Safer Care Victoria

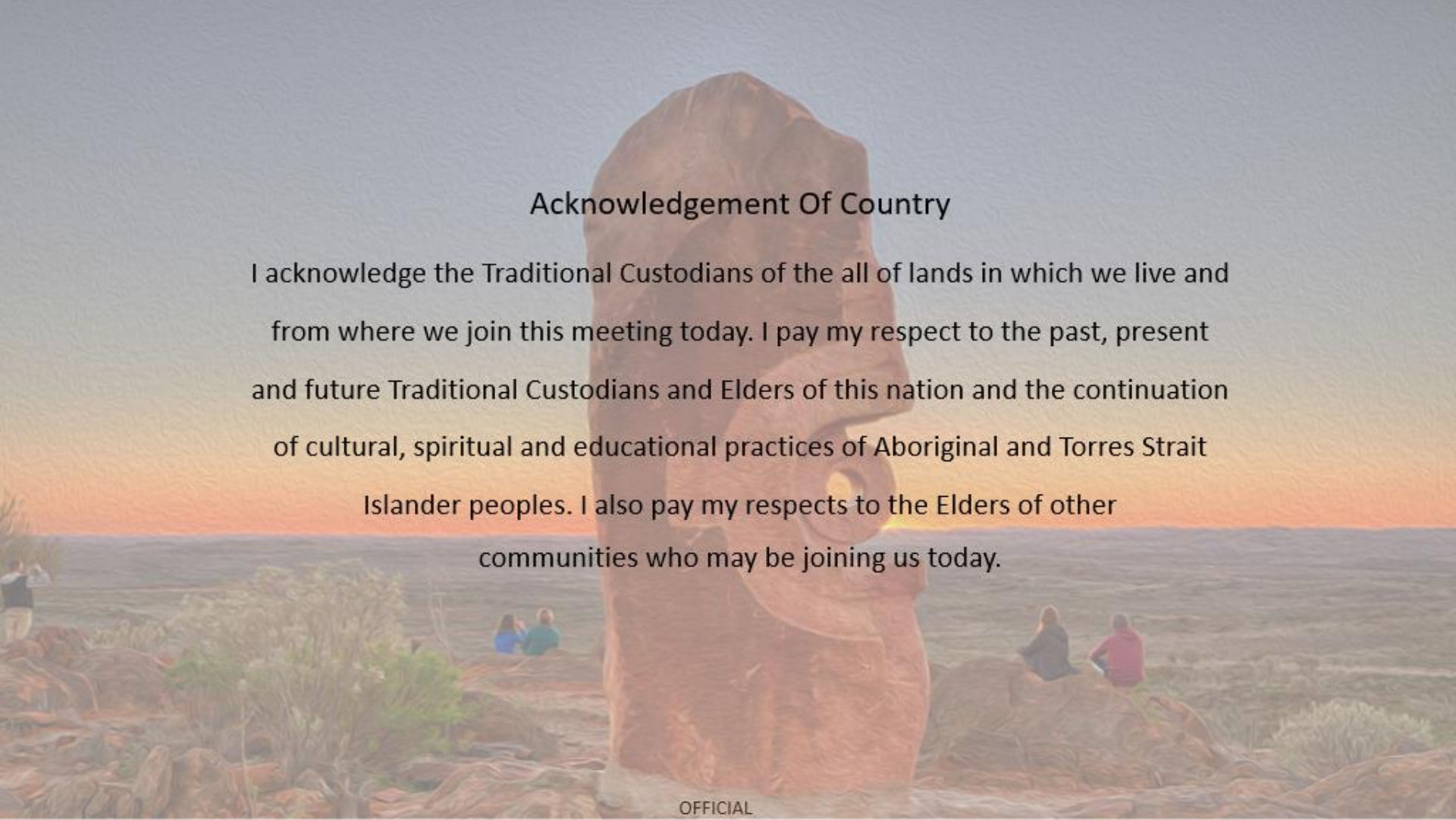
Wednesday 19 January, 2022

COVID + Pathway Learning Network webinar series

Webinar 13: COVID+ Pathways: Critical updates and discussion

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.

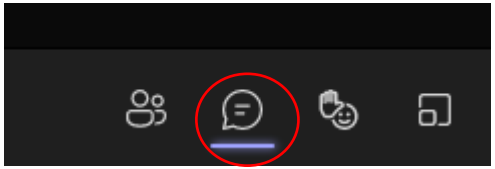
Webinar series purpose

- 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

* To share your services' experiences, innovations and learnings in delivering the COVID+ Pathway at an upcoming webinar email centresofclinicalexcellence@safercare.vic.gov.au

Before we start

Throughout the webinar you can ask questions by typing your 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.

This session will be recorded and made available on the SCV website https://www.bettersafercare.vic.gov.au/support-training/learning-networks/covid-pathways

Overview

Topic	Presenter
The Health Service Response Centre	**Shannon Wight** Executive Director, Health Service Response Centre
Questions	
Learning from the NHS	**Prof Mike Roberts** Chief Executive Officer, Safer Care Victoria
National Clinical Evidence Taskforce update	**A/Prof Steve McGloughlin** Director Department of Intensive Care & Hyperbaric Medicine Alfred Health Associate Professor, School of Public Health and Preventive Medicine Executive Director, National COVID-19 Clinical Evidence Taskforce
Questions	
COVID + Pathway update	**Louise Galloway** Executive Director, COVID+ Pathways
Questions	

Health Service Response Centre

Shannon Wight – Executive Director
19 January 2022

VICTORIA State Government | Department of Health

Health Service Response Centre (HSRC)

Purpose: Established within the Department of Health, under the Deputy Controller, to support health services coordinate system-wide patient flow and system configuration in response to the Omicron outbreak.

Key functions

Support, coordinate and monitor service reconfigurations and impacts – Lead decision making regarding the reconfiguration and cessation of services and manage endorsement and approval by State Controller Health

Changes to services – Lead advice on the cessation of surgery and other key services. Manage endorsement and approval by State Controller Health of critical decisions at the system wide level

Out of hospital care – Monitor HITH & C+P capacity against tiers; supported discharge arrangements and lead the advice regarding the delivery of OOHC based on system risks

Interstate demand – Coordinate and lead decision making regarding the provision and receipt of interstate/ other supports (review of requests and liaison)

Patient flow coordination – Active coordination of the service sector to monitor and respond to emerging and current health service operational needs that impact patient flow across the sector

ED/AV interface – Monitor demand and commence intervention to ensure system wide distribution maximises available capacity

Inpatient demand - Monitor demand and commence intervention to ensure Ward and ICU load sharing and support maximise available capacity, including relationship with private hospitals

Health Service Response Centre (HSRC)

Operations

- The centre will operate as a single point of contact, via a phone line and central email, for issues to be raised by CEOs, COOs and HSP leads (or their delegates)
- Hours – Initially 8.00 to 18.00 with on call services provided from 18.00 until 23.00. View to expand these hours as required.

Issue escalation

- Health services are asked to escalate issues to the HSRC that may have a significant impact on patient access and flow at a system level as well as major workforce and service configuration.

NOTE: Health services and the workforce will continue to have responsibility for clinical and operational decisions that impact on patients and communities. For example, decisions regarding how to manage internal patient flow within a health service as well as the assessment, treatment and referral of patients.

Questions

Please type your question in the chat

Learning from the NHS

Omicron

Prof Mike Roberts

Chief Executive Officer, Safer Care Victoria

Prevalence

	England	Wales	Northern Ireland	Scotland
Estimated proportion of population	6.00% (95% CI: 5.80% to 6.19%)	5.20% (95% CI: 4.57% to 5.91%)	3.97% (95% CI: 3.10% to 4.91%)	4.52% (95% CI: 3.98% to 5.09%)
Estimated number of cases	3,270,800 (95% CI: 3,163,500 to 3,377,500)	157,900 (95% CI: 138,900 to 179,600)	72,900 (95% CI: 56,800 to 90,100)	238,000 (95% CI: 209,300 to 268,000)
Estimated rate per person	1 in 15 (95% CI: 1 in 15 to 1 in 15)	1 in 20 (95% CI: 1 in 20 to 1 in 15)	1 in 25 (95% CI: 1 in 30 to 1 in 20)	1 in 20 (95% CI: 1 in 25 to 1 in 20)
Estimated antibody positivity (20 December 2021 to 23 December 2021)	97.5% (95% CI: 97.0% to 97.9%)	96.8% (95% CI: 95.9% to 97.5%)	97.4% (95% CI: 96.0% to 98.2%)	97.7% (95% CI: 97.1% to 98.2%)

Omicron – Vaccine effectiveness

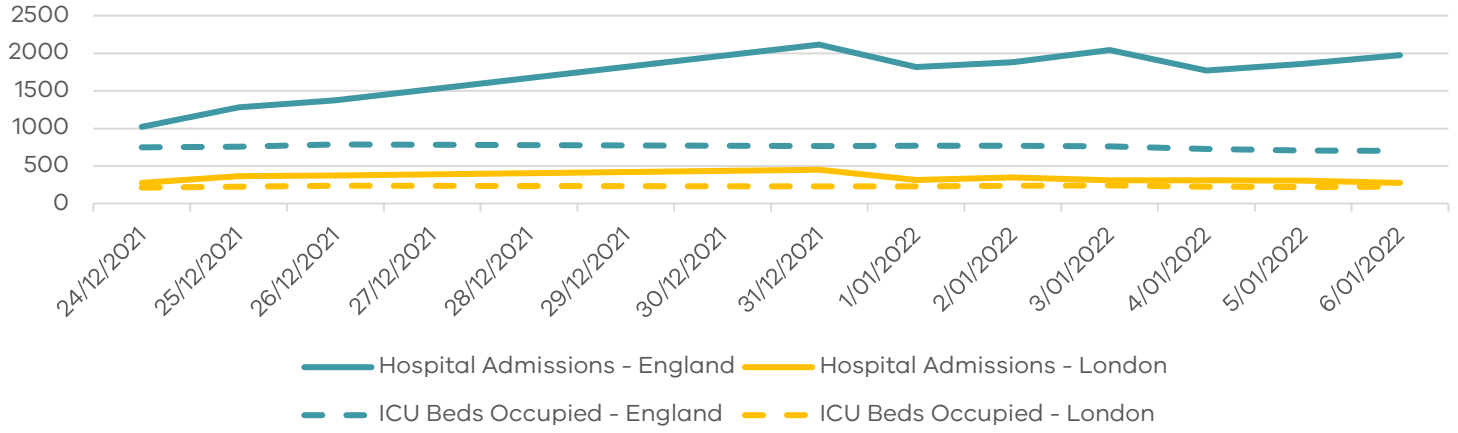
Table 6: Vaccine effectiveness against hospitalisation for Omicron (all vaccine brands combined). OR = odds ratio, HR = hazard ratio, VE = vaccine effectiveness (CI=Confidence interval)

Dose	Interval after dose	OR against symptomatic disease (95% CI)	HR against hospitalisation (95% CI)	VE against hospitalisation (95% CI)
1	4+ weeks	0.74 (0.70-0.77)	0.65 (0.30-1.42)	52% (-5-78)
2	2-24 weeks	0.82 (0.80-0.84)	0.33 (0.21-0.55)	72% (55-83)
2	25+ weeks	0.98 (0.95-1.00)	0.49 (0.30-0.81)	52% (21-71)
3	2+ weeks	0.37 (0.36-0.38)	0.32 (0.18-0.58)	88% (78-93)

Source: SARS-CoV-2 variants of concern and variants under investigation (publishing.service.gov.uk)

Hospital impact all of England/ London
56 million/8.98 million population

COVID+ Hospital Admissions by day										
	24 Dec	25 Dec	26 Dec	31 Dec	1 Jan	2 Jan	6 Jan	7 Jan	8 Jan	9 Jan
England	1020	1281	1374	2114	1819	1881	2043	1772	1862	1975
London	278	364	374	450	314	347	310	312	307	277
ICU Beds occupied										
England	748	758	789	765	769	769	762	728	708	704
London	213	224	238	229	230	236	242	224	220	224



Other lessons

- Possibly a two wave process, young then older
- Some indication that under 5s may be affected but small numbers
- Less ICU admission at present than expected but see above
- Unvaccinated the biggest proportion of the very sick
- Major impact on health care workforce around 5% off work
- Use of RAT to reduce isolation period

Safer Care Victoria Webinar
Taskforce Update

A/Prof Steve McGloughlin

January 19, 2022

NATIONAL
COVID-19
CLINICAL
EVIDENCE
TASKFORCE


2019
Avoid negative people
2020
Avoid positive people
2021
Avoid people
2022
A void

What we do

NATIONAL COVID-19 CLINICAL EVIDENCE TASKFORCE

The Taskforce brings together 32 peak professional bodies across Australia to support Australian clinicians with continually updated, evidence-based guidance for the clinical care of people with COVID-19

We:

Provide national, evidence-based guidelines for the clinical care of people with COVID-19

Undertake continuous evidence surveillance to identify and rapidly synthesise research every week

Offer a trusted, unified, national clinical voice providing reassurance to Australian clinicians

Members


Cochrane
Australia


Allied Health
Professions
Australia


AAAPC
Australasian Association for
Academic Primary Care Inc.


AAG
Australian
Association of
Gerontology


Australasian College
for Emergency Medicine


ACIPC
Australasian College
for Infection Prevention and Control


ASID


ASCEPT


ANZCA
FPM


ANZICS


Australian & New Zealand Society for
Geriatric
Medicine


acm
Australian College of
Midwives


ACCCN


Australian
College of
Nursing


apna


AUSTRALIAN
RESUSCITATION
COUNCIL


Australian College of
Paramedicine


Australian College of
Rural & Remote Medicine
WORLD LEADERS IN RURAL PRACTICE


AUSTRALASIAN
sleep
ASSOCIATION


ASA
Australian Society of Anaesthetists


CENA
College of Emergency Nursing Australasia Ltd


CRANA
plus
improving
remote
health


NACCHO
National Aboriginal Community
Controlled Health Organisation
www.naccho.org.au


PalliativeCare
AUSTRALIA


RACP
Specialists. Together
EDUCATE. ADVOCATE. INNOVATE.


RACGP
Royal Australian College of General Practitioners


Royal Australasian
College of Surgeons

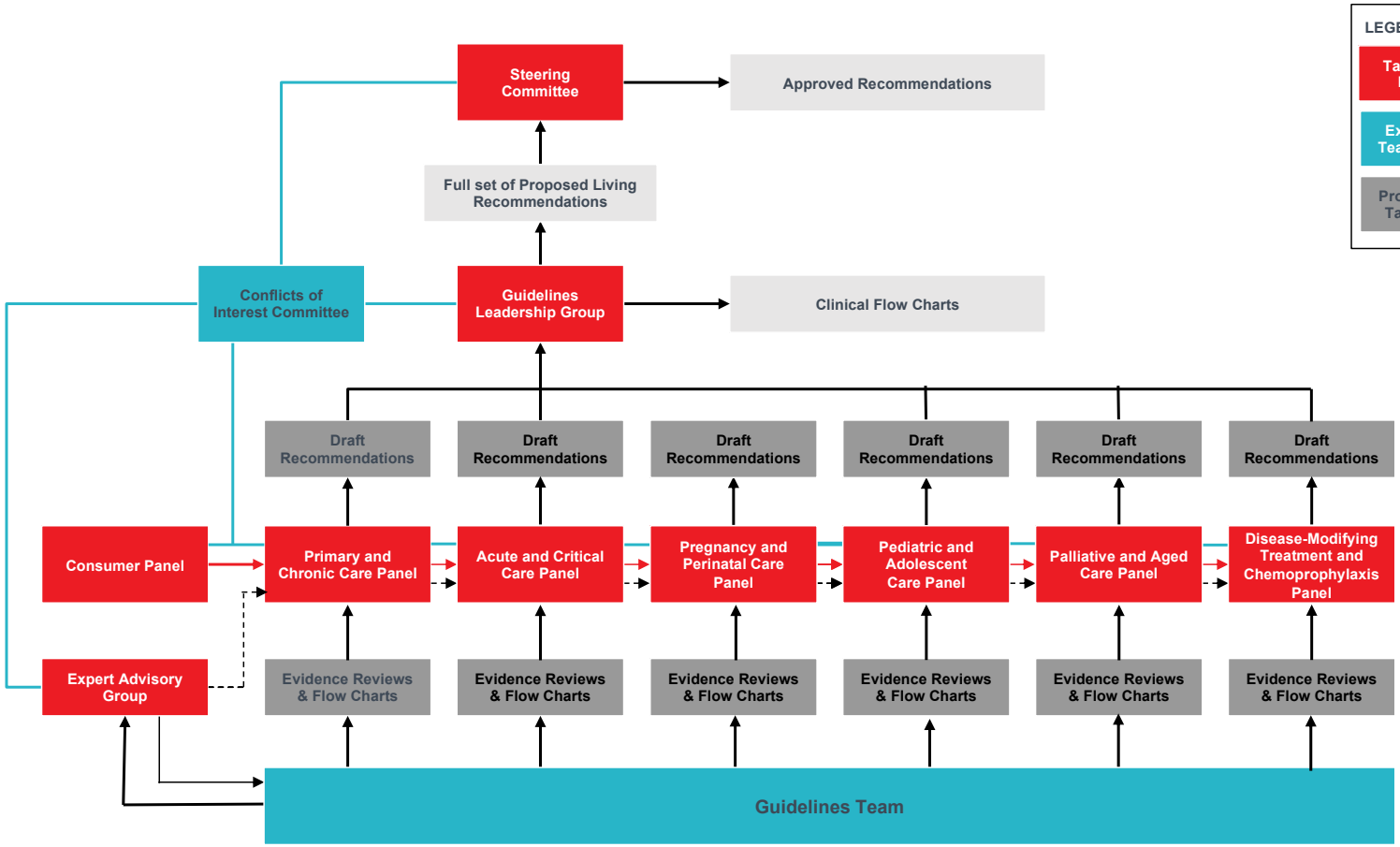

The Royal Australian
and New Zealand
College of Obstetricians
and Gynaecologists
Excellence in Women's Health


RMSANZ
Rehabilitation Medicine Society of Australia and New Zealand


shpa


THANZ
Thrombosis & Haemostasis society
of Australia and New Zealand


The Thoracic Society
of Australia & New Zealand
LEADERS IN LUNG HEALTH


LEGEND
Taskforce Entity
Executive Team Entity
Products of Taskforce
NATIONAL COVID-19 CLINICAL EVIDENCE TASKFORCE
Steering Committee
Approved Recommendations
Full set of Proposed Living Recommendations
Conflicts of Interest Committee
Guidelines Leadership Group
Clinical Flow Charts
Draft Recommendations
Draft Recommendations
Draft Recommendations
Draft Recommendations
Draft Recommendations
Draft Recommendations
Consumer Panel
Primary and Chronic Care Panel
Acute and Critical Care Panel
Pregnancy and Perinatal Care Panel
Pediatric and Adolescent Care Panel
Palliative and Aged Care Panel
Disease-Modifying Treatment and Chemoprophylaxis Panel
Expert Advisory Group
Evidence Reviews & Flow Charts
Evidence Reviews & Flow Charts
Evidence Reviews & Flow Charts
Evidence Reviews & Flow Charts
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Evidence Reviews & Flow Charts
Guidelines Team

covid19evidence.net.au

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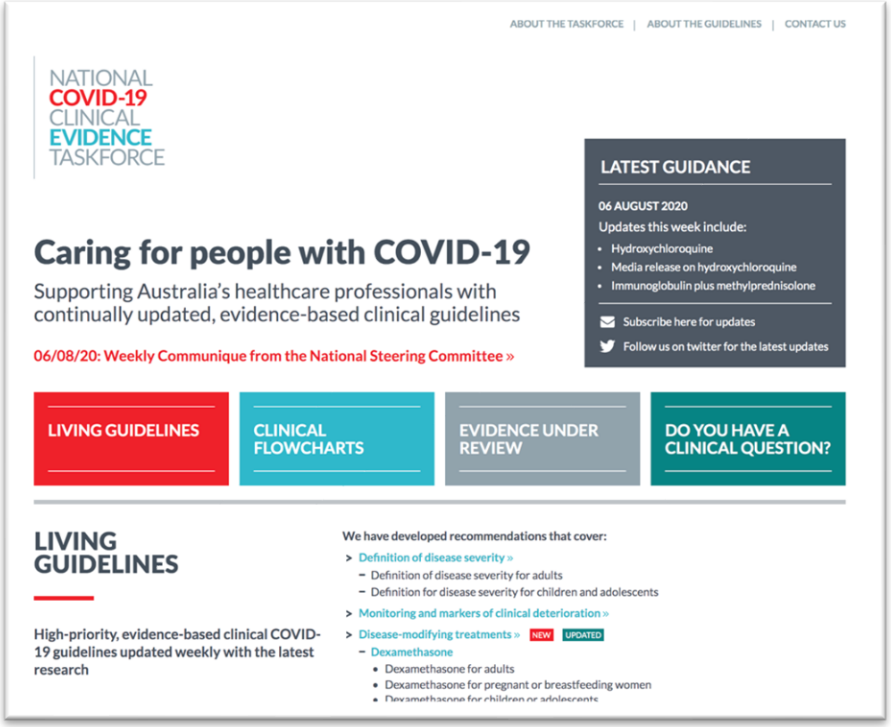
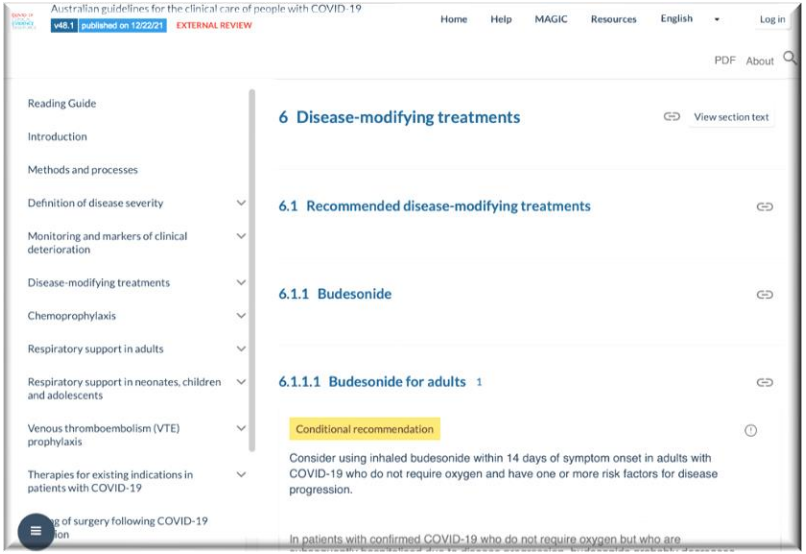


Living guidelines on MAGICapp



NATIONAL COVID-19 CLINICAL EVIDENCE TASKFORCE

CLINICAL FLOWCHARTS

Flowcharts incorporating living guideline recommendations and guidance issued or endorsed by Taskforce members

We have developed clinical flowcharts that cover:

- Disease-modifying treatments for adults with COVID-19 » NEW
- Pathways to care for adults with COVID-19 » UPDATED
- Pathways to care for children and adolescents with COVID-19 » NEW
- Management of adults with mild COVID-19 » UPDATED
- Management of adults with moderate to severe COVID-19 » UPDATED
- Management of adults with severe to critical COVID-19 » UPDATED
- Respiratory support for adults with severe to critical COVID-19 » UPDATED
- Management of people with COVID-19 who are older and living with frailty and/or cognitive impairment »
- Management of people with COVID-19 who are receiving palliative care »
- Care of people with post-COVID-19 »
- Preparedness for CPR during the COVID-19 pandemic »
- CPR for adults with COVID-19 in healthcare settings »
- Basic Life Support for adults in the community during the COVID-19 pandemic » UPDATED

DISEASE-MODIFYING TREATMENTS FOR ADULTS WITH COVID-19

NATIONAL COVID-19 CLINICAL EVIDENCE TASKFORCE

VERSION 1.1
PUBLISHED 13 JANUARY 2022

	Not requiring oxygen WITHOUT lower respiratory tract disease	Not requiring oxygen WITH lower respiratory tract disease	Requiring oxygen WITHOUT mechanical ventilation	Requiring invasive mechanical ventilation
DEFINITION OF DISEASE SEVERITY	**Mild** An individual with no clinical features suggestive of moderate or more severe disease: • no or mild symptoms and signs (fever, cough, sore throat, malaise, headache, muscle pain, nausea, vomiting, diarrhoea, loss of taste and smell) • no new shortness of breath or difficulty breathing on exertion • no evidence of lower respiratory tract disease during clinical assessment or on imaging (if performed)	**Moderate** A stable patient with evidence of lower respiratory tract disease: • during clinical assessment, such as – oxygen saturation 92-94% on room air at rest – desaturation or breathlessness with mild exertion • or on imaging	**Severe** A patient with signs of moderate disease who is deteriorating OR A patient meeting any of the following criteria: • respiratory rate ≥30 breaths/min • oxygen saturation <92% on room air at rest or requiring oxygen • lung infiltrates >50%	**Critical** A patient meeting any of the following criteria: • respiratory failure (defined as any of) – severe respiratory failure (PaO_2/FiO_2 <200) – respiratory distress or acute respiratory distress syndrome (ARDS) – deteriorating despite non-invasive forms of respiratory support (i.e. non-invasive ventilation (NIV), or high-flow nasal oxygen (HFNO)) – requiring mechanical ventilation • hypotension or shock • impairment of consciousness • other organ failure
RECOMMENDED			Use dexamethasone 6 mg daily intravenously or orally for up to 10 days (or acceptable alternative regimen) in adults with COVID-19 who are ***receiving oxygen*** (including mechanically ventilated patients).	

Treatments under review

NATIONAL COVID-19 CLINICAL EVIDENCE TASKFORCE

- Nirmatrelvir and ritonavir (Paxlovid) **NEW**
- Tixagevimab and cilgavimab (Evusheld) **NEW**
- Molnupiravir
- Sotrovimab
- Regdanvimab
- Casirivimab plus imdevimab
- Dexamethasone
- Care of people with post-COVID-19

Omicron and treatment of people with COVID-19

NATIONAL COVID-19 CLINICAL EVIDENCE TASKFORCE

CONDITIONAL RECOMMENDATION FOR

Not requiring oxygen WITHOUT lower respiratory tract disease	Not requiring oxygen WITH lower respiratory tract disease	Requiring oxygen WITHOUT mechanical ventilation	Requiring invasive mechanical ventilation
Consider using inhaled budesonide ***within 14 days of symptom onset*** in adults with COVID-19 who ***do not require oxygen*** and have one or more ***risk factors***^ for disease progression.		Consider using remdesivir in adults with COVID-19 who ***require oxygen but do not require non-invasive or invasive ventilation.***	
Consider using one of the following:			
Consider using casirivimab plus imdevimab ***within 7 days of symptom onset*** in adults with COVID-19 who ***do not require oxygen*** and have one or more ***risk factors***^ for disease progression. #	Consider using casirivimab plus imdevimab in ***seronegative*** adults hospitalised with moderate to critical COVID-19. *		
Consider using sotrovimab ***within 5 days of symptom onset*** in adults with COVID-19 who ***do not require oxygen*** and have one or more ***risk factors***^ for disease progression. #		**Consider using one of the following:**	
		Consider using baricitinib in adults hospitalised with COVID-19 who r***equire supplemental oxygen.***	
		Consider using tocilizumab for the treatment of COVID-19 in adults ***who require supplemental oxygen***, particularly where there is evidence of ***systemic inflammation.***	
		Consider using sarilumab for the treatment of COVID-19 in adults who ***require high-flow oxygen, non-invasive ventilation or invasive mechanical ventilation.*** *	

Sotrovimab and treatment of people with COVID-19

NATIONAL COVID-19 CLINICAL EVIDENCE TASKFORCE

Conditional recommendation

Consider using sotrovimab within 5 days of symptom onset in adults with COVID-19 who do not require oxygen and have one or more risk factors for disease progression.

Consensus recommendation

Within the patient population for which sotrovimab is conditionally recommended for use (as listed above), decisions about the appropriateness of treatment with sotrovimab should be based on the patient's individual risk of severe disease, on the basis of age or multiple risk factors, and COVID-19 vaccination status.

Consider using sotrovimab in unvaccinated or partially vaccinated patients and patients who are immunosuppressed regardless of vaccination status.

Do not routinely use sotrovimab in fully vaccinated patients unless immunosuppressed.

Sotrovimab is appropriate for use in adults with the following:

- COVID-19 positive with symptom onset equal to or less than 5 days
- Partially or not vaccinated for COVID-19 (people who have had two vaccinations and are due for a booster may be considered partially vaccinated)
- no oxygen therapy or ventilation required

and include the presence of at least one of the following:

- immunosuppressed (irrespective of vaccination status)
- age ≥ 50 years
- type 1 or 2 diabetes mellitus (requiring medication)
- obesity (BMI > 30 kg/m2)

chronic kidney disease (i.e. eGFR < 60 by MDRD)

- congestive heart failure (NYHA class II or greater)
- cardiovascular disease including hypertension treated with medication
- chronic lung disease (including asthma treated with regular medication)
- moderate-to-severe asthma (requiring an inhaled steroid to control symptoms or have been prescribed a course of oral steroids in the previous 12 months)
- chronic liver disease

Priority questions from frontline clinicians

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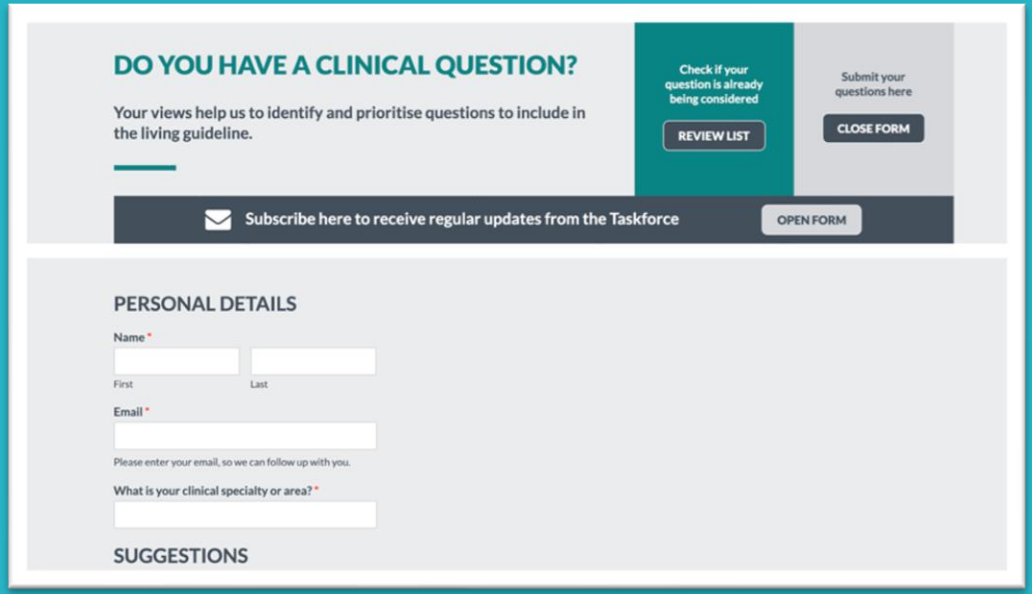


DO YOU HAVE A CLINICAL QUESTION?

Your views help us to identify and prioritise questions to include in the living guideline.

Check if your question is already being considered

REVIEW LIST

Submit your questions here

CLOSE FORM

Subscribe here to receive regular updates from the Taskforce

OPEN FORM

PERSONAL DETAILS

Name *

First

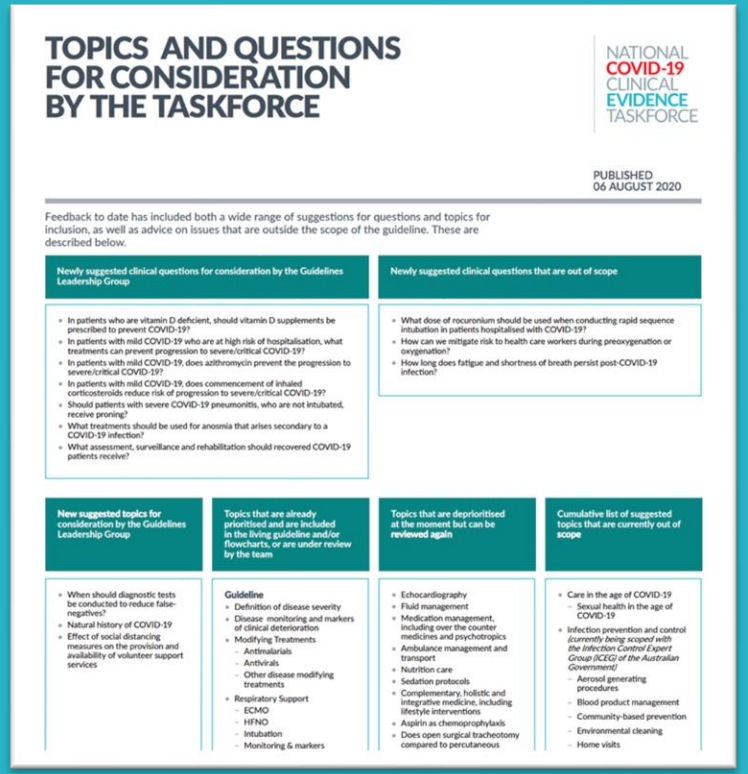
Last

Email *

Please enter your email, so we can follow up with you.

What is your clinical specialty or area? *

SUGGESTIONS



TOPICS AND QUESTIONS FOR CONSIDERATION BY THE TASKFORCE

NATIONAL COVID-19 CLINICAL EVIDENCE TASKFORCE

PUBLISHED 06 AUGUST 2020

Feedback to date has included both a wide range of suggestions for questions and topics for inclusion, as well as advice on issues that are outside the scope of the guideline. These are described below.

Newly suggested clinical questions for consideration by the Guidelines Leadership Group

- In patients who are vitamin D deficient, should vitamin D supplements be prescribed to prevent COVID-19?
- In patients with mild COVID-19 who are at high risk of hospitalisation, what treatments can prevent progression to severe/critical COVID-19?
- In patients with mild COVID-19, does azithromycin prevent the progression to severe/critical COVID-19?
- In patients with mild COVID-19, does commencement of inhaled corticosteroids reduce risk of progression to severe/critical COVID-19?
- Should patients with severe COVID-19 pneumonitis, who are not intubated, receive proning?
- What treatments should be used for anosmia that arises secondary to a COVID-19 infection?
- What assessment, surveillance and rehabilitation should recovered COVID-19 patients receive?

Newly suggested clinical questions that are out of scope

- What dose of rocuronium should be used when conducting rapid sequence intubation in patients hospitalised with COVID-19?
- How can we mitigate risk to health care workers during preoxygenation or oxygenation?
- How long does fatigue and shortness of breath persist post-COVID-19 infection?

New suggested topics for consideration by the Guidelines Leadership Group

- When should diagnostic tests be conducted to reduce false-negatives?
- Natural history of COVID-19
- Effect of social distancing measures on the provision and availability of volunteer support services

Topics that are already prioritised and are included in the living guideline and/or flowcharts, or are under review by the team

Guideline

- Definition of disease severity
- Disease monitoring and markers of clinical deterioration
- Modifying Treatments
  - Antimalarials
  - Antivirals
  - Other disease modifying treatments
- Respiratory Support
  - ECMO
  - HFNO
  - Intubation
  - Monitoring & markers

Topics that are deprioritised at the moment but can be reviewed again

- Echocardiography
- Fluid management
- Medication management, including over the counter medicines and psychotropics
- Ambulance management and transport
- Nutrition care
- Sedation protocols
- Complementary, holistic and integrative medicine, including lifestyle interventions
- Aspirin as chemoprophylaxis
- Does open surgical tracheotomy compared to percutaneous

Cumulative list of suggested topics that are currently out of scope

- Care in the age of COVID-19
  - Sexual health in the age of COVID-19
- Infection prevention and control *(currently being scoped with the Infection Control Expert Group (ICEG) of the Australian Government)*
  - Aerosol generating procedures
  - Blood product management
  - Community-based prevention
  - Environmental cleaning
  - Home visits

Stay connected

NATIONAL COVID-19 CLINICAL EVIDENCE TASKFORCE

- **Follow us on Twitter**  **@evidenceCOVID19**
- **Sign up for our email updates covid19evidence.net.au/#subscribe**
- **Share our guidance with your colleagues via your networks**
- **Provide feedback guidelines@covid19evidence.net.au**

Questions

Please type your question in the chat

COVID Positive Pathways

Omicron Program Summary
Louise Galloway

19th January 2022

VICTORIA State Government | Department of Health

C+P response to Omicron

Overview

- Since the identification of the new Omicron variant, Victoria has experienced a rapid and sustained surge in COVID case numbers across the state. As the ability to contract trace at scale becomes more difficult, a pivot toward Covid Positive Pathways (C+P) Program becomes all the more important.
- A key challenge for the C+P Program is ensuring that timely contact is made with individuals who test positive to COVID-19 so they can be placed into the appropriate care pathways based their clinical and social risk.

The Solution

Important refinements and changes have been made to the C+P Program to better respond to the increased demands and pressures placed on Health Services and resources. These refinements include:

1. Ensuring that a positive Rapid Antigen Test (RAT) result is an entry point into the pathway program
2. Establishing 'self-care' pathway to divert low risk patients away from health services reducing the downstream burden on the Health resources
3. Using digital tools (eg Covid Monitor) across the metro and some regional Health Service Partnerships (HSP) to enable daily symptom reporting and provide escalation of care, if required
4. Partnering with Healthdirect Australia (HDA) to support C+P staff with outbound the intake assessment and prioritisation of individuals entering the program
5. Refining the patient risk / prioritisation framework, to ensure that those people most at risk are contacted and monitored

Key priorities and refinements

Next steps

Whilst there have been a number of important refinements made to the C+P Program in response to the omicron variant, a number of challenges remain to be overcome to ensure the sustainability of the program with ongoing caseload increases. As part of this, there are three key areas of initial focus to further refine the program:

1 Data and Reporting:

Current reporting is largely a manual process which does not provide full visibility of issues and key challenges across the system. Work is underway to develop an automated dashboard which extracts data from both the TREVI system and the various remote monitoring tools and provides a single, end-to-end view of the pathway.

2 Increasing system capacity and efficiency:

A number of program work streams have been instigated to increase the capacity and improve the overall efficiency of the program to better respond to increased caseloads. These include:

a. **Commencing a GP notification pilot** in North East Melbourne to connect lower risk patients to primary and community care (pilot go-live 24th Jan).

b. With increasing numbers, **continuing to redesign / refine the standardised priority assessment** definitions to ensure that the highest priority patient receive the right care at the right time.

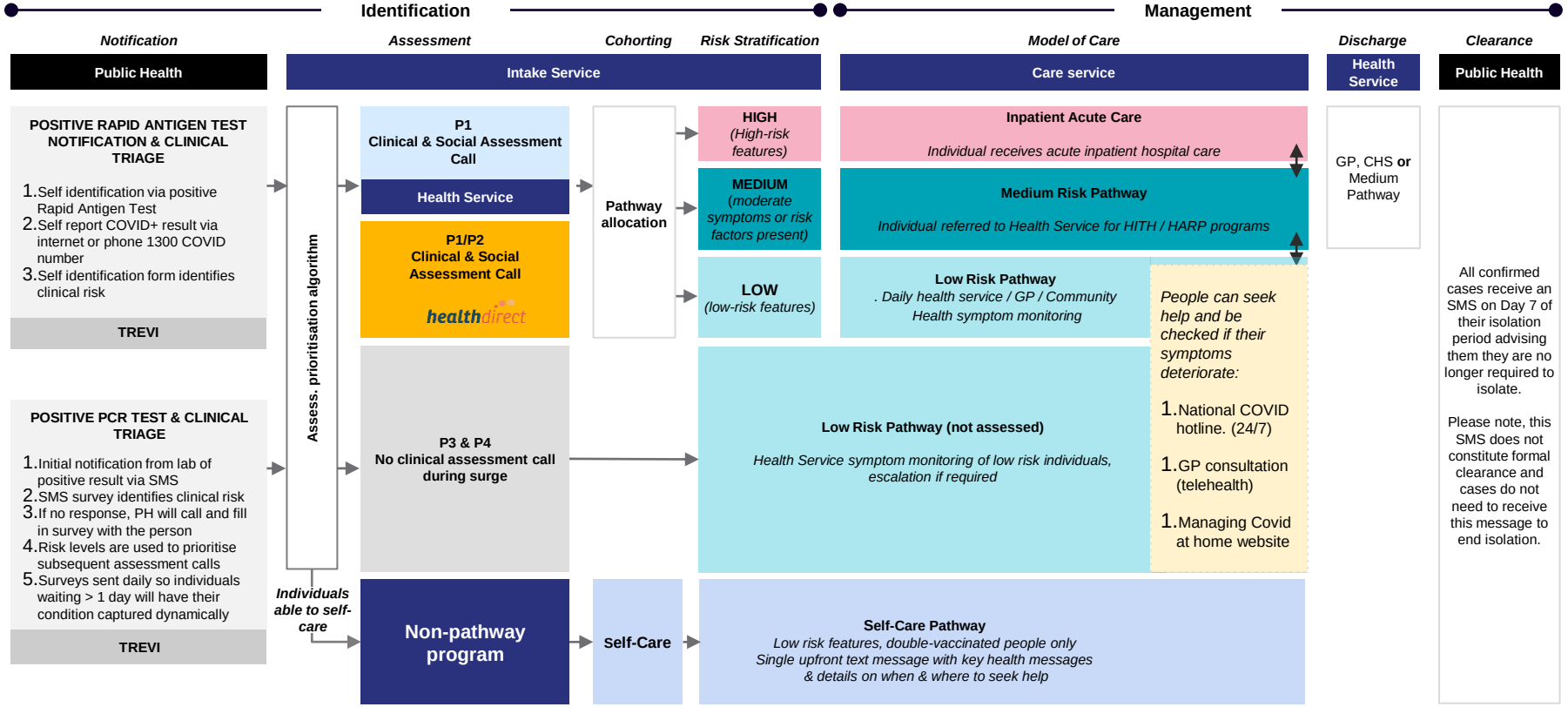
c. **Improving case load balancing within the program by utilising additional resources** to provide support to C+P staff with intake assessment calls and prioritisation. Healthdirect have provided an additional 300 FTE who are supporting the HSPs to assess the highest priority patients.

3 Vulnerable patient cohorts

Improving access for vulnerable patient cohorts (disability, Aboriginal & Torres Strait Islander (ATSI), and immunocompromised) by bringing these groups into the Pathways Program.

Refined Covid Positive Care Pathways Program

Updated version to reflect new Omicron Variant



Thank You

VICTORIA State Government | Department of Health

Questions

Please type your question in the chat

Future webinars

- The next webinar is planned for the 02/02/22
- To register for future webinars email us: centresofclinicalexcellence@safercare.vic.gov.au

Get in contact

- Please complete our short survey
- If you have specific questions relating to the COVID+ Pathways please email the Department of Health at covid+pathways@health.vic.gov.au

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