COVID + Learning Network Webinar Questions

OFFICIAL

Launch – Updated COVID-19 Positive Care Pathways

Presenter: Shannon Wight, Executive Director COVID + Pathways, Department of Health

Questions and Answers

Q: Is there a link somewhere to the text message questionnaires?

A: The link is not released yet but will be on the 29 October as a soft launch and then it will go live early next week. If you email covid+pathways@health.vic.gov.au the team can send you the questions once they are live.

Q: Will the pathway be applied to the regions? Subregions or only metro?

A: Small communities and regions often have their own unique ways of working and the pathways team were mindful not to duplicate the work that has already been done in regional areas. The pathways team will begin the work shortly with regional areas.

Q: Will the initial questionnaire go out to all covid positive patients in metro and regional? And where/how will the information then be delivered to relevant CPP?

A: If responses indicate more support is needed then this is flagged to C+P HSPs to contact via text and a phone call.

Q: For example, a newly diagnosed patient in Ararat will receive the triage questionnaire via text and if any flags, this will be identified centrally and then forwarded to the EGHS/BHS COVID positive pathway?

A: In the COVID positive pathway, lab results land in TREVI (public health system) – this activates the survey. Then if the survey responses indicate that the client is not suitable to self-care then this will flow through in TREVI to TRACE (Local PHU system) that the C+ client needs an assessment call for pathway allocation.

Q: Does Healthdirect link COVID positive patients with social support by providing a number or it is a warm handover to a social support agency?

A: Healthdirect links clients into supports depending on their individual needs. Communication will depend on whether the client has been informed or if a warm handover is required.

Q: Could the pathway let the patient's GP know when they are positive and when they enter a pathway for GPs need to collect the feedback on the care plan for the patient?

A: It has been the intention and priority to have GPs involved in each step of the COVID + Pathway development. There are exemplary pockets around metropolitan areas and in some cases, more GPs are keen to be involved. A survey of GP's has also been developed to see who would like to be engaged to care for the person with COVID-19.

It has been important to listen to feedback to design the pathways and workflows to reflect what is happening. In the South East, things have evolved differently depending on the demand. For example, health services are using internal GP's, there is also local GP engagement and larger practices which are able to take on many patients. In this region, there are many more people without a GP compared to last year.

Q: What percentage of COVID positive patients are declining involvement at the consent step?

A: 85% of the patients respond to the text messages. Those who did not reply will automatically be classified as Priority 2 (P2) and will receive a phone call (with an interpreter if required).

Q: What is the process and responsibility of the healthcare services/providers when people are in the program but not answering calls, people who did not get or cannot read the text message since they are culturally and linguistically diverse (CALD)?

A: The people in this group who do not actively report symptoms or cease to report symptoms are also prioritised for telephone follow-up and a welfare check if uncontactable.

Q: If a person doesn't consent to involvement in the pathway is there a referral to a GP?

A: A follow up phone call will be initiated. There are safety nets around the person to support them. As yet we have not configured the pathway to Aboriginal and Torres Strait Islander populations. This work is dynamic and evolving. If we don't hit the mark the first time, then we will build upon the work and refine as we go.

Q: Given the fairly narrow clinical criteria and time-sensitivity, are questions to trigger referral for Sotrovimab embedded in Health Direct triage (or for other pharmacotherapies as they come online?

A: We are doing this routinely in triage within our pathway (particularly for Priority 1 and Priority 2 at triage) and this has been very effective.

Q: Is there a central point for resources, pathways etc so we can ensure a consistent approach across the state?

A: This is currently a work-in-progress. Once available, more details will be shared.

Q: Is there a GP clinical reference group at Safer care for this work?

A: Not at this time however GP's have been engaged by the Department of Health to develop and inform the COVID + Pathways.

Q: If rapid antigen testing at home becomes a thing how will people enter a pathway if they are positive?

A: All testing results will still be recorded by a lab and/or a public health team, which then activates the client into the pathway intake if clinically and socially required

Q: Is there a possible timeline for Healthdirect intake assessments for regional areas?

A: This work and a standardised approach is currently be scoped and the timeline is yet to be determined – but prioritised.

Q: Is there a lag time when a patient may contact their GP before being contacted by the triage service? If so, what should GP do?

A: Yes, there may be a lag between GP consult and trigae service. We encourage the COVID + Community to contact their GP when advised of result using telehealth or phone consult. The GP should appropriately treat the COVID positive client for their symptoms and monitor their care as part of a GP's clinical governance over that client.

Key comments

- Engage with GP's locally in each region to incorporate their views in the development of these pathways
- Triage needs to align with eligibility for Sotrovimab and Budesonide as well
- Please check with PHNs before sending out surveys from SCV to GPs as some regions have done this already and would be good to augment not duplicate
- A critical issue has been to understand that the delays involved in the shift from one database to another e.g. TEST, Tracker, TREVI, Trace, Monitor. Now moving to have active clinical management, monitor and treat sit alongside the Public Health Response (Trace)
- We have a gold opportunity to demonstrate that Victoria is the first state prepared to break down federated funding in the interests of the best outcomes for Victorian patients and the sustainability of Victorian general practice (and therefore the health system at large)
- Agree that public health messaging is tough – in one breath we are telling people that COVID kills and in the next we are saying that they can manage independently. Both are true but this is the nuance of messaging and how we reassure that health outcomes are good for those that are taking precautions and vaccinated, and that self-care can be effective, but those that need more help will access this predominantly in their own home. This needs a room of clever communications teams to get the message out. We need a shift in the dialogue and tailored messaging for different groups and cultures.
- Given that at least 70% of these patients will be cared for by GP's under the low stream, it is important to ensure GPs are familiar with any patient resources supplied (some of the PHNs in Metro area already use these resources). It is good to combine existing and new resources.