
COVID + Learning Network Webinar Questions

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GP Perspective on COVID + Pathways: Learnings and future directions

Questions and Answers

Q1: The northwest region has a really diverse community and I'm interested to hear your experience of the package of care you were able to mobilize around people to support them both through care navigation and the 551 number, either in outcomes or anecdotally what impact do you think that made on keeping people at home and avoiding unnecessary transfer to hospital?

A: We are currently undertaking some analysis of this, but I think care navigation has always been a really critical role. The pathway was founded on the social determinants that would help people stay at home and bring the best health outcomes. We've always collected demographic information about language, spoken language, interpreter use, and we think that is really important, not necessarily to have a special pathway for each individual group, but to actually make sure the pathway was responsive to whether you were non-English speaking, identified as Aboriginal or Torres Strait Islander, if you had a disability. There are other parts of the community health response and the cohealth response that we've integrated with specifically the high-risk residential response group to provide some care navigation that crossed over into different programs.

An example might be supporting a single mother of four who's just returned home from hospital COVID positive with a newborn baby and her washing machine has broken and she's stuck in 14 days of isolation. Also supporting someone to access their opioid substitution therapy as well as people who are homeless, elderly or reluctant to be tested and ringing them to provide advice. There are many different ways where a comprehensive localized response has been successful and working with partners, we had agreed points when someone would go into the medium pathway but if someone had very good supports in the community, we didn't necessarily have to send them into the medium pathway if we could coordinate care in the community. There is also the flexibility and ability to ring people to discuss difficult issues for example, in August last year a number of children were being left at home for a short period of time while both parents were transferred into hospital. All these sorts of things have been challenges and now we have milder disease, a shorter isolation period and a highly vaccinated population. So again, we've got to shift, and these shifts are coming every 5-6 weeks.

Additionally, we've had a lot of standardization across pathways in the last several months and sometimes standardization can be the enemy of innovation. We should encourage people to have minimum standards of care and then be able to innovate within their local area and local catchment because they know the best solutions. Standardization has its place, but I think it can hold up innovation.

Q2: With the changes in severity of symptoms with Omicron, where do you see the opportunities for innovation and how do you see these types of models evolving for other chronic disease in which they might be transferable in the future for supporting people in the community?

A: I (Janelle Devereux) have been having conversations with the policy team at state health about the critical success factors of models of this kind and certainly the social and clinical component as well as the partnership model are critical in supporting continuity of care. Some of the challenges include that there are a whole range of clinical conditions that need attention at the moment in terms of deferred or delayed care. We want to look at the data in terms of burden on the community. We want to understand where there is the greatest value of a community based and a social determinants approach and then actually look to demonstrate at sites where you have engaged clinicians willing to work together in an integrated way. If I took that from a west metro perspective, there's opportunity for us in relation to cancer. Many others and I are concerned about delayed diagnosis of cancer at the moment. We also know that cancer patients have a range of needs outside of their clinical cancer treatment.

We are starting a pathway that leveraged from the lessons learned from COVID + that is specifically related to dyspnoea so working with the same respiratory teams, but also heart failure patients to say how can we identify consumers early from admission to prevent readmissions into hospital. We're working with cohealth and Merri Health to provide the care navigation component and we're supporting the GPs to participate in that. I would suggest that on a health service partnership basis you look at those elements of burden of disease, engaged clinicians, ability of GPs and community health to be able to add significant value.

From a population health perspective as an epidemiologist this is really important. Delivery of systems is part of epidemiology, it's not just the documentation of disease in populations, it's actually looking at solutions. I (Nicole Allard) think what we also need to do is start with the consumer at the centre of the matrix and not start by looking at hospital diversion as the key point but looking at the consumer as the focus and then how can we make the consumers journey best through a system that will result in less ED and hospital admissions.

Q3: Did you receive any feedback from your patient cohort regarding care exhaustion due to frequent monitoring phone calls especially if multiple positive family members? BSWPHU RPM received this feedback daily

A: We have had reports of care fatigue during the COVID response. With the Omicron variant being milder there is a need for service redesign and a good public education campaign and activating calling GPs etc. We would also advocate for an evaluation of the current use of Covid Monitor as this is pushing out a lot of surveys.