Safer Care Victoria

COVID + Learning Network Webinar Questions

OFFICIAL

COVID+ Pathways: NSW’s Experience and Learning’s from Omicron

Questions and Answers

Q1: Do you have any information that you can speak to about the breadth of regular GP engagement with COVID+ Pathways in terms of sign up of GP involvement and the equity of how mainstream general practices engage with COVID+ Pathways and across Victoria?

A: I (Louise Galloway) think that the Northwest has been very strong at linking in with GPs right through from where this program started. In terms of the model of linking in, the PHN’s have been charged by the Commonwealth to identify GP practices who are happy to look after their own patients because most of them will be through telehealth, and GP practices that are happy to take on patients that are not their own. The Commonwealth has also recontracted the Commonwealth GPRCs. They’ve also charged them with looking after patients. What I do know is that most of the primary care forum that I'm engaged with, most GPs, do want to look after their own patients. It's just that they don't know they are positive unless the patient contacts them, or they are notified through some of the other systems. Some practices are not equipped to do face-to-face and separate patients and that's where I think some messaging about our GP respiratory clinics and GP-to-GP referral is needed. The short answer is that we don't know, but what people tell me is they would like to look after their own patients and I'm still waiting on an update from the Commonwealth about the PHN work.

Q2: Did you test how clear GPs were in relation to their duty of care for patients they are “notified” about? It will be essential that there are clear escalation protocols in place for individuals whose GP does not engage with care following notification.

A: There have been a number of GPs on the pilot working group to ensure points like yours were considered. The current pilot notification message does not outline information for the GP to consider. At this stage of testing, the notification of positive patients is indicating the individual is under health service clinical care and there is no action for the GP to take. As this program expands, your points around escalation will be discussed.

Q3: Looking forward, how do you (Amith Shetty) see the progression of the next steps of your response in NSW?

We've been working closely with our primary care partners. I had a meeting with them yesterday as well and we've been talking about whilst people are focused on virtual care, we need to move away from virtual care especially with Omicron, unless things change. What we really need to focus on next is high complexity patients who need a holistic model of care and it's not delivered through local health districts or hospitals; it's delivered in primary care.

COVID is probably not going to be a problem for people who have complicated medical illness. Yes, there will be the 2% who have the risk of deterioration but what about the percentage of others who have diabetes or autoimmune illness? This is where I think working with primary care, sharing those risk details, providing access to COVID therapies and taking care of the underlying illnesses is important. We are aiming to use the bridges we have built currently with primary care to push our integrated care and integrated health models with primary care. I think that's where we see this moving to because we've now had 13% or 15% of our population infected. That's the recorded population anyway.

Q4: Have you managed to think of an approach to the vexed issue of those that don't self-report (and therefore aren't engaged and likely quite a high-risk group)?

A: This is a conversation we had in December and early January and a lot of communication highlights the current challenge and the high-risk group populations who probably have trust issues with health systems. I have highlighted that this is not a COVID problem. This is a problem we had before COVID, which we continue to have through COVID, and we will continue to have post COVID. The strategies of how we engage with these communities needs to be beyond just for COVID and the fear tactics saying, 'if you get COVID and don't register, you can end up in ICU'. This really doesn't work. It hasn't worked up until now and it's probably not likely to work in the future.

I think it's about the local models and working with their representative groups. We're finding it does help us significantly to better reach these communities. On the other hand, I also have a lot of community teams who have been concerned that once you move to the opt in model, this is no different to any other disease. We've been very clear with our communications with patient groups that this is now not an endemic disease, but it is an endemic state, and it is about escalation and opting in just like any other disease model. Rather than us being paternalistic, it's about trying to engage proactively. In saying that, we do the best we can, but we can't fix everyone. That is the message we're sending out.

Q5: Where does congruent living like nursing homes and disability support accommodation fit into your model?

A: We used to have working groups for aged care centres and for disability homes. We do continue doing a lot with disability homes, but aged care we have started just supporting staffing models at this point. Like Victoria, we have had a bunch of sites which have been provided oral therapies. Working closely with our GP clients, I can see that a lot of the oral prescriptions in aged care facilities have followed NSW guidelines and they are using the NSW prescribing pathway. It's sort of letting go of a lot of things at the moment. I think aged care is probably using an older model, which is probably not the right model. We also do have outbreak management pathways for aged care units. We do have flying squad models for oral therapies set up as well, so whatever support is needed we are able to step in. But I do know that GPs are prescribing oral therapeutics in aged care settings currently.