Safer Care Victoria

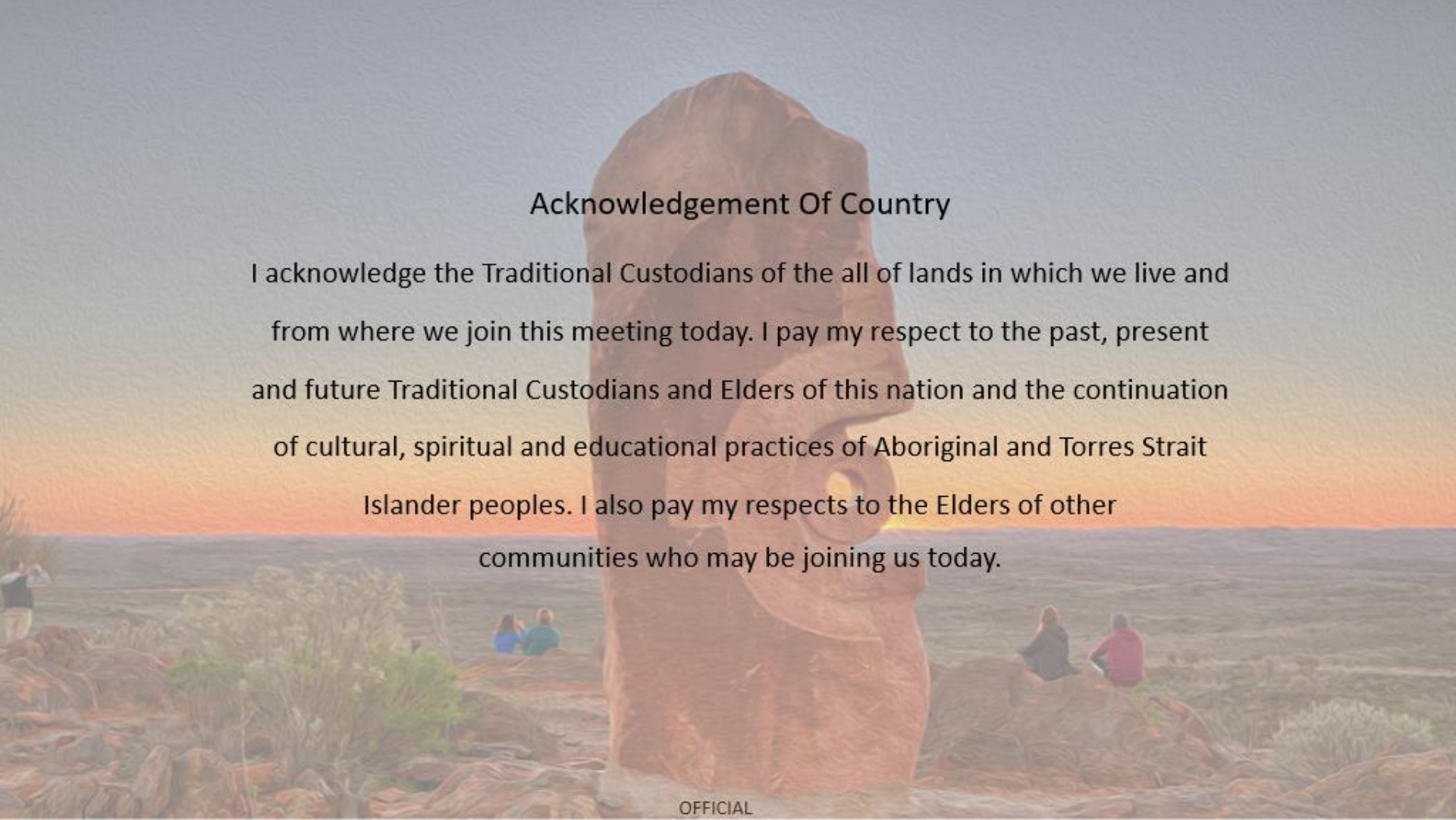
Wednesday 15 December, 2021

COVID + Pathway Learning Network webinar series

Webinar 12: The Time is Now, Managing Patient Flow beyond COVID-19

OFFICIAL

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.

Overview

Topic	Presenter
COVID + Pathway update	**Shannon Wight** Executive Lead, COVID + Pathways, Department of Health
Sotrovimab/Ronapreve update	**Prof Michael Dooley** Director of Pharmacy, Alfred Health. Professor of Clinical Pharmacy, Centre for Medicine Use and Safety, Monash University. Adjunct Professor, Department of Epidemiology and Preventive Medicine, School of Public Health and Preventive Medicine, Monash University
Questions	
The Time is Now, Managing Patient Flow beyond COVID-19	**Dean Pritchard** Northern Health/ SCV Faculty Timely Care **Kiri Stuart** Peninsula Health **Dr Amith Shetty** NSW Health
Questions	

COVID + Pathways update

Shannon Wight – Executive Director, COVID + Pathways Program

& Executive Director Clinical Operations, Eastern Health

Current priorities: Self-care program

C+P key priorities

1 Self-Care Program

- Designed for C+ individuals who are considered very low risk and capable of self-managing their own care
- Directs precious resources to those most at risk and promotes self-care,
- Anticipated self-care allocation may grow over time as the risk profile shifts as more Australian's become double vaccinated.

Criteria

To be able to self-care, individuals **must meet** the following criteria:

- > 12 and <65 years of age
- Fully vaccinated (two doses of a COVID-19 vaccine)
- Not pregnant
- No barrier to home isolation
- Nil or mild symptoms
- None or low-risk comorbidities

Model

- Individual **consents** to self care
- Individual **able to self-care** receives an SMS with information on who to call / where to go for help (if needed) and provided web information links
- Individual is **not entered** into the C+P program
- Individual **not referred to GP**
- Individual self governance **and choice**

Journey

Individual self-monitors symptoms

If individual starts to feel unwell…

Individual may contact their GP or Nurse on Call for assistance

If required, individual may receive care from a GP (off Covid Positive Pathways)

If individual's condition continues to deteriorate…

Individual may call ED Virtual Triage, be referred for the ED by their GP for further assessment or may call 000.

If admitted to a HITH program, clinical governance is with health service until point of discharge. Then individual may choose C+P program or GP for remaining COVID+ care if needed

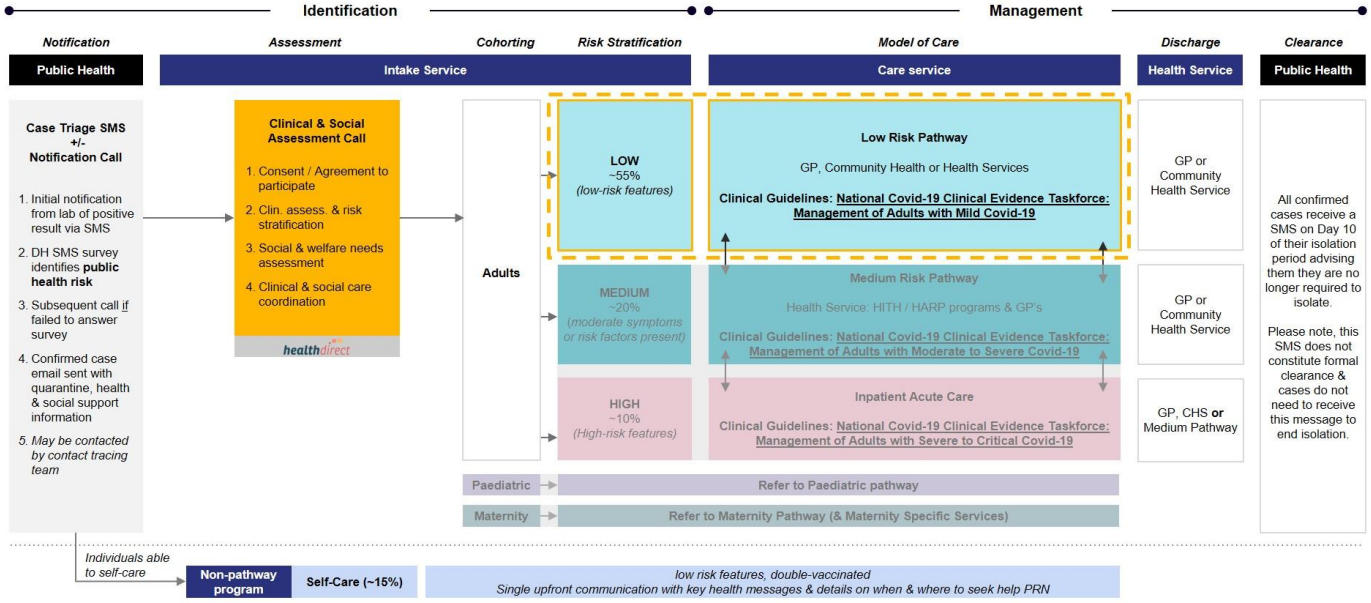
Clinical Risk Process: SCV Clinical Advisory Group and C+P Taskforce: Extensive sector wide and departmental consultation with repeated clinical algorithm analysis on self care allocations

Current priorities cont'd

C+P key priorities

2 **Establishment of National C+P model**

- Commonwealth, Healthdirect Australia and Victoria are working together to define the national C+P rollout, with Victoria identified as the leading jurisdiction.
- Oversee the pilot project to successfully transition Healthdirect to undertake all GP referrals in the NE, as part of the C+P program.
- Enable stakeholder engagement to deliver the pilot project and identify opportunities to ensure future scalability.
- North East leading the pilot site with the North East HSP.



COVID Positive Pathways Program
Vic Department of Health

Current priorities cont'd

C+P key priorities

3	**Disability**	• Working closely with SRS's to identify who can be cared for on a pathway • Work underway to review pathway eligibility in order to ensure people living in supported residential services and disability accommodation settings receive the clinical care they require at the right time, in the right place throughout the duration of their illness
4	**Public messaging**	• Updated, informative messaging and web content to the Victorian community on how to self-care and live with COVID https://www.coronavirus.vic.gov.au/managing-covid-19-home https://www.coronavirus.vic.gov.au/covid-positive-pathways
5	**Consideration/ reform opportunities**	• Consideration to expand the C+P program to support patients with chronic disease/ frequent presenters. • Work underway between the department and SCV to consider opportunities to integrate long-COVID care into the 'pathways' model and consult with primary care in delivering support.

Sotrovimab/Ronapreve update

Prof Michael Dooley

Director of Pharmacy, Alfred Health. Professor of Clinical Pharmacy, Centre for Medicine Use and Safety, Monash University. Adjunct Professor, Department of Epidemiology and Preventive Medicine, School of Public Health and Preventive Medicine, Monash University

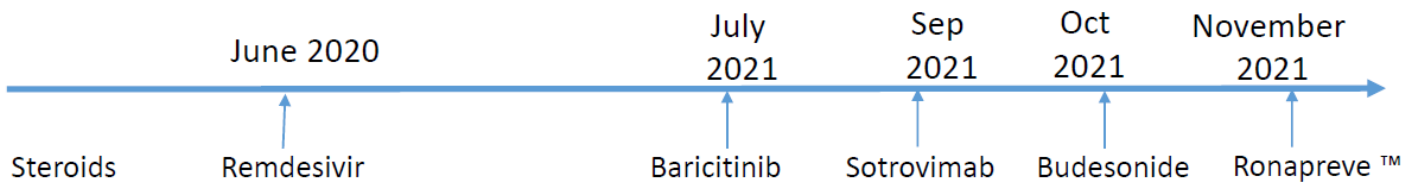
Medications for COVID-19

Prophylaxis

Pre exposure

Post exposure

x



Treatment

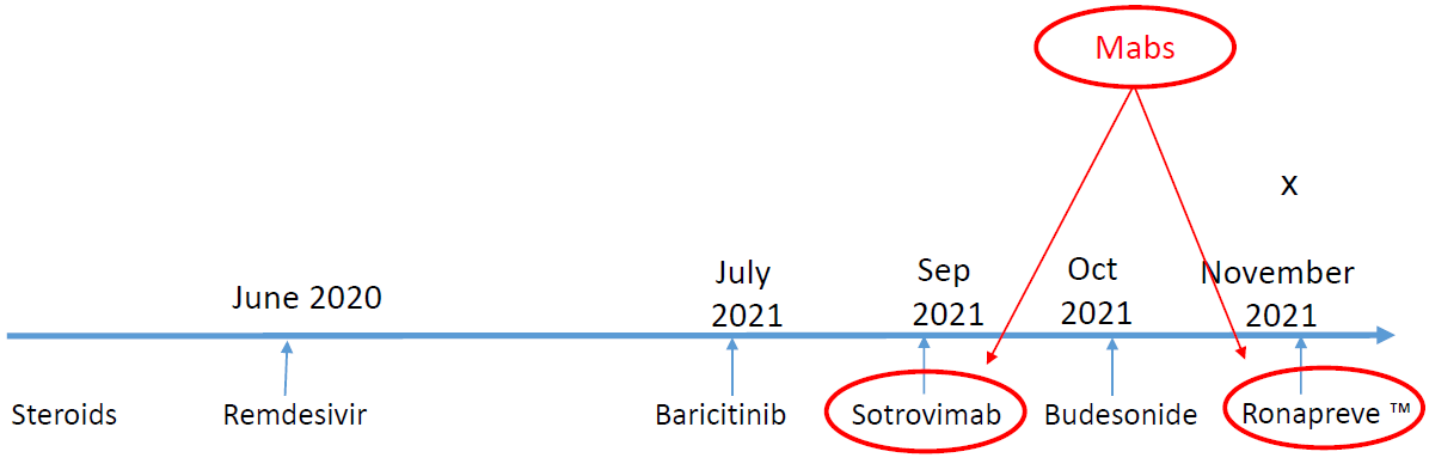
	Steroids	Remdesivir	Baricitinib	Sotrovimab	Budesonide	Ronapreve ™
Mild				x	x	x
Moderate	x	x	x			x
Severe	x	x	x			x
Critical	x					x

Medications for COVID-19

Prophylaxis

Pre exposure

Post exposure

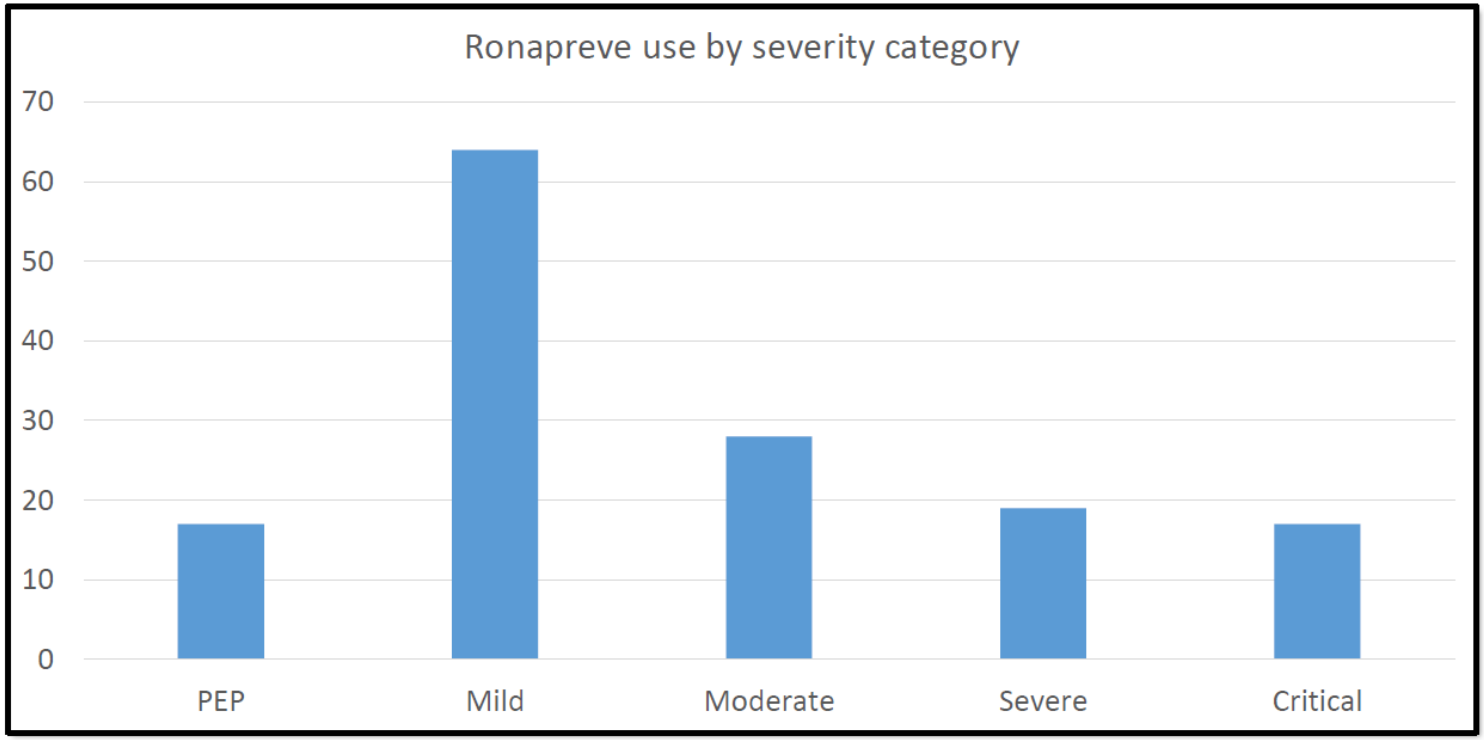


Treatment

Mild				x	x	x
Moderate	x	x	x			x
Severe	x	x	x			x
Critical	x					x

Ronapreve ™ (casirivimab + imdevimab)

Indication	TGA approved	National Clinical Guidelines
Post Exposure Prophylaxis	1200mg IV or sc single dose (600mg casirivimab + 600mg imdevimab) **Post-exposure prophylaxis** Ronapreve is indicated for the prevention of COVID-19 in adults and adolescents (aged 12 years and older and weighing at least 40 kg) who have been exposed to SARS-CoV-2 AND who either: • have a medical condition making them unlikely to respond to or be protected by vaccination, OR • are not vaccinated against COVID-19.	Conditional recommendation Consider using subcutaneous casirivimab plus imdevimab as prophylaxis in seronegative or PCR-negative close household contacts of individuals with confirmed COVID-19.
Treatment Symptomatic Mild	1200mg IV or sc single dose (600mg casirivimab + 600mg imdevimab) **Treatment** Ronapreve is indicated for the treatment of COVID-19 in adults and adolescents (aged 12 years and older and weighing at least 40 kg) who do not require supplemental oxygen for COVID-19 and who are at increased risk of progressing to severe COVID-19.	Conditional recommendation Consider using casirivimab plus imdevimab for the treatment of COVID-19 in **mild outpatients** who have one or more risk factors for disease progression within 7 days of onset of symptoms.
Treatment Symptomatic moderate/severe/critical	8000mg IV (4000mg casirivimab + 4000mg imdevimab)	Conditional recommendation Consider using casirivimab plus imdevimab in **seronegative patients** hospitalised with moderate to critical COVID-19. Not recommended Do not use casirivimab plus imdevimab in **seropositive patients** hospitalised with moderate to critical COVID-19.


Ronapreve use by severity category
70
60
50
40
30
20
10
0
PEP
Mild
Moderate
Severe
Critical

Post Exposure Prophylaxis

ACCESS CRITERIA (tick each criteria that applies to confirm the access criteria has been met)

VACCINATION STATUS (must meet one):

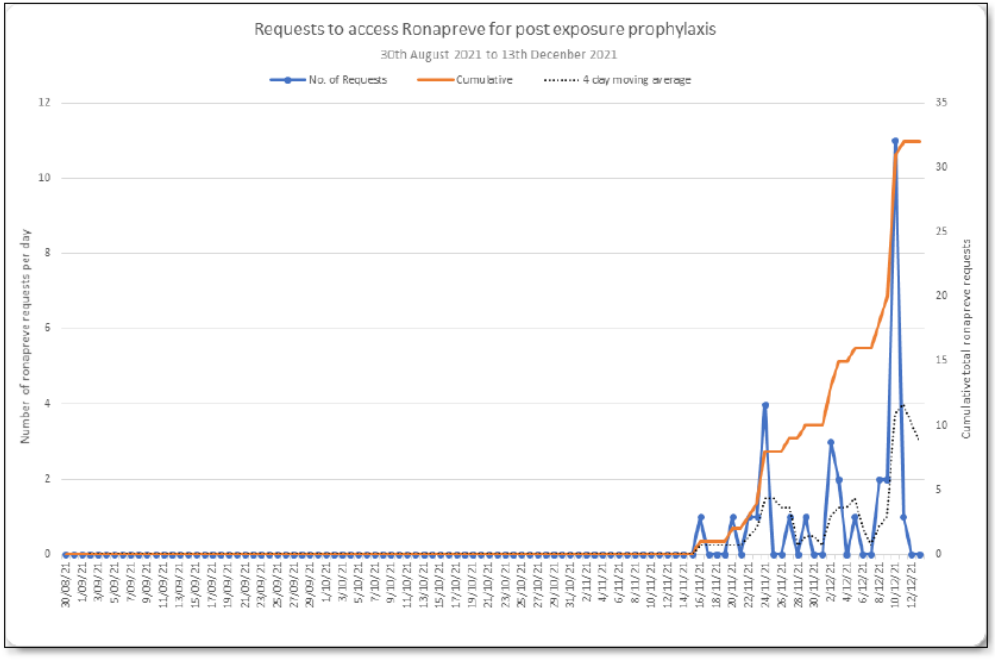
- ☐ Not vaccinated against COVID-19 (unvaccinated or partially vaccinated)
- ☐ Immunosuppressed regardless of vaccine status (please select which apply below)
  - ☐ Primary or acquired immunodeficiency
  - ☐ Haematologic neoplasms: leukaemias, lymphomas, myelodysplastic syndromes
  - ☐ Post-transplant: solid organ (on immunosuppressive therapy), haematopoietic stem cell transplant (within 24 months)
  - ☐ Immunocompromised due to primary or acquired (HIV/AIDS) immunodeficiency
  - ☐ Other significantly immunocompromising conditions. Specify _____
  - ☐ Immunosuppressive therapy (current or recent) examples include:
    - Chemotherapy or radiotherapy
    - High-dose corticosteroids (≥20 mg of prednisone per day, or equivalent) for ≥14 days
    - All biologics and most disease-modifying anti-rheumatic drugs (DMARDs)

MUST MEET ALL (Age ≥ 18 years, or aged ≥12 and <18 years of age and weighing ≥40kg):

- ☐ Contact of individual with confirmed SARS-Cov2
  - ☐ Household contact OR
  - ☐ Care setting contact of significant exposure
- ☐ Asymptomatic or negative PCR result (NOTE: symptomatic patients awaiting PCR results are not eligible)
- ☐ ≤4 days from exposure (Day of first exposure is day 0)

MUST MEET ONE OR MORE BELOW (Unless immunocompromised regardless of vaccine status):

- ☐ Diabetes mellitus treated with medication (Type 1 or 2)
- ☐ Obesity (BMI > 30 kg/m2 or for paediatric patients BMI >95th centile for age)
- ☐ Chronic kidney disease (i.e. eGFR < 60 by MDRD)
- ☐ Cardiovascular disease (including hypertension treated with medication)
- ☐ Age ≥ 50 years
- ☐ Chronic lung disease (including asthma treated with regular medication)
- ☐ Chronic liver disease
- ☐ For paediatric patients (≥12 years): Other significant comorbidities including sickle cell disease or Paediatric Complex Chronic Conditions (PCCC): congenital and genetic, cardiovascular, gastrointestinal, malignancies, metabolic, neuromuscular, renal and respiratory conditions



Exposure	N (%)
Care setting	58.8
Household	41.2

Vaccine status	N (%)
Unvaccinated or partial	29.4
Immunocompromised	70.6

Treatment
Symptomatic Mild

ACCESS CRITERIA (tick each criteria that applies to confirm the access criteria has been met)

VACCINATION STATUS (must meet one):

- ☐ Unvaccinated OR
- ☐ Partially vaccinated OR
- ☐ Immunosuppressed regardless of vaccine status (please select which apply below)
  - ☐ Primary or acquired immunodeficiency
  - ☐ Haematologic neoplasms: leukaemias, lymphomas, myelodysplastic syndromes
  - ☐ Post-transplant: solid organ (on immunosuppressive therapy), haematopoietic stem cell transplant (within 24 months)
  - ☐ Immunocompromised due to primary or acquired (HIV/AIDS) immunodeficiency
  - ☐ Other significantly immunocompromising conditions. Specify _____
  - ☐ Immunosuppressive therapy (current or recent) examples include:
    - Chemotherapy or radiotherapy
    - High-dose corticosteroids (≥20 mg of prednisone per day, or equivalent) for ≥14 days
    - All biologics and most disease-modifying anti-rheumatic drugs (DMARDs)

MUST MEET ALL (Age ≥ 18 years, or aged ≥12 and <18 years of age and weighing ≥40kg):

- ☐ Confirmed SARS-CoV2
- ☐ No oxygen requirements

SYMPTOM ONSET AND DRUG INFORMATION (must meet one)

Date of symptom onset: _____

- ☐ Day 0-5 from symptom onset: sotrovimab 500mg IV
- ☐ Day 6-7 from symptom onset: Ronapreve® 1200mg (600mg of both casirivimab and imdevimab)
  - ☐ S/C (4x2.5ml injection)
  - ☐ IV

MUST MEET ONE OR MORE BELOW (Unless immunosuppressed regardless of vaccine status):

- ☐ Diabetes mellitus treated with medication (Type 1 or 2)
- ☐ Obesity (BMI > 30 kg/m2 or for paediatric patients BMI >95th centile for age)
- ☐ Chronic kidney disease (i.e. eGFR < 60 by MDRD)
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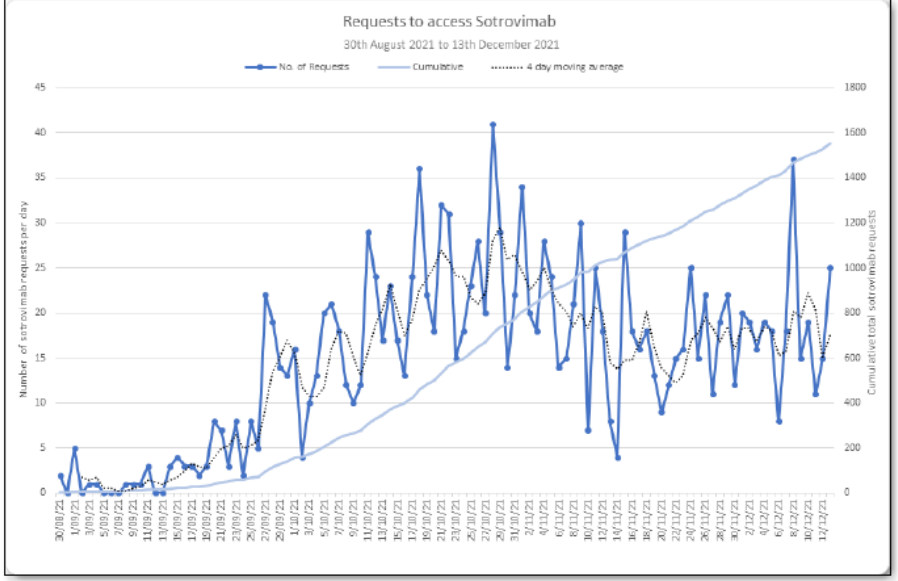
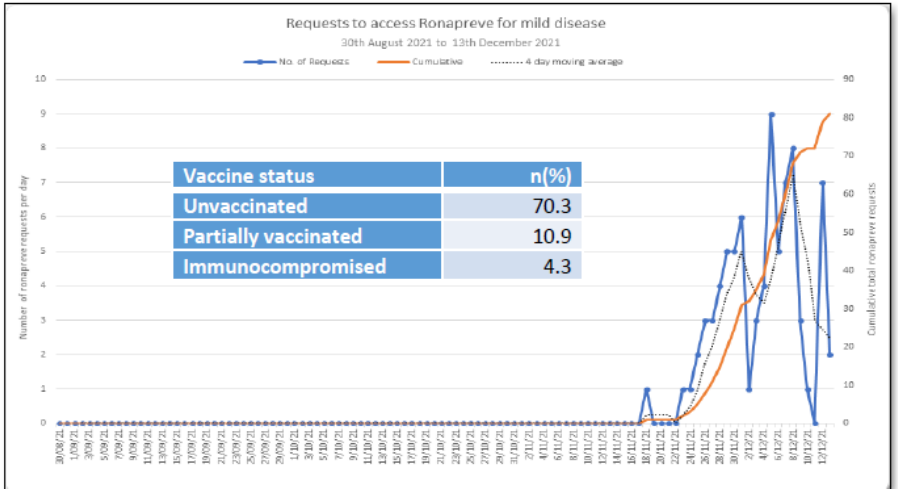
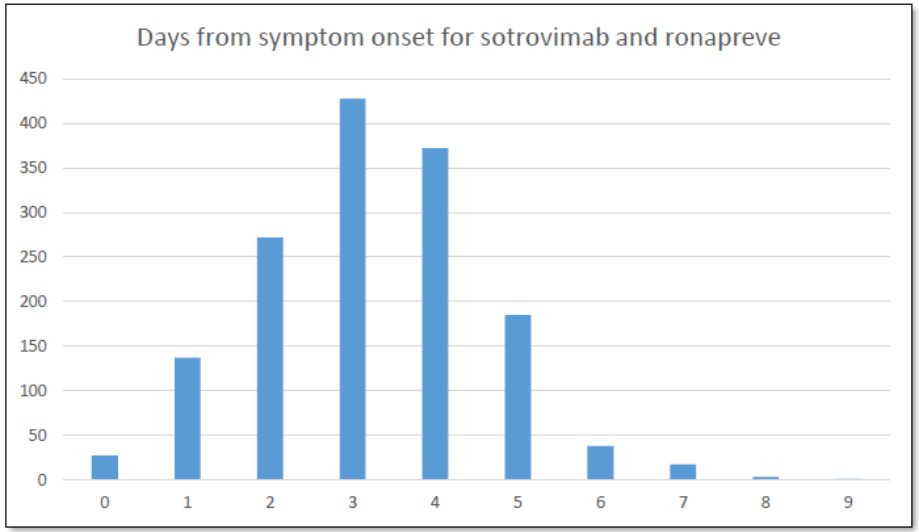
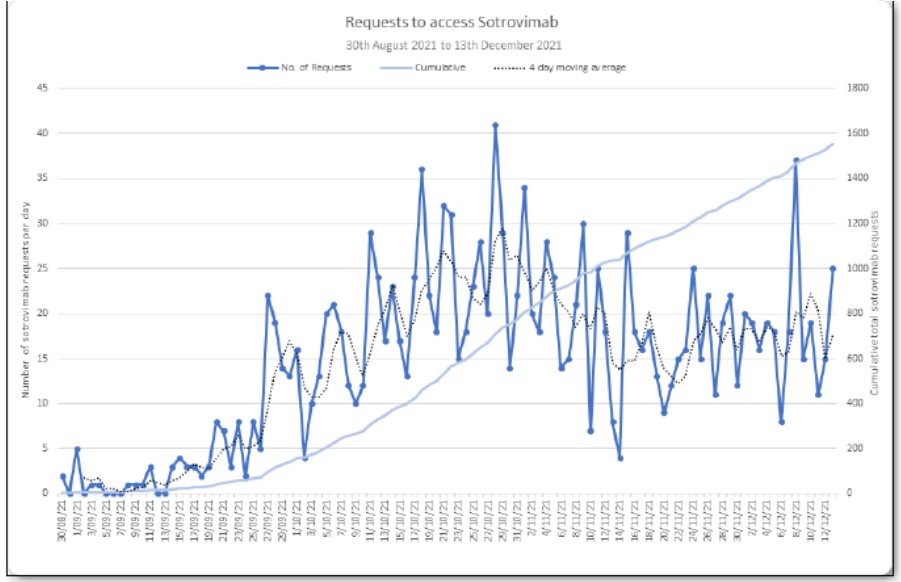


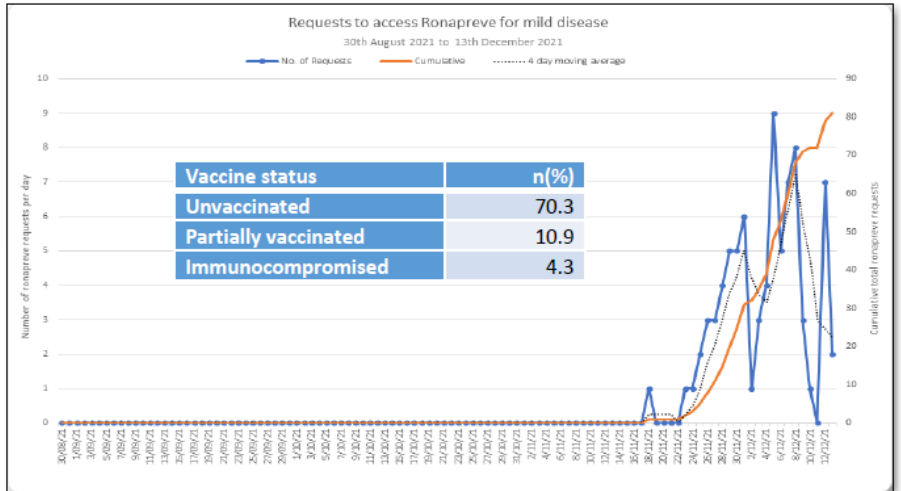


Vaccine status	n(%)
Unvaccinated	70.3
Partially vaccinated	10.9
Immunocompromised	4.3

Treatment
Symptomatic Mild







Vaccine status	n(%)
Unvaccinated	70.3
Partially vaccinated	10.9
Immunocompromised	4.3

Treatment
Symptomatic
moderate/severe/critical

ACCESS CRITERIA

MUST MEET ALL (Age ≥ 18 years, or aged ≥12 and <18 years of age and weighing ≥40kg):

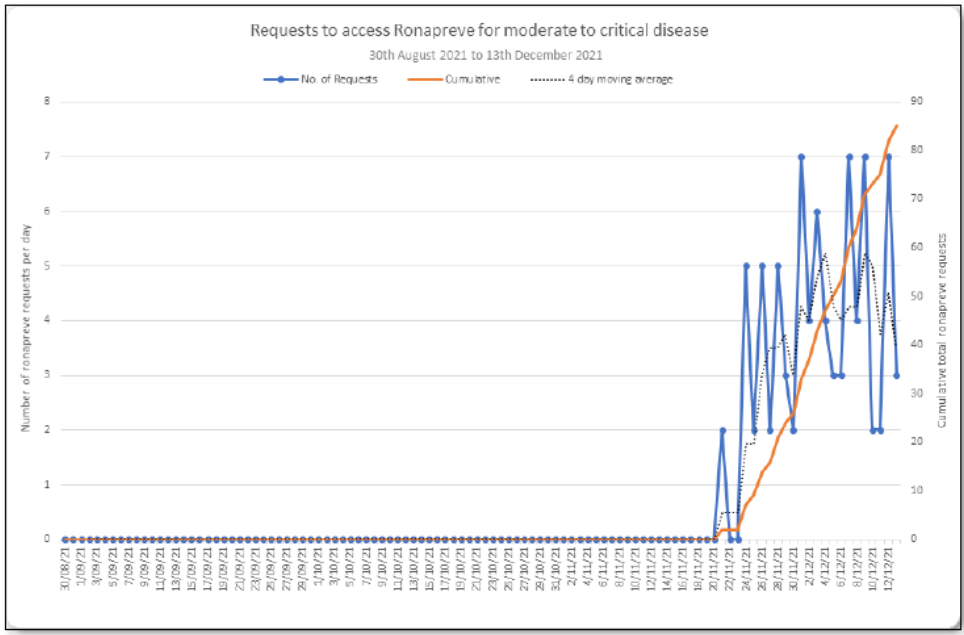
- ☐ Confirmed SARS-CoV2
- ☐ Seronegative for antibodies to SARS-Cov2

SEVERITY CRITERIA FOR ADULTS ≥16 YEARS (must meet one or more below)

- ☐ Moderate disease
  - ☐ Stable patient presenting with respiratory and/or systemic symptoms or signs. Able to maintain SpO2 > 92% at rest (or above 90% for patients with chronic lung disease) with up to 4L/min oxygen via nasal prongs.
- ☐ Severe disease (any of the below)
  - ☐ Respiratory rate ≥30 breaths/min
  - ☐ SpO_2 ≤92% at rest
  - ☐ Arterial partial pressure of oxygen (PaO2)/inspired oxygen fraction (FiO2) ≤ 300
- ☐ Critical disease (any of the below)
  - ☐ Occurrence of severe respiratory failure (PaO2/FiO2 < 200), respiratory distress or acute respiratory distress syndrome (ARDS). This includes patients deteriorating despite advanced forms of respiratory support (NIV, HFNO) OR patients requiring mechanical ventilation
  - ☐ Other signs of significant deterioration (including hypotension or shock, impairment of consciousness or other organ failure)

SEVERITY CRITERIA FOR CHILDREN <16 YEARS (must meet one or more below)

- ☐ Moderate disease (meets 4.2 definition of disease severity for children and adolescents)[1]
- ☐ Severe disease (meets 4.2 definition of disease severity for children and adolescents)[1]
- ☐ Critical disease (meets 4.2 definition of disease severity for children and adolescents)[1]



Disease category	N (%)
Moderate	43.8
Severe	29.7
Critical	26.6

The time is now: Managing patient flow beyond COVID-19

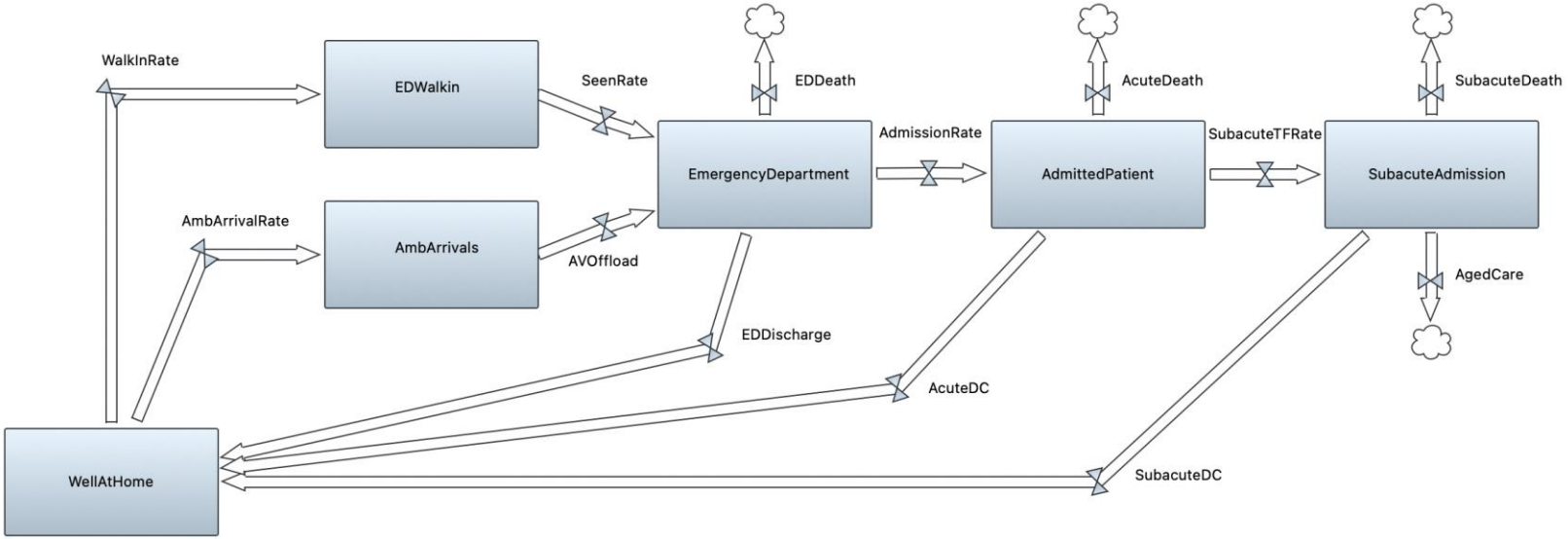
Hospital Access Block

Raising the bar with COVID…

Picture: The Australian (2021).

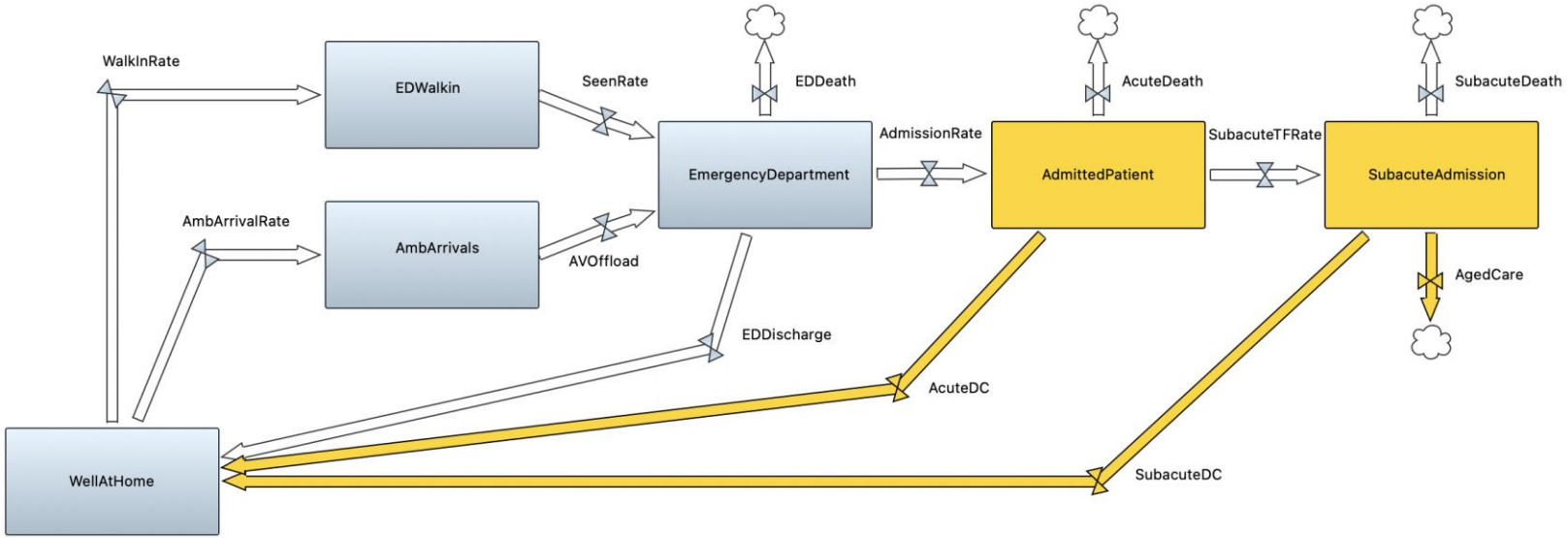
The Whole of System Approach

Unplanned arrivals



The Whole of System Approach

Unplanned arrivals



Timely Care Collaborative

Peninsula Health

Kiri Stuart

NSW GOVERNMENT Health

Dr. Amith Shetty

Using improvement science to reduce unnecessary bed days

December 2021

Peninsula Health

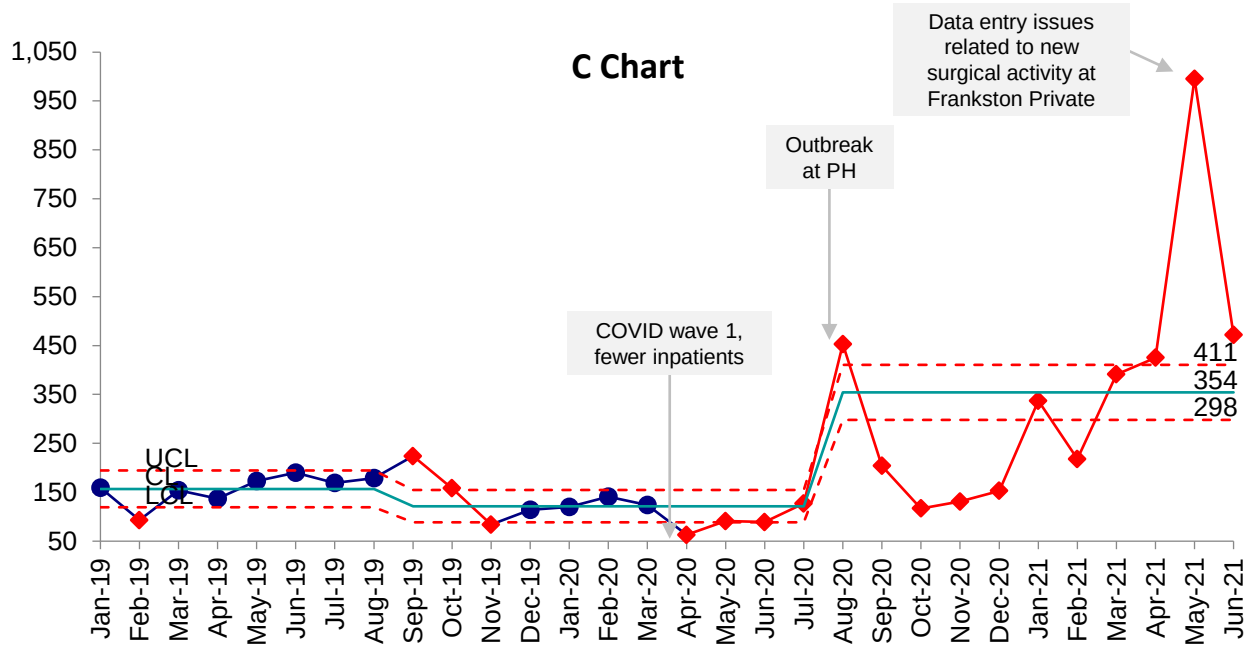
Objectives

Context	Failing to achieve **hospital wide patient flow** – the right care, in the right place, at the right time – **puts patients at risk for suboptimal care and potential harm**. Optimizing flow and improving outcomes for patients requires an appreciation of the entire system of care.
Trigger	**A hospital wide audit** of unnecessary bed days, as part of the Timely Care Collaborative, indicated **Residential Aged Care patients may present greatest opportunity** to improve flow
Question	**How can we improve timely care and reduce flow delays for this patient cohort?**

This review aims to:

1. **Describe the problem** we are trying to solve
2. Describe how **improvement science** is being used to **reduce unnecessary bed days**
3. Outline **improvement action plan**

Unnecessary bed days have increased significantly since 2019



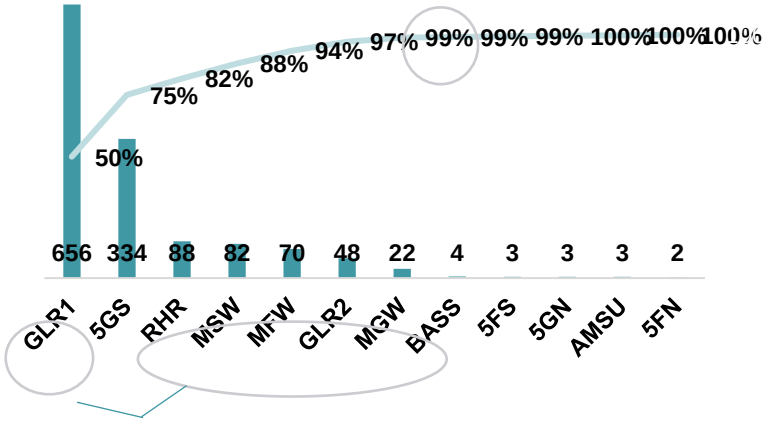
Definition: All days patients in hospital past their "Day 0" date – the date they are medically clearer for discharge.
Included: Acute Medical and Surgical unit, Frankston Hospital

Insights

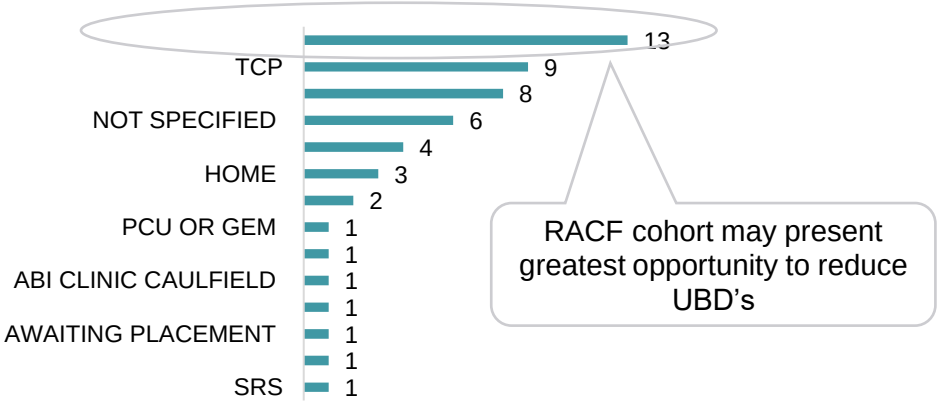
- This measure is derived form our "Countdown to Discharge" process. Unfortunately the process is inconsistently followed, so the data has to be interpreted with caution.
- Historically, medical and surgical units at Frankston Hospital carried between 130 and 150 unnecessary bed days per month (around 5 per day).
- This dropped during the first wave of covid, with fewer inpatients.
- A spike during the outbreak at PH likely reflects increased challenges in discharging patients, as well a reduced focus on timely discharges.
- The spike in May 2021 likely reflects teething issues with data from elective surgery contracted out to a private hospital.

A deeper dive into the data showed almost 99% of UBD's came from subacute wards, specifically patients waiting for t/f to aged care facilities

Patients on medical, surgical and subacute wards over day 0 on discharge readiness whiteboard , Thursday 14th October 2021, n = 52 patients & 1,313 UBD's



Subacute wards



- *5GS includes 1 patient with 327 UBD's*
- *GLR1 includes 1 patient 348 UBD's and 125 UBDs*

Source: Audit of Discharge Readiness whiteboards,

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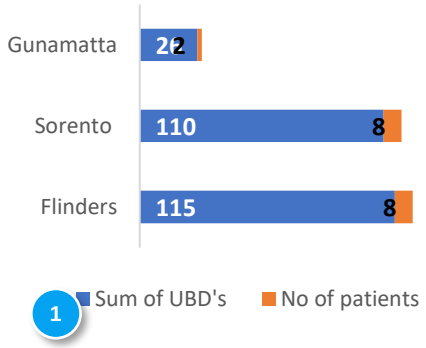
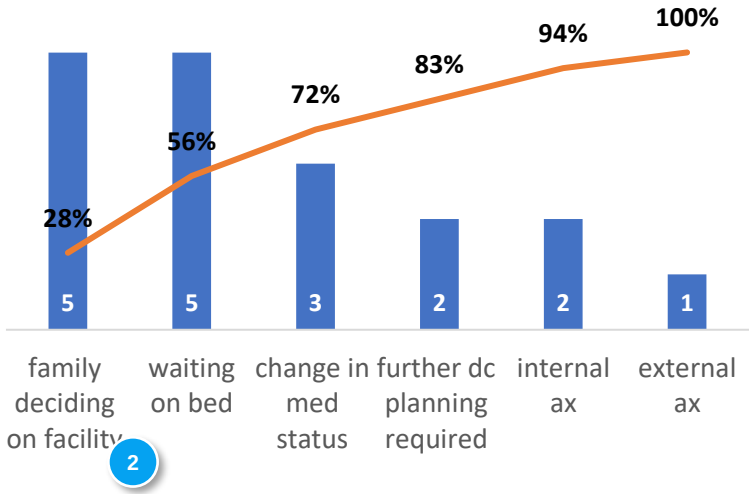
Family deciding on facility and waiting on a bed account for 56% of delays

Patients being discharged to a RACF with 1 or more UBD and cumulative UBD's 14th - 26th October, n = 18 & cumulative UBD's of 251



Reason for UBD for patients being discharged to RACF 14th - 26th October , n = 19 patients



Insights

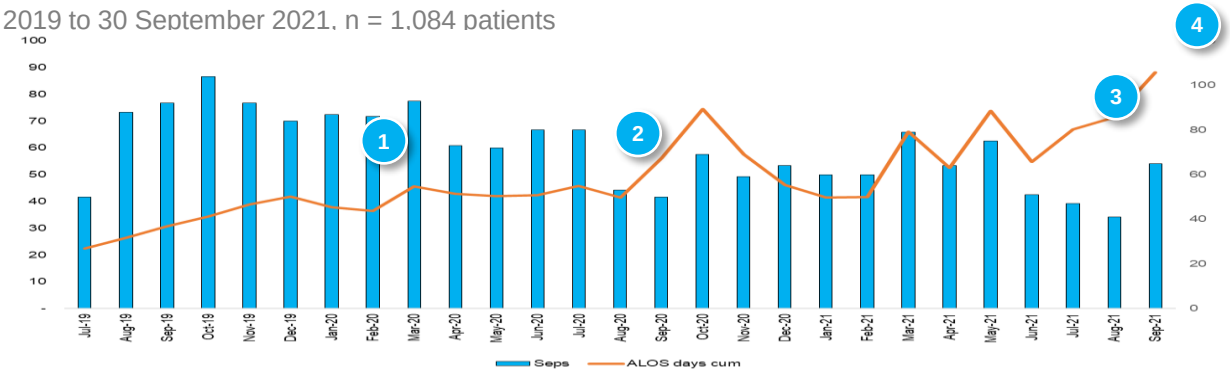
1. Flinders and Sorrento had highest no. of patients being discharged to a RACF with 1 or more UBD. Flinders had greatest cumulative UBD's
2. Family deciding on facility and waiting on a bed account for 56% of delay reasons

Source: Audit discharge readiness whiteboard

There is a corresponding increase in ALOS for subacute to aged care transfers by 66 days since 2019

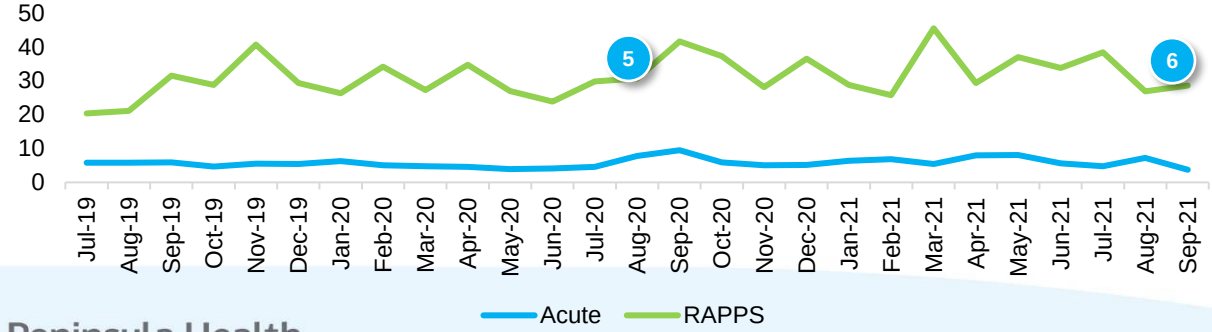
ALOS and separations for RAPPS – RACF patients

— 1 July 2019 to 30 September 2021, n = 1,084 patients



Acute and RAPPS ALOS for RAPPS – RACF patients

1 July 2019 to 30 September 2021, n = 1,084 patients



Insights

1. First lockdown in Melbourne Impacts of lockdowns include families unable to view facilities, some facilities not accepting patients until cleared of COVID, decreased community supports available i.e. PCA, family
2. Second lock down & **50% reduction in rehab bed capacity at Golf Links Road (GLR)**
3. Beginning of Delta outbreak
4. PH became a streaming hospital 1 October
5. Patient cohort changed when closed beds at GLR
6. Acute ALOS relatively flat while RAPPS increased ALOS 8.3 days

With an increase in UBD in patients waiting for transfer to residential aged care there is an increase in ALOS

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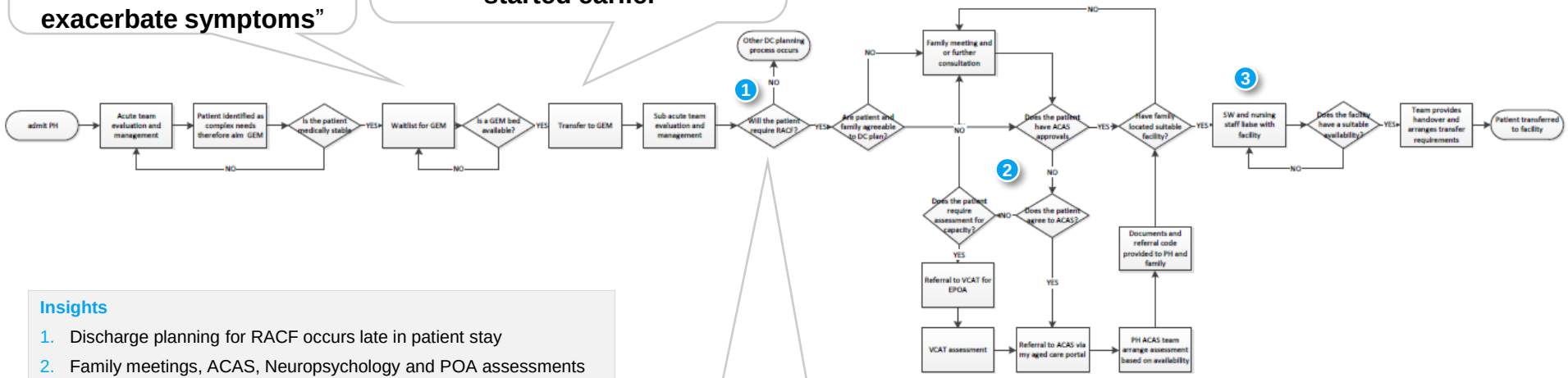
Source: Online report A076

Workflow mapping showed discharge planning occurs late in the patient's journey

"**Transfers and bed moves** for patients with delirium and dementia **exacerbate symptoms**"

"Sub acute often have to be the **bearers of bad news**, this conversation should have **started earlier** "

"These are **challenging** and **life changing conversation** to have with families"



Insights

1. Discharge planning for RACF occurs late in patient stay
2. Family meetings, ACAS, Neuropsychology and POA assessments often need to occur and can be have significant waits / delays
3. Process relies on families to source and decide on a facility

"For many patients the **discharge destination is not clear** – they want the chance to **try to get home** "

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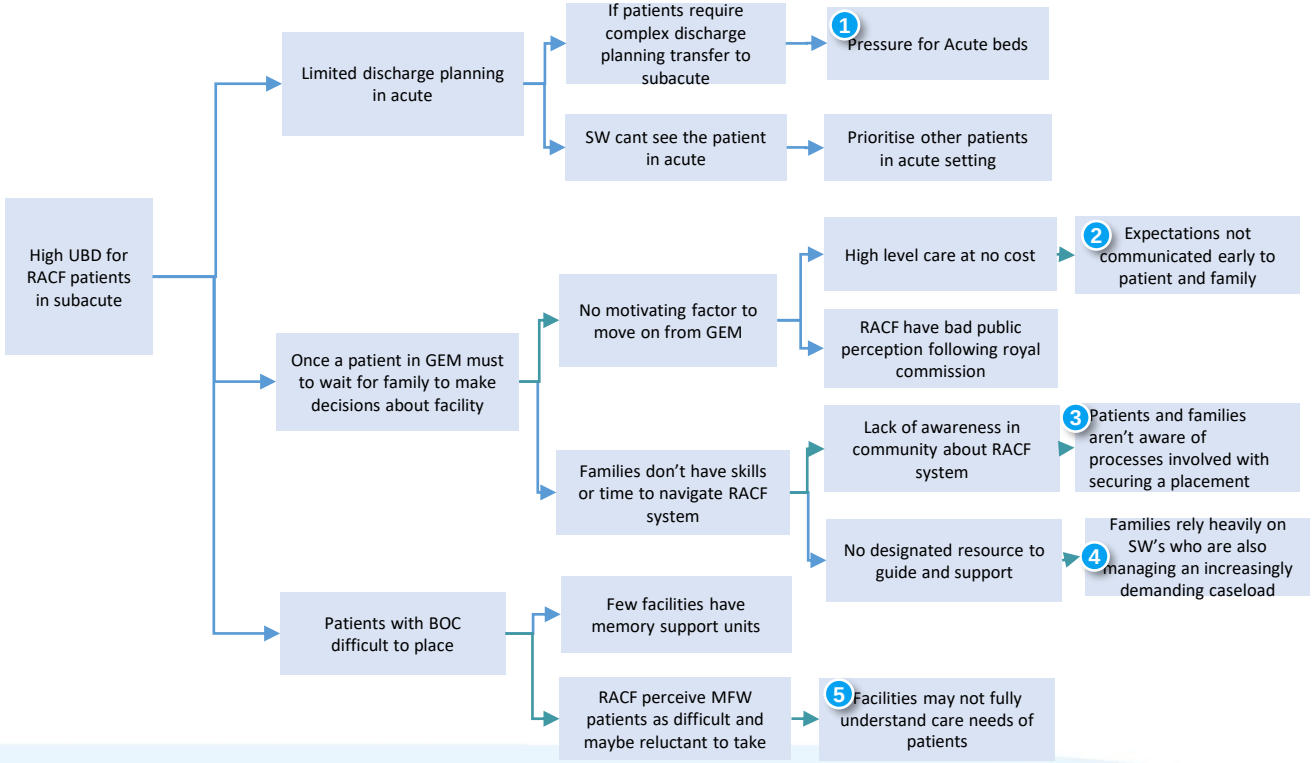
Pressure for acute beds and patient and family expectations contribute to high unnecessary bed days



Opportunities:

- Allow longer acute stay for patients identified as needing RACF in acute
- Have conversation in acute where appropriate and complete ACAS on the spot in acute wards
- Embed designated resource to manage patient cohort, support families and liaise with facilities

Challenges

Patients and families often need the chance to "try" and get home

Nursing home placement is a very difficult decision that cant be rushed, feedback from families they are often not ready to have these conversations earlier and don't want to feel pressured.

Several projects already completed in the space

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Improvement action plan

- Acknowledge challenges, continue to engage team to understand issues
- Engage leadership team and broader stakeholder group to understand implications of longer acute length of stay
- Establish a cross continuum team to test and measure PDSA cycles
- Continue to track UBD trends across the health service

NSW COVID-19 Care in the Community

Amith Shetty

Clinical Director, NSW Ministry of Health

NSW GOVERNMENT Health

Background

- In the current surge, as of 16th October, there have been 74919 COVID-19 cases in NSW
  - 1633 ICU episodes (2.2%),
  - 8354 hospitalisations (11.2%),
  - 12353 ED episodes (16.5%),
  - 18714 HITH episodes (25%)
  - 5089 Medihotel admissions (6.8%) and
  - 24674 out of hospital (32.9%)

- On 24th June, NSW had administered 748701 vaccine doses and as of yesterday, 12,099,297 doses had been administered
- The risk to the community has drastically changed over the last 4 months
- Majority of the care will continue to occur in the Community setting

A tumultuous journey…

NSW GOVERNMENT Health

Action Plan and Progress

COVID-19 Care in the Community 7-point action plan (Original)

COVID-19 Care in the Community teams

- LHD/ Networks teams development

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COVID-19 Care in the Community guideline

- ACI/MOH/RPA virtual partnership
- Paediatric Community care guideline

COVID-19 Confirmed Community Patient tracker

- PFP live patient tracker
- ROH-based risk scoring and daily severity tracker

Care in Community Supply Chain

- Modelling-informed Pulse oximeter/ home-monitor procurement.

Virtual Care Strategy

- Patient engagement Apps
- Virtual Accelerator achievements.
- Ambulance VCC secondary triage

COVID-19 community care clinical pathways

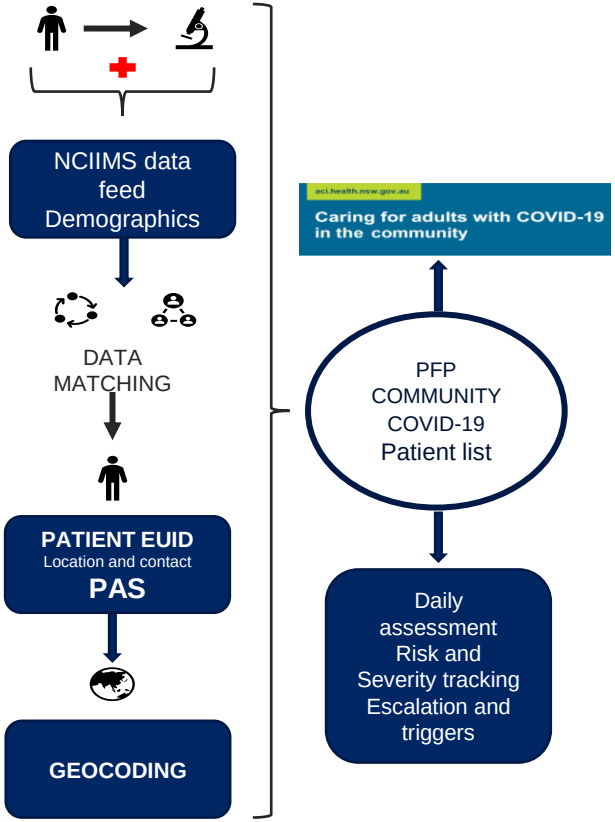
- COVID-19 Proactive life planning
- ED / Hospital avoidance
- Ambulance CCC pathway

COVID-19 mental health support

- Support resources in isolation – Apps
- Pathway for patients with mental illness.

NSW GOVERNMENT Health

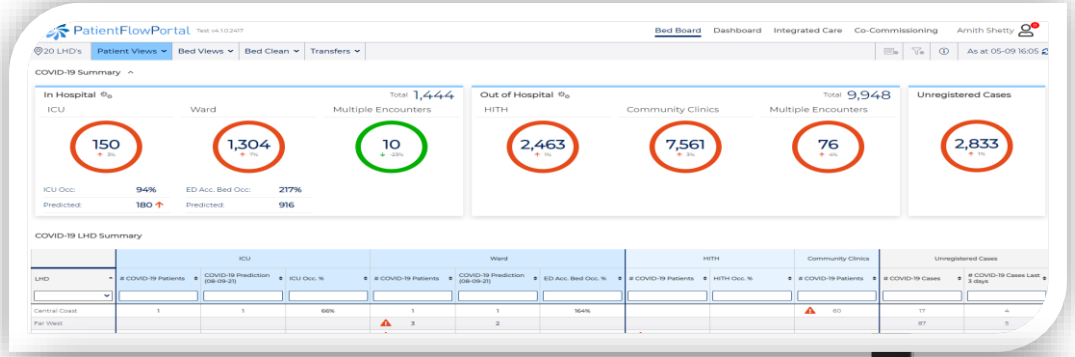
COVID-19 Confirmed Community patient tracker

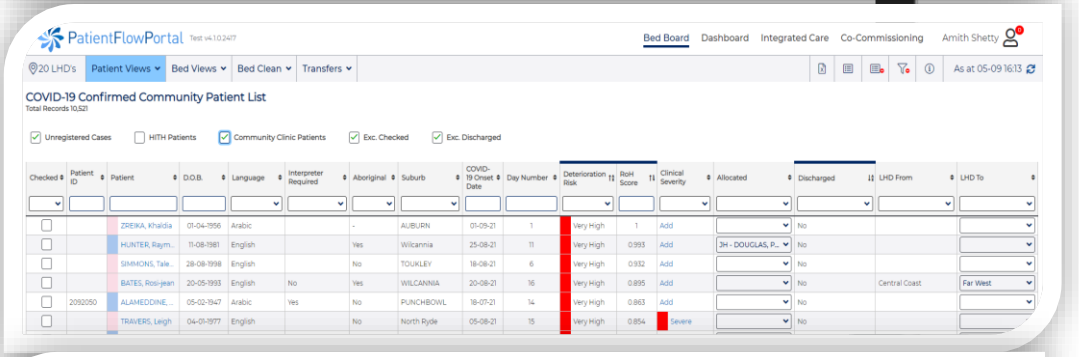


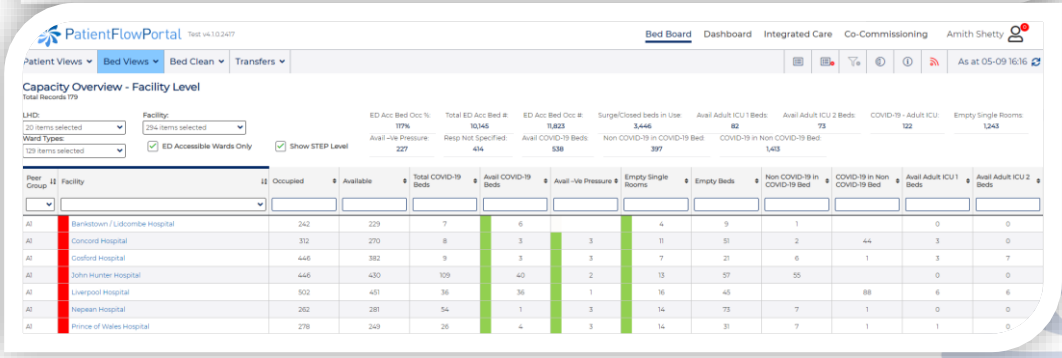
- NCIIMS and Operational Data Store (PAS) linkage
- Automated, real-time – data management
- Iterative designing and solution delivery
- State-wide, all services and demographics
- Ability to share patients list and integrate with VC platforms, Apps, peripherals
- Ability to send SMS/ e-mail notifications (under development)

NSW GOVERNMENT Health

COVID-19 Summary dashboard







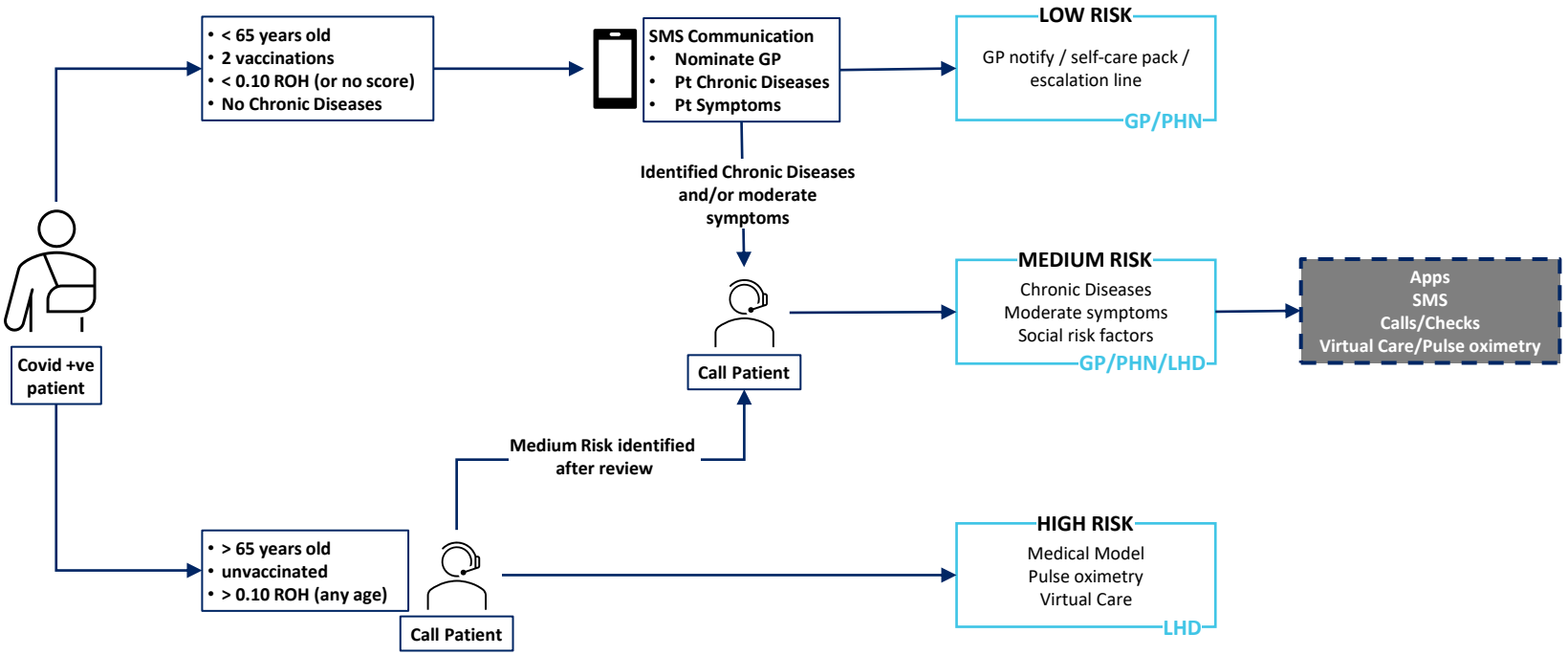
NSW GOVERNMENT

Key components to the strategy

Activity is monitored in real-time through our **Ambulance Arrivals Board**, and **Patient Flow Portal** providing **visibility and coordination** across system	**Intensive Care Unit (ICU)**
► Ambulance demand ► Transfer of Care ► Out of Hospital Care activity ► Community COVID-19 cases ► Emergency Department activity and Short Term Escalation Plan (STEP) ► Hospital Activity and STEP level ► ICU Activity and STEP level	► Monitoring and coordination of ICU capacity and demand ► Ventilator management and distribution ► Equipment, consumables, pharmaceutical monitoring and distribution ► ICU staff deployment ► ICU Pandemic Short Term Escalation Plan ► Intensive Care Advisory Service (ICAS)- virtual support ► Temporary hospital solutions
Centralised Patient Flow Unit	

SUMMARY WORKFLOW – FUTURE STATE – PATIENT JOURNEY

Identify | 1st triage | Notify | 2nd triage | Management



Age < 65, ROH <0.10 or No chronic disease flag and doubly vaccinated people have 1 in 1000 risk of ICU

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Action Plan and Progress

COVID-19 Care in the Community 7-point action plan (Current)

COVID-19 Care in the Community teams

- Baseline composition
- Define surge and capacity limits
- Funding models.

COVID-19 Care in the Community guideline

- ACI adult V3 and Pediatric
- Co-designing healthpathways and transition workflows

COVID-19 Confirmed Community Patient tracker

- De-isolation
- Auto-triaging for primary care transition
- Technical integration

Analytics-driven Supply Chain Management

- Equipment and Therapeutics.

Virtual Care Strategy

- Quality safety frameworks
- Costing and Evaluation.
- Capacity and sourcing

COVID-19 community care models

- COVID-19 Proactive life planning
- ED / Hospital avoidance
- Post/Long- COVID
- Transition to Primary care

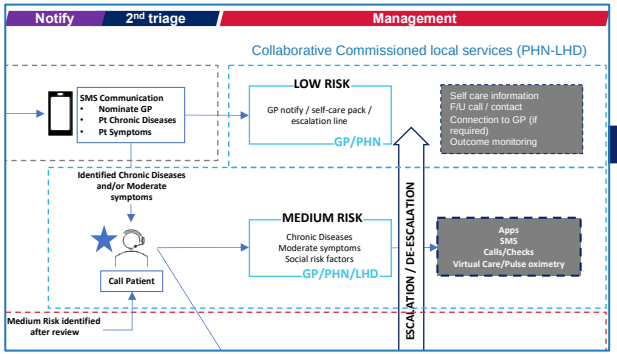
COVID-19 Psychosocial Wellbeing support

- Mapping and cleansing
- Redesign – central versus local models

NSW GOVERNMENT Health

What could the one-system environment look like?

Regional partnerships will design and commission services appropriate for their local needs, leveraging their existing services and providers



Systems and technology enablers

- Health Pathways
- Regional providers
- Patient Flow Portal
- LUMOS
- PRMs*

*For further development

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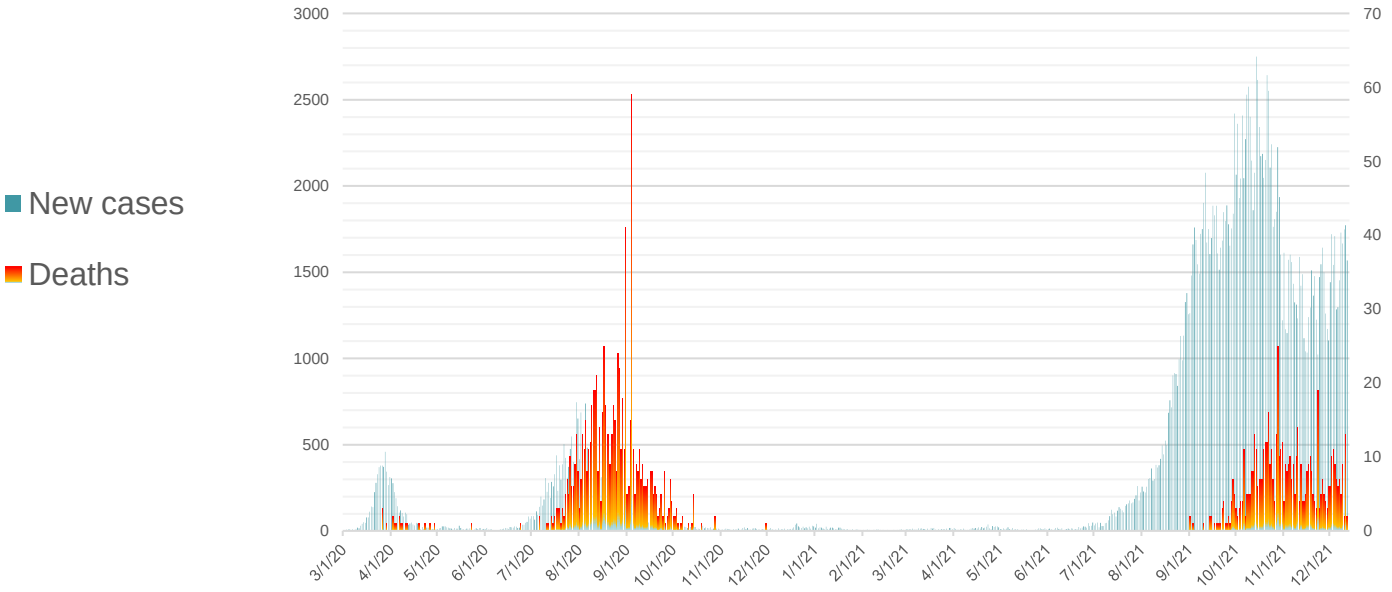
The Third COVID Wave



COVIDcrowding

The End of a Tough Year…

Picture: Sunset over Bolte Bridge, Melbourne / DocklandsTony / creativecommons

Questions

Please type your question in the chat

Merry Christmas/Happy New Year

This is the final COVID + Pathway Learning Network webinar for 2021. We will resume on 19 January 2022.

Resources

1. Learning Network webinar recordings and slides
   https://www.bettersafercare.vic.gov.au/support-training/learning-networks/covid-pathways

2. COVID Clinical Shared Resources SharePoint page - Secure site for sharing, with permission, health service developed COVID-19 resources.

   - To register for access and to share resources contact centresofclinicalexcellence@safercare.vic.gov.au

3. Department of Health COVID-19 clinical guidance and resources
   https://www.health.vic.gov.au/covid-19/for-health-services-and-professionals-covid-19

Get in contact

- Please complete our short survey
- To register for future webinars email us: centresofclinicalexcellence@safercare.vic.gov.au
- If you have specific questions relating to the COVID+ Pathways please email the Department of Health at covid+pathways@health.vic.gov.au