Safer Care Victoria

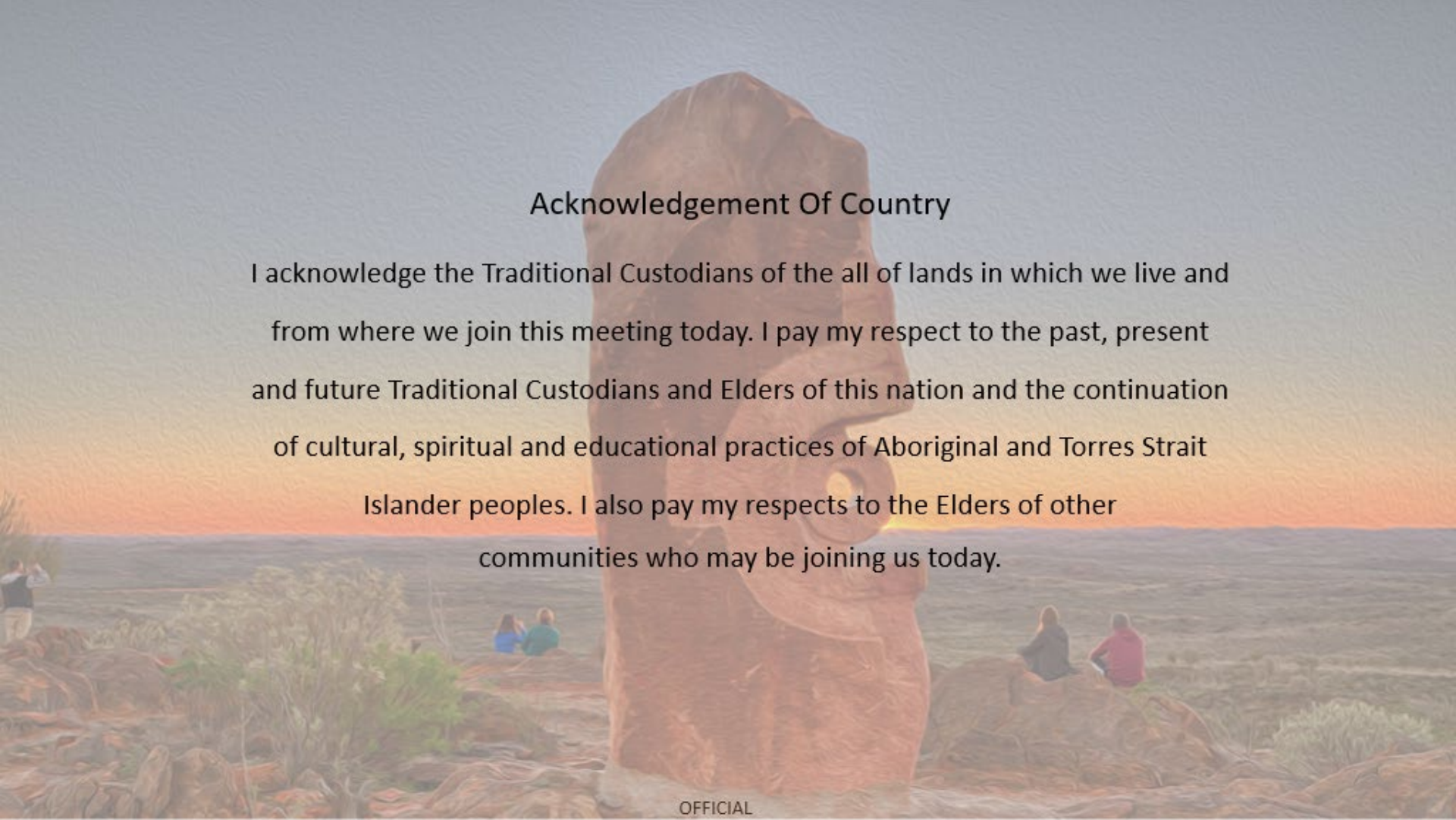
**Wednesday 2 March, 2022**

# COVID+ Pathway Learning Network webinar series

Webinar 16: GP perspective on COVID + Pathways: Learnings and future directions

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.

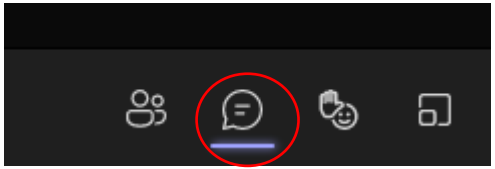
# Webinar series purpose

- 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

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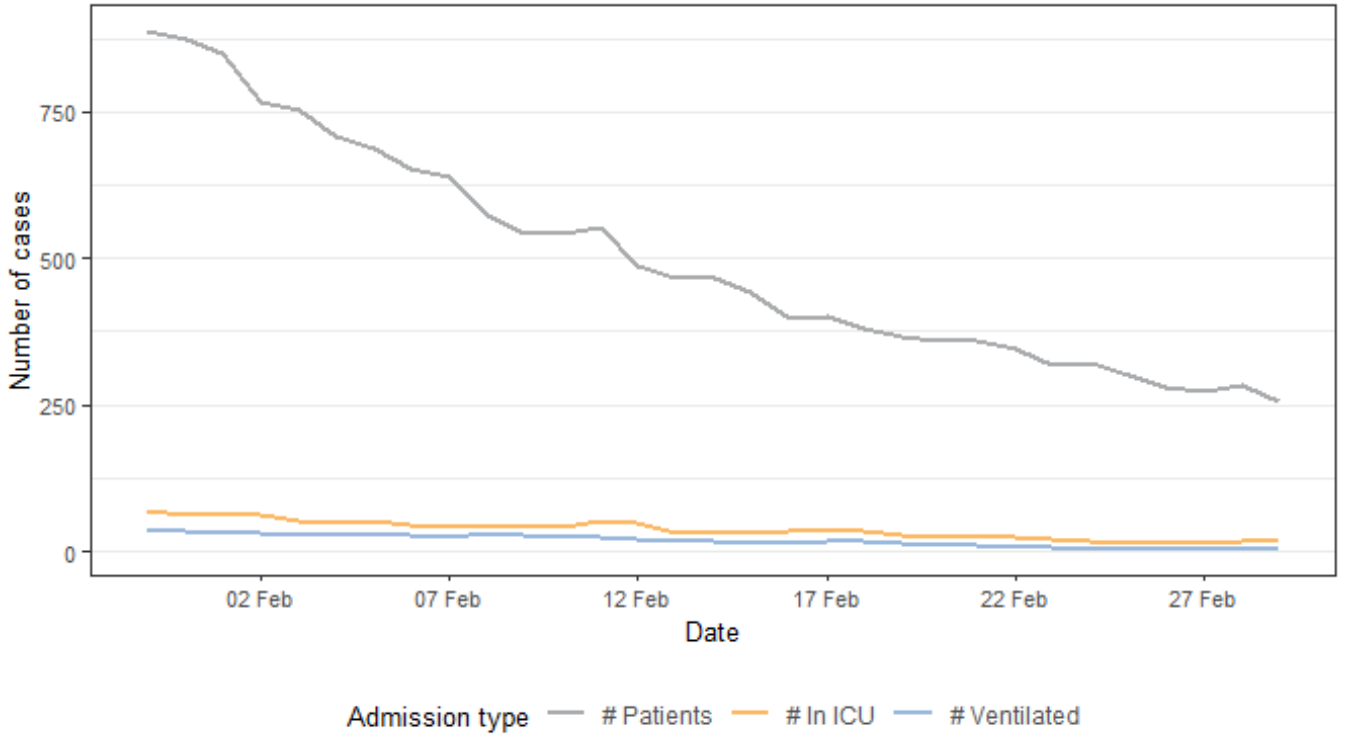
# Overview

| Topic | Presenter |
| --- | --- |
| **National Clinical Evidence Taskforce update** | A/Prof Steve McGloughlin |
| **Questions/Discussion** | |
| **GP perspective on COVID + Pathways: Learnings and future directions** | Dr Nicole Allard & Janelle Devereux |
| **Questions/Discussion** | |

# Victorian inpatient data

| Age Range (years) | # Patients | % Patients vaccinated (2 doses) | # In ICU | % In ICU vaccinated (2 doses) | # Ventilated | % Ventilated vaccinated (2 doses) |
|---|---|---|---|---|---|---|
| Less than 1 year | 3 | 0% | 0 | - | 0 | - |
| 01-09 | 9 | 0% | 0 | 0% | 0 | - |
| 10-19 | 7 | 71% | 0 | - | 0 | - |
| 20-29 | 16 | 50% | 2 | 0% | 0 | - |
| 30-39 | 21 | 48% | 0 | - | 0 | - |
| 40-49 | 25 | 32% | 3 | 33% | 1 | 0% |
| 50-59 | 36 | 47% | 4 | 25% | 1 | 0% |
| 60-69 | 63 | 40% | 5 | 60% | 1 | 100% |
| 70-79 | 91 | 37% | 3 | 33% | 0 | - |
| 80-89 | 103 | 44% | 3 | 0% | 0 | - |
| 90+ | 38 | 53% | 0 | - | 0 | - |
| Total | 412 | 42% | 20 | 29% | 3 | 33% |

# Hospitalised cases (by admission types)






*01:45, 01/03/2022*

# National COVID-19 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

# Safer Care Victoria Webinar
# Taskforce Update

**A/Prof Steve McGloughlin,**
**Executive Director**

March 2, 2022

NATIONAL
COVID-19
CLINICAL
EVIDENCE
TASKFORCE


# *Good Year sued for false advertising*

The Chaser | February 25th, 2022

# What is Evusheld

NATIONAL COVID-19 CLINICAL EVIDENCE TASKFORCE

- EVUSHELD is administered as two separate, sequential injections of two long-acting monoclonal antibodies, **tixagevimab** and **cilgavimab**.
- These antibodies bind to the spike protein of the SARS-CoV-2 virus at two different sites to stop the virus from entering the body's cells and causing infection.
- Approved by the TGA for pre-exposure prophylaxis on 24 February 2022.

# Taskforce Evusheld recommendation

NATIONAL COVID-19 CLINICAL EVIDENCE TASKFORCE

Taskforce consensus recommendation (28/2)

Do not routinely use tixagevimab plus cilgavimab as pre-exposure prophylaxis, however use may be considered in exceptional circumstances, in individuals who are severely immunocompromised.

Given the limited evidence of benefit or safety, small effect sizes and absence of evidence evaluating the effectiveness of tixagevimab plus cilgavimab for prevention of infection by SARS-CoV-2 variants of concern, rigorous data collection should be undertaken on indications and key outcomes for adults who receive pre-exposure prophylaxis with tixagevimab plus cilgavimab.

# New recs for remdesivir in adults with mild COVID-19 (18/2)

NATIONAL COVID-19 CLINICAL EVIDENCE TASKFORCE

Conditional recommendation

Consider using remdesivir within 7 days of symptom onset in unvaccinated* adults with COVID-19 who do not require oxygen and who have one or more risk factors for disease progression.

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

# New recs for remdesivir in adults with mild COVID-19 (18/2)

NATIONAL COVID-19 CLINICAL EVIDENCE TASKFORCE

Consensus recommendation

In addition to at-risk unvaccinated adults, also consider using remdesivir within 7 days of symptom onset in adults with COVID-19 who do not require oxygen and:

- are immunocompromised regardless of vaccination status;

or

- have received one or two doses of vaccine and who are at high risk of severe disease on the basis of age and multiple risk factors.

# New rec for molnupiravir in partially vaccinated patients (3/2)

NATIONAL COVID-19 CLINICAL EVIDENCE TASKFORCE

Consensus recommendation

In addition to at-risk unvaccinated adults, also consider using molnupiravir within 5 days of symptom onset in adults with COVID-19 who do not require oxygen and:

- are immunocompromised regardless of vaccination status;

or

- have received one or two doses of vaccine and who are at high risk of severe disease on the basis of age and multiple risk factors

**AND** where other treatments (such as sotrovimab or nirmatrelvir plus ritonavir) are not suitable or available.

# Paediatric and adolescent care

NATIONAL COVID-19 CLINICAL EVIDENCE TASKFORCE

## New recommendations

- Molnupiravir (Lagevrio) – Only in research settings
- Nirmatrelvir plus ritonavir (Paxlovid) – Only in research settings

## Flowcharts

- NEW flowchart for disease-modifying treatments
- UPDATED Pathways to Care

# DISEASE-MODIFYING TREATMENTS FOR ADULTS WITH COVID-19

NATIONAL COVID-19 CLINICAL EVIDENCE TASKFORCE

**VERSION 4.1**
PUBLISHED 25 FEBRUARY 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**<br>An individual with no clinical features suggestive of moderate or more severe disease:<br>• no OR mild symptoms and signs (fever, cough, sore throat, malaise, headache, muscle pain, nausea, vomiting, diarrhoea, loss of taste and smell)<br>• no new shortness of breath or difficulty breathing on exertion<br>• no evidence of lower respiratory tract disease during clinical assessment or on imaging (if performed) | **Moderate**<br>A stable patient with evidence of lower respiratory tract disease:<br>• during clinical assessment, such as<br>– oxygen saturation 92-94% on room air at rest<br>– desaturation or breathlessness with mild exertion<br>• or on imaging | **Severe**<br>A patient with signs of moderate disease who is deteriorating<br>OR<br>A patient meeting any of the following criteria:<br>• respiratory rate ≥30 breaths/min<br>• oxygen saturation <92% on room air at rest or requiring oxygen<br>• lung infiltrates >50% | **Critical**<br>A patient meeting any of the following criteria:<br>• respiratory failure (defined as any of)<br>– severe respiratory failure ($PaO_2/FIO_2$ <200)<br>- respiratory distress or acute respiratory distress syndrome (ARDS)<br>– deteriorating despite non-invasive forms of respiratory support (i.e. non-invasive ventilation (NIV), or high-flow nasal oxygen (HFNO))<br>– requiring mechanical ventilation<br>• hypotension or shock<br>• impairment of consciousness<br>• 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). | |

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 one of the following:** | | **Consider using one of the following:** | |
| Consider using **sotrovimab** ***within 5 days of symptom onset*** in ***unvaccinated***[#] adults with COVID-19 who ***do not require oxygen*** and who have one or more ***risk factors***^ for disease progression.<br>Within the patient population for which sotrovimab is conditionally recommended for use (see Remark), 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 and multiple risk factors, COVID-19 vaccination status and time since vaccination.<br>*Note: Refer to the related consensus recommendation for additional guidance.* | | 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 **baricitinib** in adults hospitalised with COVID-19 who ***require supplemental oxygen.*** | |
| | | Consider using **sarilumab** for the treatment of COVID-19 in adults who ***require high-flow oxygen, non-invasive ventilation or invasive mechanical ventilation.*** * | |
| Consider using **nirmatrelvir plus ritonavir** ***within 5 days of symptom onset*** in ***unvaccinated***[#] adults with COVID-19 who ***do not require oxygen*** and who have one or more ***risk factors***^ for disease progression.**<br>Within the patient population for which nirmatrelvir plus ritonavir is conditionally recommended for use (see Remark), decisions about the appropriateness of treatment with nirmatrelvir plus ritonavir should be based on the patient's individual risk of severe disease, on the basis of age and multiple risk factors, COVID-19 vaccination status and time since vaccination.<br>*Note: Refer to the related consensus recommendation for additional guidance.* | | Consider using **remdesivir** in adults with COVID-19 who ***require oxygen but do not require non-invasive or invasive ventilation.*** | |
| Consider using **remdesivir** ***within 7 days of symptom onset*** in ***unvaccinated***[#] adults with COVID-19 who ***do not require oxygen*** and who have one or more ***risk factors***^ for disease progression.<br>Within the patient population for which remdesivir is conditionally recommended for use (see Remark), decisions about the appropriateness of treatment with remdesivir should be based on the patient's individual risk of severe disease, on the basis of age and multiple risk factors, COVID-19 vaccination status and time since vaccination.<br>*Note: Refer to the related consensus recommendation for additional guidance.* | | | |
| 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. * | | |

| | 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 |
|---|---|---|---|---|
| CONSENSUS RECOMMENDATION FOR | In addition to at-risk unvaccinated adults, also consider using **sotrovimab** ***within 5 days of symptom onset*** in adults with COVID-19 who ***do not require oxygen*** and:<br>• are ***immunocompromised*** regardless of vaccination status; or<br>• have received one or two doses of vaccine and who are at ***high risk of disease*** on the basis of age and multiple risk factors^. | | | |
| | In addition to at-risk unvaccinated adults, also consider using **nirmatrelvir plus ritonavir**** ***within 5 days of symptom onset*** in adults with COVID-19 who ***do not require oxygen*** and:<br>• are ***immunocompromised*** regardless of vaccination status; or<br>• have received one or two doses of vaccine and who are at ***high risk of severe disease*** on the basis of age and multiple risk factors^. | | | |
| | In addition to at-risk unvaccinated adults, also consider using **remdesivir** ***within 7 days of symptom onset*** in adults with COVID-19 who ***do not require oxygen*** and:<br>• are ***immunocompromised*** regardless of vaccination status; or<br>• have received one or two doses of vaccine and who are at ***high risk of severe disease*** on the basis of age and multiple risk factors^. | | | |
| | Consider using **molnupiravir** ***within 5 days of symptom onset*** in ***unvaccinated***[a] adults with COVID-19 who ***do not require oxygen*** and who have one or more ***risk factors***^ for disease progression, where other treatments (such as sotrovimab or nirmatrelvir plus ritonavir) are not suitable or available.<br>Within the patient population for which molnupiravir is recommended for use (see Remark), decisions about the appropriateness of treatment with molnupiravir should be based on the patient's individual risk of severe disease, on the basis of age and multiple risk factors, COVID-19 vaccination status and time since vaccination. | | | |

| 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 |
|---|---|---|---|

**CONDITIONAL RECOMMENDATION AGAINST**

In addition to at-risk unvaccinated adults, also consider using **molnupiravir** ***within 5 days of symptom onset*** in adults with COVID-19 who ***do not require oxygen*** and:

- are ***immunocompromised*** regardless of vaccination status; or
- have received one or two doses of vaccine and who are at ***high risk of severe disease*** on the basis of age and multiple risk factors^

***AND*** where other treatments (such as sotrovimab or nirmatrelvir plus ritonavir) are not suitable or available.

**DO NOT** routinely use **dexamethasone** (or other systemic corticosteroid) to treat COVID-19 in adults who ***do not require oxygen***.

**NOT RECOMMENDED**

**DO NOT** use the following for the treatment of COVID-19:

- aspirin
- azithromycin
- colchicine
- convalescent plasma
- hydroxychloroquine
- hydroxychloroquine plus azithromycin
- interferon β-1a
- interferon β-1a plus lopinavir-ritonavir
- lopinavir-ritonavir

**DO NOT** use **casirivimab plus imdevimab** in ***seropositive*** adults hospitalised with moderate to critical COVID-19.

**DO NOT** start **remdesivir** in adults hospitalised with COVID-19 who ***require non-invasive or invasive ventilation.***

# Upcoming guidance

NATIONAL COVID-19 CLINICAL EVIDENCE TASKFORCE

- New pregnancy disease-modifying treatments flowchart
- Tixagevimab and cilgavimab (Evusheld) – for special populations
- Molnupiravir (Lagevrio) – for pregnant and breastfeeding women
- Nirmatrelvir plus ritonavir (Paxlovid) - for pregnant and breastfeeding women
- Remdesivir - for special populations
- Metformin
- Inhaled corticosteroids

# In development

- Decision aid for disease-modifying treatments for adults

# Presentation

**“GP perspective on COVID + Pathways: Learnings and future directions”**

Dr Nicole Allard, GP, Public Health Lead cohealth

Janelle Devereux, Executive Director, Health Systems Integration

# *"GP perspective on COVID + Pathways: Learnings and future directions"*

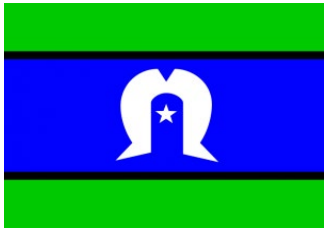
*Dr Nicole Allard, GP, Public Health Lead cohealth*
*Janelle Devereux, Executive Director, Health Systems Integration*

Safer Care Victoria 2-3-22

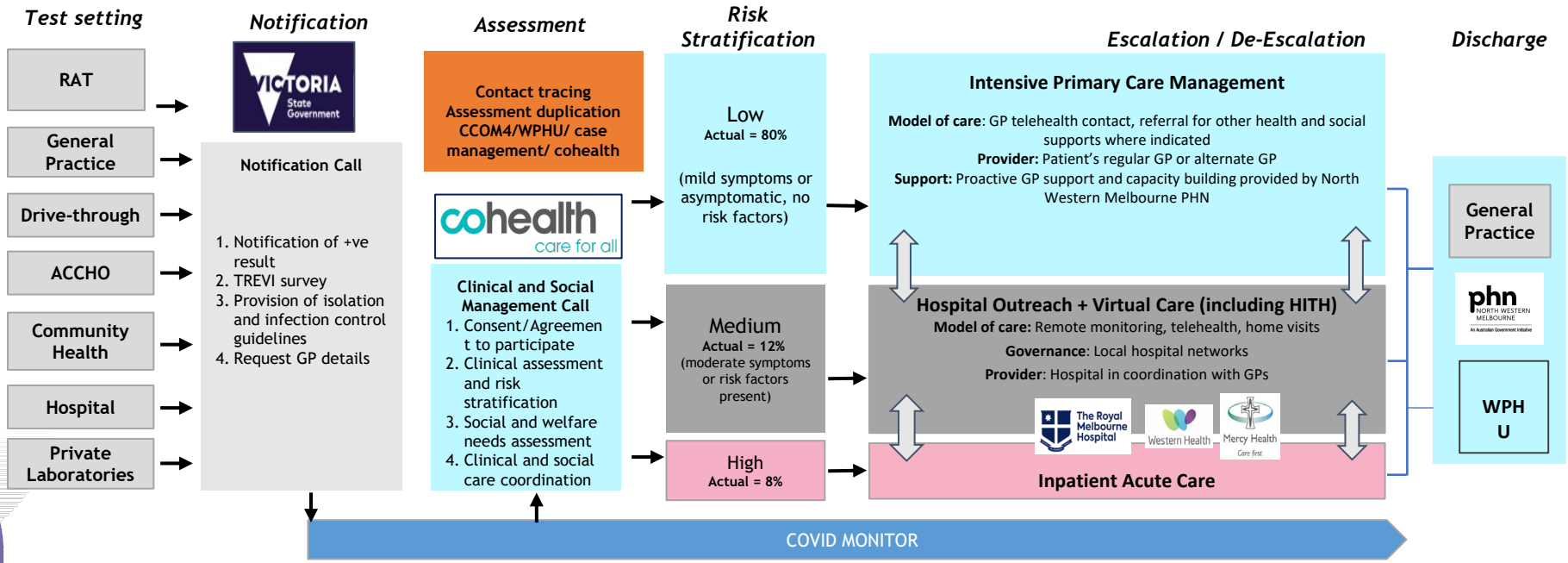
# *Acknowledgement of Country*

North Western Melbourne Primary Health Network would like to acknowledge the peoples of the Kulin nation as the traditional custodians of the land on which we're meeting today.

We recognise their continuing connection to the land, waters and culture, and would like to pay our respects to Elders past, present and emerging.



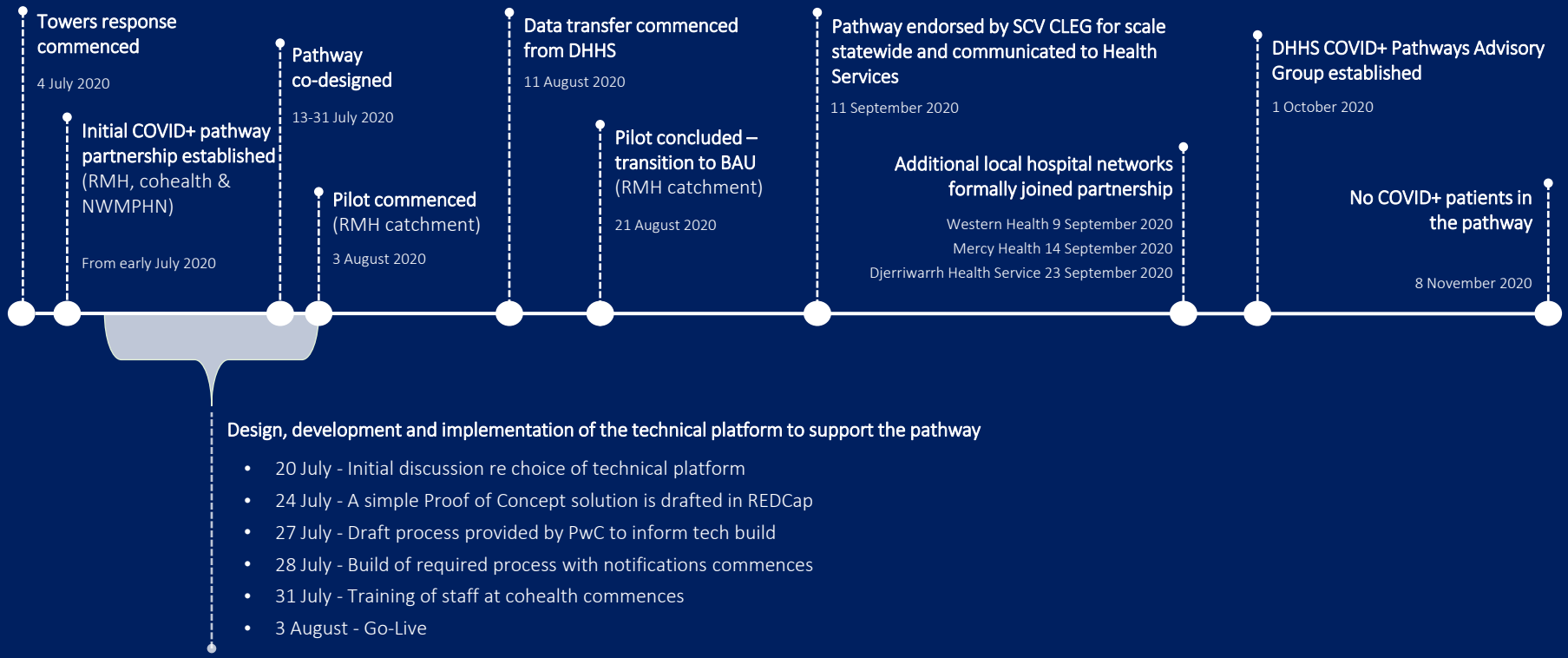
# Western Metro COVID+ Pathway



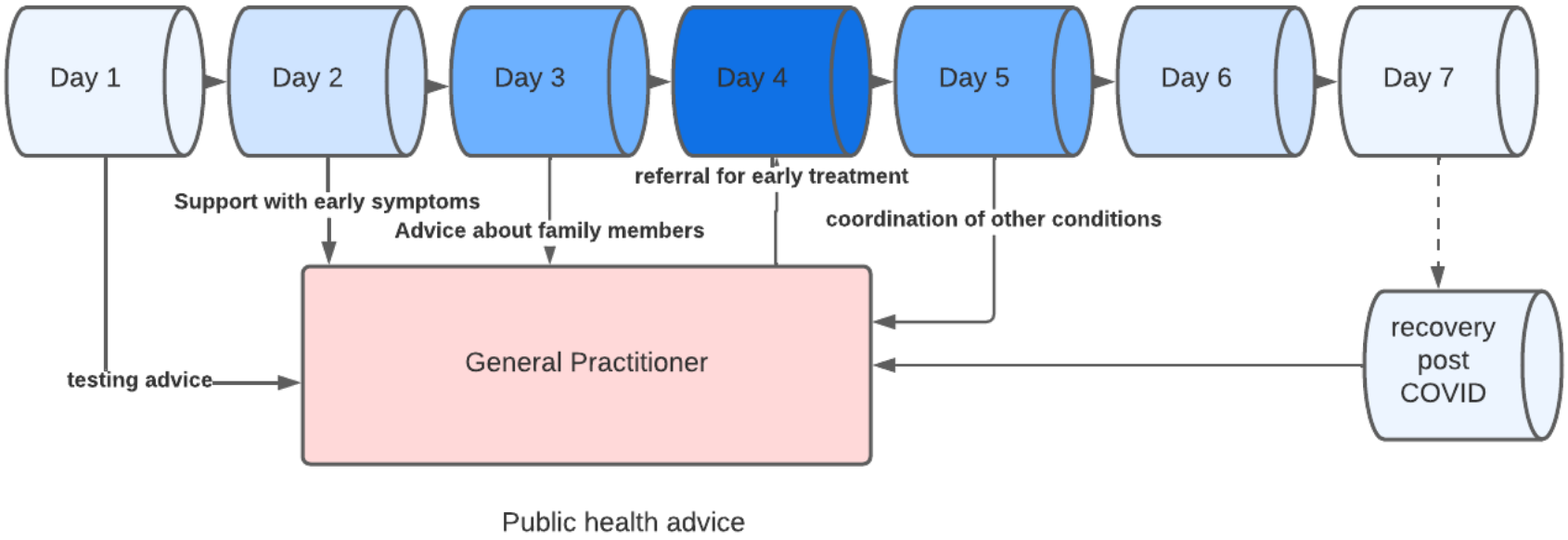
# *Principles of the establishment of GP care*

- ✓ GPs are trusted providers
- ✓ The 563 practices and over 2500 GPs were a valued resource
- ✓ GPs are aware of the complex comorbidities of their clients
- ✓ COVID 19 was over time likely to become a common respiratory condition
- ✓ People were best served if there was good communication between hospitals and GPs
- ✓ Integration needed to occur at the outset of program design

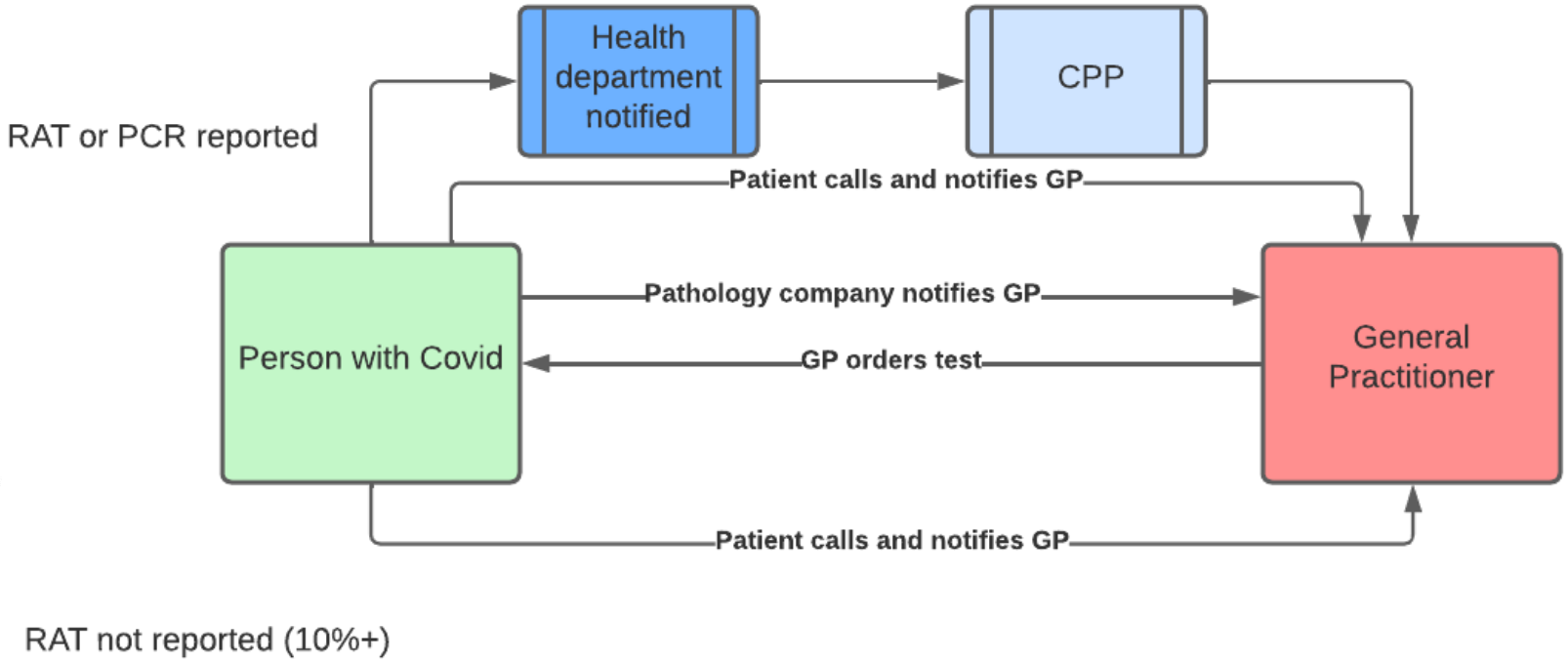
# 2020 Timeline of events



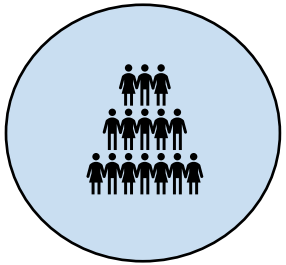
# *Interaction between PWC19 (people with Covid 19) and GPs*



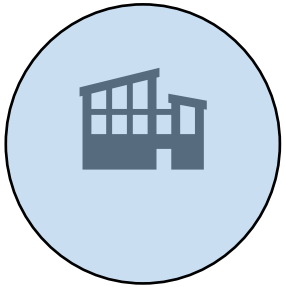
# *Interaction inside and outside pathways*



# *Before December 2021 (August 2020 – December 2021)*



37,734 cases
1/3 Victoria's cases
10,389 referred to GPs
76% of those streamed to care

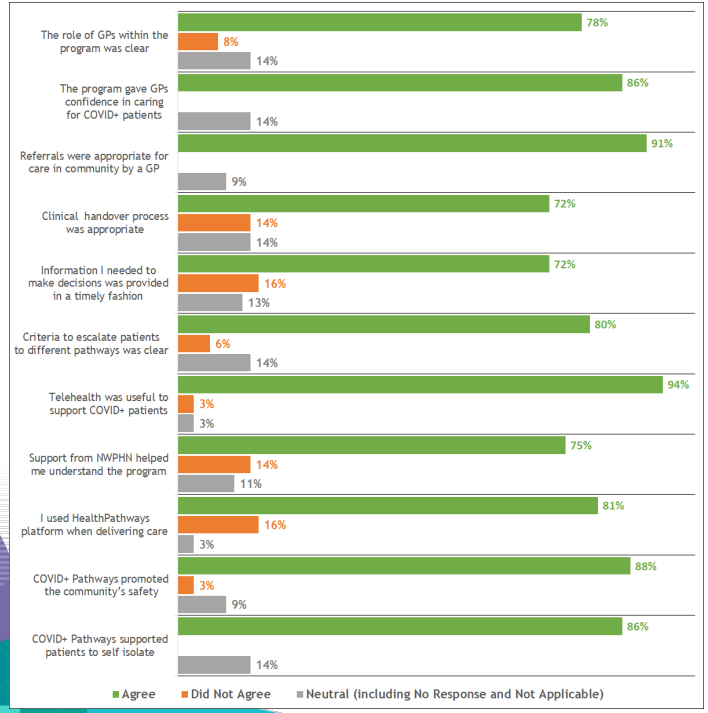


420 GP practices

>1500 GPs involved in care
Engagement with RedCap 60-90%

# We invited GPs involved in the Low-Risk Pathway to share their experiences

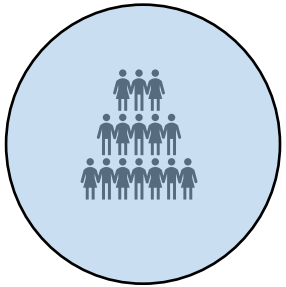
## GP Experience Survey Results



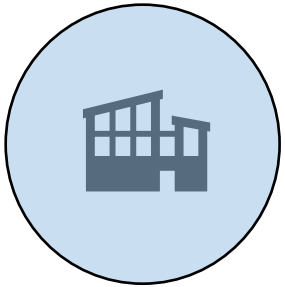

## Who did we hear from and what did they tell us

| | |
|---|---|
| **Who did we hear from** | • 292 GPs sent survey via email - 22 % (64) responded<br>• 91% of these GPs were in private practice<br>• 60% cared for a single COVID+ patient whilst 7% cared for 10 or more patients<br>• 100% completed REDCap reviews of their patients |
| **Referrals to GPs** | • **78%** agreed the patients referred to them were appropriate for being cared for in the community by a GP in the community<br>• **72%** agreed that **clinical handover was appropriate** whilst **14% did not**<br>• **72%** agreed they got the information they needed to make decisions in a timely manner whilst 13% disagreed |
| **Caring for COVID+ Patients** | • **86%** agreed that the program gave them confidence in caring for a COVID+ patient in the community. No GP expressed a negative response<br>• **94%** agreed that **telehealth was a useful mechanism** to support COVID+ patients<br>• **80%** agreed the criteria to escalated clients to higher risk pathways was clear |
| **Caring for Community** | • **86%** agreed the program helped to support patients to self-isolate<br>• **88%** agreed the program promoted the community's safety |
| **Support for GPs** | • **78%** agreed that they understood their role as a GP within the program.<br>• **75%** agreed the support provided by NWPHN helped them understand the program<br>care |

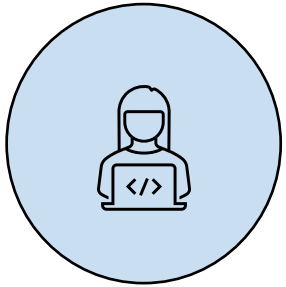
# *Since December 2021 we switched to COVID monitor*



19113 cases referred
80% routine GPs*
65% of cases assessed



596 GP practices



6970 log ins by GP users

507 cases referred to care navigation

* Not including cohealth or agency GPs

# *What is care navigation?*

A family of three- adult daughter, and two elderly parents were referred for care navigation

The parents are both NDIS clients and had daily care in the home

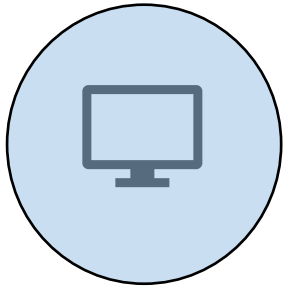
The daughter was very distressed when the navigators called, she was worried that her parents would have to go into care as NDIS supports had been withdrawn (while the family were in isolation).

The navigators contacted the family's GP, (who had the connections into their NDIS provider) and with them worked together to have care supplies dropped off to the family, and the navigators then provided the daughter with support to step into using those supplies to keep her parents at home, while the GP provided clinical support and monitoring of their covid.

Outcome was that the family stayed at home and together, and parents were able to be provided with care from their GP and cohealth for their isolation period.

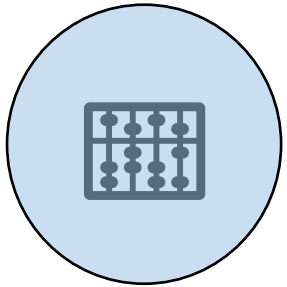
cohealth
care for all

# *Communication and education to support GPs*



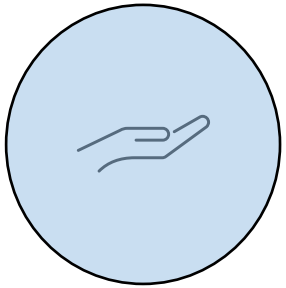
178 e-blasts
4000 recipients
35-40% open rate

17 webinars
1115 attendees
16,801 views



Health Pathway development
Regular updating
1154 views per month

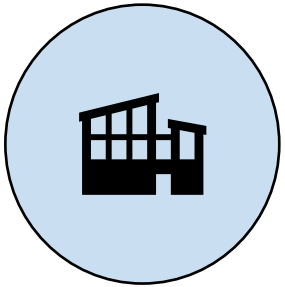
# *Targeted phone support for general practice by the NWMPHN and cohealth*



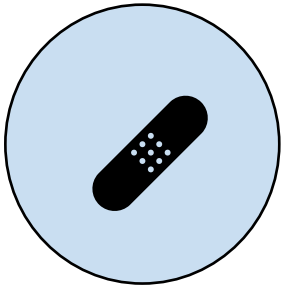
- Proactive calls to check familiar with model and GP role > 11,000 contacts since August 2020
- Support for RedCap and now COVID Monitor enrolment and use

GP clinician hotline (mobile number)
to talk to GP or experienced assessment centre doctor
e.g., clinical advice, escalation advice, interpretation of public health rules and timing of vaccination

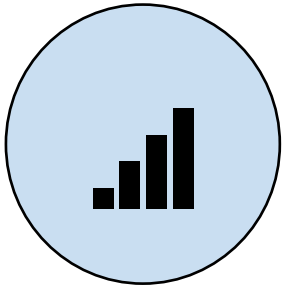
# *We surveyed practices in NWMPHN in February 2022*



173 practices
(30% of practices)



97% role in PLWC19



51% fully engaged using CM
40% take referrals
6% accept patient self referral
3% not caring for covid

# *Support for PWC19 in the West Metro pathway 9448551*

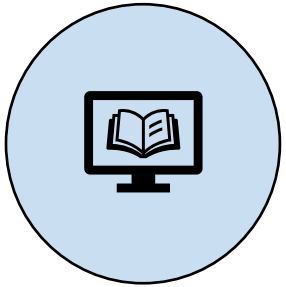
| | Calls | % of Calls |
|---|---|---|
| **Calls** | **2853** | |
| - calls made by client directly | 2386 | 83.6% |
| - calls made someone else on client's behalf | 467 | 16.4% |

| **Requests for** | Calls | % of Calls |
|---|---|---|
| - Food Supports | 1507 | 52.8% |
| - Medical Supplies | 583 | 20.4% |
| - Move to HQ | 14 | 0.5% |
| - Feeling unwell and seeking support | 407 | 14.3% |
| - Covid 19 Testing | 29 | 1.0% |
| - Clearance | 2 | 0.1% |
| - Vaccination | 1 | 0.0% |
| - General Support Questions | 849 | 29.8% |

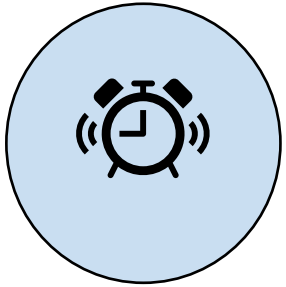
## *We asked the North West Melbourne PHN COVID GP Leadership group about the future of COVID care*

- Consumer focused with Equity of access for all patients
- Primary care led – with escalation to higher levels as needed
- Integrated and maximizing learnings from CPP
- Timely access (including identification of those eligible for early treatment)
- Include face-to-face assessment in primary care (needs to be supported by adequate PPE/infrastructure etc.) Links with GPRCs
- Efficient, effective and sustainable
- Needs to be funded
  - To enable teams to work at the top of their scope
  - Incentives for practices to keep telehealth appointments open for COVID + patients

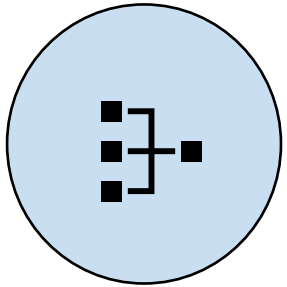
## *What is required in system for COVID to become usual care*



Public education campaign

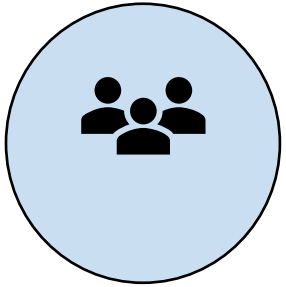


GPs to be notified of positive tests



Software needs to be co designed with GPs

Early treatment access in General Practice



Flexibility in funding and design of COVID care

# *Key enablers*

- Commitment of local GPs to support their communities
- Partnership between PHN and GPs, cohealth, and HSP
- Coordinated hospital approach
- Social support provided by cohealth
- Clear escalation pathways and clinical support provided across sectors

*Thank you*

# Get in contact

- Please complete our poll questions that will appear on your screen or in the chat
- 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

# Resources

- Learning Network webinar recordings and slides
- 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
- Department of Health COVID-19 clinical guidance and resources