer participation** in design and feedback • **Utilise a document repository** for consistent communication across teams • **Agree the role of police** for welfare checks for non-contactable people • **Refine the GP survey processes**, particularly for part-time GPs and those who do not regularly use emails • **Shared data / information system** • **Agreed acknowledgement of partner contributions**
Technology & Data	• **Adaptability and speed of implementation** of RedCap as a standalone platform	• **Consent process limited data feed,** constraining outcomes • **A lack of transparency** due to pending data sharing agreement caused confusion and miscommunication • **A lack of clear data** for reporting required assumptions to be investigated further • **Lack of access to a multi-party data platform and limitations with RedCap** • **Manual data transfer** from DHHS and upload	• **Implement a multi-party data sharing agreement** (RMH, cohealth, PHN) • **Use a more robust, fit for purpose solution** including leveraging electronic medical records infrastructure • **Undertake robust monitoring of processes and outcomes** • **Utilise e-health and m-health solutions** for remote monitoring • Working more closely with DHHS to **automate data flow**
Org. Structure	• **Alignment of RMH services based on patient acuity** (vs funding) • **Establishment of internal structures at RMH** for	• Delay in bringing on additional health services across the West Metro Health Service Partnership region	• **Operationalise pathways into existing structures** to provide flexibility to step up/down • **Potential for better liaising across the North**

September 2021

Daily new cases in Victoria

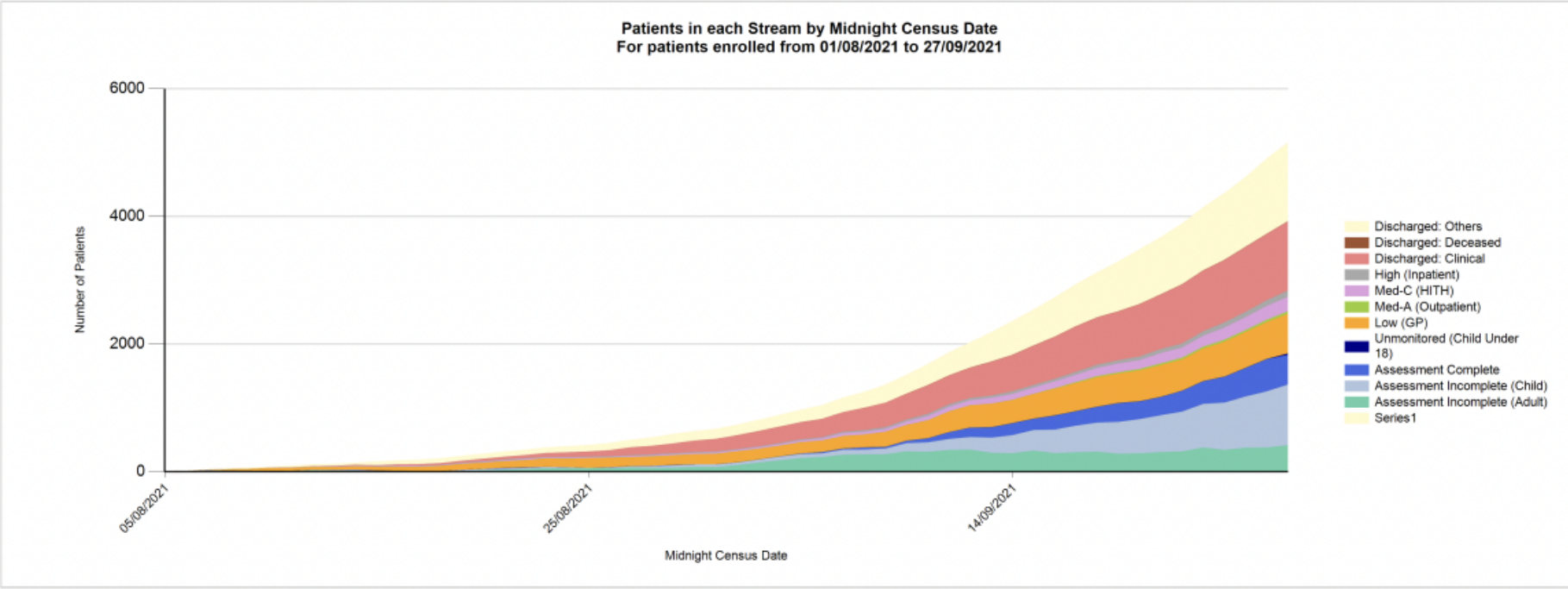


https://www.coronavirus.vic.gov.au/victorian-coronavirus-covid-19-data Accessed 28/9/2021

Cases by age group and gender

https://www.coronavirus.vic.gov.au/victorian-coronavirus-covid-19-data Accessed 28/9/2021

Patients in each Stream over Time



Since early August 5000 individuals have been referred to the pathway
77.5 % low care with GPs, 17.5 % medium care and 5% admitted as inpatients
84% of GPs completing surveys when requested

Adaptions to increasing burden

- We have increased our capacity
- We have modified our assessment
- Children are considered as part of the household and not assessed separately
- We are increasing staffing numbers
- The hospital services are standing up virtual care models to create more medium capacity
- We are working with Ambulance to improve timely transfer

General practice does the heavy lifting when it comes to care

- 546 private GPs in 378 practices have participated supported by NWMPHN
- 80% of GPs have agreed to participate
- Numbers per practice range from low (2) to “hero status” (116)
- Competing priorities, furloughed staff, clinic closures and a focus and incentive payment for vaccination affect GP readiness to accept patients
- While Medicare ineligible patients are less proportionally this wave numbers are growing

Summary

- The North Western pathway is unique as multiple health services share a system
- Utilisation of GP ‘regular care” in low stream
- Creating a workforce of GPs more experienced in managing COVID in the community
- Uses community health to assess and provide in community social supports
- Has formed strong partnerships and rapid problem solving across the network.

Acknowledgments

- The over GPS and their practices who have participated in pathways
- The work of the NWMPHN in both their commitment to promoting decentralised care model and doing the practical work of linking GPS and supporting GPs in the program.
- Melbourne Health, Werribee Mercy Western Health and WH Bacchus Marsh/ DJHS
- The cohealth COVID 19 team.

The Royal Melbourne Hospital

phn NORTH WESTERN MELBOURNE

An Australian Government Initiative

Western Health

Mercy Health

Questions

Please type your question in the chat

Future webinars

- Interested in sharing your services' experiences, innovations and learnings in delivering the COVID+ Pathway at an upcoming webinar?
- Did not receive this webinar invite directly and would like to register for future webinars?

  Email us:

centresofclinicalexcellence@safercare.vic.gov.au

Survey

Please complete our short survey to help us identify future topics for the COVID + Pathway Learning Network webinar series.

Survey