South Eastern Melbourne COVID-19 Primary Care Management

- COVID-19 Care Pathways Program

Contents

Last updated: 27 October 2021

This pathway is specifically for South Eastern Melbourne General Practitioners who will be working with Alfred Health, Monash Health and Peninsula Health, now clustered into the South Eastern Health Services Partnership (HSP) in managing low risk COVID-19 positive patients who have minimal symptoms and are living in the community. The South Eastern Public Health Unit (South East PHU) provides oversight for this pathway, which includes patient notification, intake assessment, clinical care and discharge/clearance.

This pathway has been adapted from the work of North Western Melbourne PHN and Eastern Melbourne PHN and we acknowledge and thank them for the time and effort they put into this work.

Changes to the COVID Positive Pathways – Information Provided to Patients 27th October 2021

As the numbers of cases grow across Melbourne, there have been several changes to how people who test positive are communicated with in the early parts of the pathway and this information is provided to General Practice and Primary Care organisations to understand what the patient is experiencing and what information you should expect to have

When a person tests positive;

- Their name and contact details are allocated to the local Public Health Unit (PHU), depending on the person's postcode
- The PHU then allocates the patients to the Local Health Network according to the postcode. In the south east of Melbourne, this can either be The Alfred, Monash Health or Peninsula Health

Patient is then contacted;

- Once allocated to an LHN, the person will be sent a text message, introducing them to the Pathway
- They are invited to respond to some simple questions and self report their symptoms via simple yes/no questions
- The above information is then processed via an algorithm and this algorithm sorts responses into priority categories of Priority 1 (P1=high priority) to Priority 4 (P4=low priority)

PRIORITY 1 and 2 (P1 and P2) patients

- Patients are contacted for Triage Assessment by Community Health Partners
- They are assessed by the current risk stratification tool into High, Medium or Low risk and streamed accordingly
- Patients continue to follow the pathway as currently published

PRIORITY 3 and 4 (P3 and P4) patients

- P3 and P4 patients are communicated via text message informing them
    - To contact their own GP should they require medical attention
    - To invite them to continue to submit their self assessed symptoms as prompted via SMS daily for 14 days
- The algorithm that assesses the priority rating of the patient is a dynamic system and as long as the patients continue to submit data, it will automatically rate the patient accordingly
- If the patients self-assessed symptoms elevate their priority to either P1 or P2, they will then be contacted for Triage Assessment and re-enter the pathway as currently published
- Patients will remain on the list of COVID Positive Pathway patients until Day 15, when if they remain P3 or P4, they will be automatically discharged from the pathway.

GPs should note the following:

- The priority assessment will take place before the patient is personally contacted.
- At this time the system does not link the patient to a GP, thus there is no mechanism for the GP to be notified of the patient being in the pathway
- If the patient's priority rating continues at either P3 or P4 through the entire episode, there will be no contact from the pathway directly to the GP
- Patients will need to initiate contact with their GP should they require care.

Red flags

New or increasing shortness of breath
Chest pain or tightness
Syncope or near syncope
Altered mental state
Severe weakness or lethargy
Haemoptysis
Consistently missing meals more than one day
Respiratory rate ≥ 30 breaths/min
Oxygen < 92% at rest

Background

As part of the response to the increase in COVID 19 infections in metropolitan Melbourne in July and August 2020, the Victorian State Department of Health and Human Services (DHHS) tasked the local health networks (LHN) to monitor the clinical status of every person who tested positive to COVID 19 within their catchment areas.

SEMPHN covers three LHN areas for which South East PHU has oversight: Alfred Health, Monash Health and Peninsula Health. SEMPHN has been working with Alfred Health, Monash Health and Peninsula Health to build a program to support the monitoring process for people who test positive to COVID 19 who are being cared for within primary care.

GPs have been successfully caring for COVID 19 positive patients since the pandemic began. The purpose of this pathway is to support GPs with improved information should the patient require escalation at any time within the care episode.

Patient Entry into Program

See page 2 for updated information Alfred Health, Monash Health and Peninsula health, together with community health providers, deliver the COVID-19 Care Pathways Program. All patients in the South East catchment who test positive for COVID-19 are contacted by South East PHU for an initial interview. Where consent is provided, each case is allocated to the respective health service based on home postcode. Community health partners will complete an Intake Assessment to stream patients into one of three pathways based on low, medium or high severity of illness and social needs. The COVID-19 positive person can be escalated or de-escalated between care pathways depending on their clinical condition.

The community health provider partnering with **The Alfred Pathway is Connect Health – Nurse Connector** can be contacted on ☎ 03 9115 0202 and covidpathway@sandringhamacc.com.au. COVID Monitor web based platform available for GPs to update patient symptoms and status, information **here**

The community health provider partnering with the **Monash Pathway is Central Bayside Community Health Phone** ☎ 03 8551 7100 and covidpathways@cbchs.org.au 9am – 5pm 7 days per week COVID Monitor web based platform available for GPs to update patient symptoms and status,

information **here**

The community health provider partnership with the **Peninsula Pathway is Peninsula Health Community Health, Community Care program** ☎ 9788 1700 and communitycareenquiries@phcn.vic.gov.au
COVID Monitor web based platform available for GPs to update patient symptoms and status, information **here**

The following risk assessment tool is being used:

Risk Category	Criteria	Referred To

Low	• Aged < 60 years with either no co-morbidities or:
	  ○ controlled hypertension.
	  ○ well-controlled diabetes.
	  ○ obesity (< BMI 35).
	• Asymptomatic or mild symptoms
	• No barrier to home isolation
		General Practice and /or Community Health

Medium	• Clinically well:
	  ○ Aged > 60 years, asymptomatic or mild illness, and **no** or **well controlled concerning co-morbidities**
	  ▪ Hypertension
	  ▪ Cardiovascular disease (history of coronary artery, cerebrovascular, renovascular, or peripheral vascular disease)
	  ▪ Chronic renal failure
	  ▪ Chronic liver disease
	  ▪ Respiratory disease (poorly controlled asthma, chronic obstructive pulmonary disease, emphysema, cystic fibrosis, bronchiectasis)
	  ▪ Diabetes
	  ▪ Immunosuppression
	  ▪ Malignancy
	  ▪ History of smoking
	  ○ Aged < 60 years, asymptomatic or mild illness with **one or more concerning co-morbidities** poorly controlled
	  ▪ Hypertension
	  ▪ Cardiovascular disease (history of coronary artery, cerebrovascular, renovascular, or peripheral vascular disease)
	  ▪ Chronic renal failure
	  ▪ Chronic liver disease
	  ▪ Respiratory disease (poorly
		Managed by the referring hospitals 'Hospital in the Home' or Complex Care program.

Risk Category	Criteria	Referred To
	controlled asthma, chronic obstructive pulmonary disease, emphysema, cystic fibrosis, bronchiectasis) ▪ Diabetes ▪ Immunosuppression ▪ Malignancy ▪ History of smoking • Clinically unwell – Any age with new but mild shortness of breath and systemic symptoms • No barrier to home isolation	
High	**Red flags** New or increasing shortness of breath Chest pain or tightness Syncope or near syncope Altered mental state Severe weakness or lethargy Haemoptysis Consistently missing meals more than one day Respiratory rate ≥ 30 breaths/min	**Admission for inpatient care**

Initial Assessment by Community Health Provider

See page 2 for updated information

1. Organise initial telehealth or telephone contact with patient.
    - Ensure contact details are up-to-date and next of kin contact details are recorded.
    - Confirm with patient the **role of General Practitioner** which is to:
        - Provide regular telehealth assessment of COVID-19 symptoms to detect deterioration.
        - Ensure any co-morbid conditions remain stable.
        - Provide reassurance, education, and advice.
        - Ensure isolation guidelines are adhered to.
        - Ensure social and welfare circumstances are stable.
    - Decide with patient appropriate telehealth contact times and ensure patient has clinic number.
2. Establish **COVID-19 timeframe**
    - If symptomatic day 1 is date of initial symptoms.
    - If asymptomatic day 1 is date of test.
3. Confirm clinical status is **low risk category:**
        - Aged < 60 years with either no co-morbidities or:
        - controlled hypertension.
        - well-controlled diabetes.
        - obesity (< BMI 35).
        - Asymptomatic or mild symptoms
        - No barrier to home isolation – low risk category
    - Confirm past medical history, current medications, history of smoking (note: active smoking > 15 cigarettes per day is considered medium risk category)

- Establish whether any **low risk category** co-morbidities.
- Ask about COVID-19 symptoms and confirm mild illness severity using National COVID Taskforce definitions:

COVID 19 Illness Severity	Definition
Mild Illness	• Adults not presenting any clinical features suggestive of moderate or severe disease or a complicated course of illness. • Characteristics: o no symptoms, or o mild upper respiratory tract symptoms, or o cough, new myalgia, or asthenia without new shortness of breath or a reduction in oxygen saturation.
Moderate Illness	• Stable adult patient presenting with respiratory and/or systemic signs or symptoms. Able to maintain oxygen above 92% (above 90% If chronic liver disease) with up to 4L/min oxygen via nasal prongs • Characteristics: o Prostration, severe asthenia, fever > 38°C or persistent cough o Clinical or radiological signs of lung involvement o No clinical or laboratory indicators of clinical severity or respiratory impairment
Severe Illness	Adult patients meeting any of the following criteria: ▪ Respiratory rate ≥ 30 breaths/min ▪ Oxygen < 92% at rest

FOR PREGNANT COVID-19 POSITIVE PATIENTS

The Alfred Pathway Call Connect Health Nurse Connector on ☎ 03 9115 0202

Monash Pathway Call Complex Care Nursing Team on ☎ 0404 084 273

Peninsula Pathway Call Community Care on ☎ 03 9788 1700

-Confirm local hospital network have notified relevant obstetric service and determined low risk category.
-If patient is seeing a private specialist, contact the relevant specialist.

FOR PAEDIATRIC COVID 19 POSITIVE PATIENTS

The Alfred Pathway Call Connect Health Nurse Connector on ☎ 03 9115 0202

Monash Pathway Call Monash Children at Home on ☎ 0404 084 273

Peninsula Pathway Call Community Care on ☎ 03 9788 1700

4. Confirm **social and welfare situation to assess barriers for self isolation.**
   - High risk factors:

        - Homelessness, insecure accommodation, unsafe accommodation (risk of violence or physical danger)
        - Risk of alcohol or drug withdrawal or on withdrawal treatment
        - Dependent for activities of daily living
    - Medium Risk factors:
        - Housing – crowded housing circumstances or at risk of eviction
        - Cultural – poor health literacy, language barrier
        - Health – alcohol or drug dependency, pregnant with no antenatal care, mental health concerns, memory and/or behavioural problems, no regular general practitioner
        - Financial – evidence of financial stress, casual, temporary or cash-in-hand employment
        - Supports/dependencies – no social supports, dependants, pet
        - Activities of daily living: require help with personal care, mobility or medications; impaired vision, speech, hearing or comprehension, NDIS support
    - Low Risk factors – material requirements to facilitate isolation (provision of food, basic supplies).

5. Decide on times and frequency of telehealth or telephone review.
    - Frequency should be clinically indicated and individually tailored. Suggest:
        - At least days 2, 5, 8, 11 and more frequently if required
    - Advise if unable to contact after three attempts over several hours, including contacting next of kin, or via text message, escalation is required to DHHS to inform uncontactable patient.

Transfer of Care to General Practice

See page 2 for updated information Patients who fall into the 'low risk' category will be asked by the Community Health service if they have a regular GP and would they like their regular GP to continue to provide care.

SEMPHN has developed and will maintain a list of GPs who indicate that they are able to take on new patients and are willing to take on COVID 19 positive patients.

For those patients who do not nominate a regular GP, or for whatever reason, their regular GP is unable to provide the appropriate care, the Community Health services will contact SEMPHN to source a GP for the patient, based on their list, and ask if the patient is agreeable to be referred.

If they agree the clinical team from the Community Health service will call the relevant GP Practice and refer the patient into their care.

Ongoing Primary Care for Low Risk Patients

Clinical deterioration is most often seen from day 5 to 10 of illness.

The General Practitioner's role is to:

- provide regular support, advice, reassurance, or escalation if needed.
- regularly review COVID-19 symptoms, any co-morbidities, social and welfare situation.

1. Ask about any new symptoms or deterioration based on **clinical features script.**

Observations where available	Heart Rate
	Respiratory Rate
	Oxygen Saturation
Shortness of breath assessment	Is your breathing different from yesterday?
	Can you walk at least half the distance you walked yesterday?
	Can you lie flat without worsening shortness of breath?
	Is your breathing disturbing your sleep?
Deterioration assessment	How do you feel compared to yesterday?
	Are you having fevers or chills?
	Have you had any dizzy spells?
	Do you have muscle aches and pains?
	Do you have any lethargy?
Assessment	Stable/deterioration/improvement
Plan	Continue, Escalate, De-escalate

Download as spreadsheet to record assessments.

2. Confirm **Low risk category** level – escalate if new concerning symptoms.
   - Aged < 60 years with either no co-morbidities or:
     - controlled hypertension.
     - well-controlled diabetes.
     - obesity (< BMI 35).
   - Asymptomatic or mild symptoms
   - No barrier to home isolation – low risk category
3. Ensure isolation guidelines are being followed.
4. Assess if patient has adequate essentials (food, medications, hygiene products, masks etc). If patient requires welfare support.

The Alfred Pathway patients can be referred for social supports to:
- Star Health on ☎ 03 9525 1300 and stayconnected@starhealth.org.au

Monash Pathway patients can be referred for social supports to:
-Central Bayside Community Health- on ☎ 03 8551 7100 and covidpathways@cbchs.org.au

Peninsula Pathway patients can be referred for social supports to:
-Community Care - on ☎ 03 9788 1700 and communitycareenquiries@phcn.vic.gov.au

Assessment following COVID infection

1. For recovered patients, arrange face-to-face post-COVID-19 consultation as soon as convenient. Long term complications and prolonged recovery occur in a percentage of patients.
2. Take a history to assess ongoing symptoms:
    - Cardiac – breathlessness, fatigue, palpitations
    - Respiratory – breathlessness, cough
    - Thrombosis – leg swelling, pain, and tenderness
    - General – fatigue, difficulty concentrating, muscle aches and pains
3. Perform examination – assess vital signs and weight.
4. Consider investigations:
    - Lung function testing
    - ECG/cardiac echo
    - Routine bloods including inflammatory markers, D-Dimer
    - Doppler compression ultrasound of affected leg if suspicious of DVT

For Escalation to High Risk

Organise ambulance transfer and advise the ambulance service they are a COVID-19 positive patient.

The Alfred Pathway Call Emergency Department Admitting Officer on ☎ 03 90762960

Monash Pathway Call Monash Health Complex Care Nursing Team on ☎ 0404 084 273

Peninsula Pathway Call Community Care on ☎ 03 9788 1700

For Escalation to Medium Risk

The Alfred Pathway
8.00am – 5.00pm 7 days a week - Covid Community Medical team ☎ 0438 526 302
IntegratedCOVIDCareTeam@alfred.org.au
After Hours – Call After Hours Clinical Coordinator on ☎ 0437 693 280

Monash Pathway
9.00am – 5.00pm 7 days a week - Call Complex Care Nursing Team ☎ 0404 084 273

Peninsula Pathway
8.00am – 9.00pm and 9.00pm – midnight (medical on call) 7 days a week Call Community Care on ☎ 03 9788 1700

- Advise whether clinical or social risk factors for escalation.
- Discuss whether ongoing general practitioner assessment is required.

Guidelines for Clearance and Release from Isolation and COVID 19 Positive Pathway

See page 2 for updated information

The South East PHU are responsible for clearance and release from isolation.
The South East PHU makes frequent calls to patients to monitor their public health compliance and will usually discuss the clearance timeline.
They will do a symptom assessment and release the patient when appropriate.

If GPs have queries about clearance please contact the following:

The Alfred Pathway
Call Connect Health **Nurse Connector** on ☎ 03 9115 0202

Monash Pathway
9.00am – 5.00pm 7 days a week - Call Complex Care Nursing Team ☎ 0404 084 273

Peninsula Pathway Call **Community Care on** ☎ 03 9788 1700

- For information about close contacts please refer to DHHS – Quarantine and Isolation.

Ongoing Management and Support

1. If unable to contact the patient after three attempts over several hours, including contacting next of kin, or via text message, using clinical judgement contact the referring relevant pathway Community Health service.

The Alfred Pathway is Connect Health – Nurse Connector on ☎ 03 9115 0202 and 🖱 covidpathway@sandringhamacc.com.au

Monash Pathway is Central Bayside Community Health
☎ 03 8551 7100 and 🖱 covidpathways@cbchs.org.au

Peninsula Pathway – Peninsula Health offer ongoing support for patients who are still symptomatic through the Covid rehab program ☎ 1300 665 781 Fax: 9784 2309 and ascotreferrals@phcn.vic.gov.au **and Covid Clinic** Fax: 9784 2309 and ascotreferrals@phcn.vic.gov.au

2. Provide **information and advice** to carer/patient/household and ensure patient and carers have the ability to manage isolation.
    - Advise that all close contacts must remain in isolation.
    - Provide advice on likely course of disease:
        - If symptoms worsen this is most likely in second or third week of illness.
        - Breathing difficulties are the most important symptom to look out for.
        - Advise calling an ambulance if concerning symptoms develop.
    - Provide following medication advice:
        - Continue to take current medication including ACEI/ARBS, prescribed NSAIDS, and asthma medication.
        - For people on immunosuppressants – high dose steroids, chemotherapy, biologics, DMARDS contact relevant specialist for further advice.
        - Use ibuprofen or paracetamol for symptomatic relief.
        - Advise there are no requirements for specific disease modifying medications for those with mild infections managed in the community.
    - Offer **Nellie Support**. Nellie, SEMPHN's automated persona-based interactive SMS service, has a protocol to help people manage their **mental wellbeing** during COVID-19
        - When people subscribe to Nellie, they will receive regular, friendly text messages checking in on their wellbeing.
        - This includes information and supportive ideas and links to resources, particularly focused on mental wellbeing during COVID-19. The messages are written by doctors, nurses, and allied health clinicians, using current government guidelines.
        - Anyone can subscribe for free by texting the word **support** to **0427 741 876**.
        - If you would like to know more, get in touch with the team at nellie@semphn.org.au or **03 8514 4460**, or see the FAQ.
    - Pulse oximeter use:
        - Consider in certain circumstances, e.g. history of chronic lung disease or where patient has acquired oximeter.
    - Decide on appropriate times for follow up telehealth or telephone reviews.

3. For patients with ongoing symptoms following COVID-19:
    - Consider urgent or routine cardiology or respiratory referral if clinical assessment abnormal.
    - Provide symptomatic support.
    - Organise regular review depending on clinical need to ensure ongoing recovery.
    - Optimise management of co-morbidities.

Additional Information

For health professionals
National COVID-19 Clinical Evidence Taskforce
Management of Adults With Mild COVID-19

Clinical flowcharts

COVID Monitor web based platform

General practitioners will be invited to use the COVID Monitor web based platform.

- Allows clinicians including general practitioners to monitor their COVID-19 positive patients
- Only patients registered to the general practitioner will be visible
- General practitioner is required to:
    - Check COVID Monitor regularly throughout the day by leaving Monitor open
    - Ensure and encourage patient(s) are submitting data to CovidCare
    - Update patient symptoms and status during telehealth review
    - Escalate to Monash Health if necessary
    - Request de-isolation/clearance once DHHS clinical criteria are met, by clicking on relevant button
- See COVID Monitor User Guide for GPs for detailed information

For patients

- Australian Department of Health – Coronavirus (COVID-19) Resources for the General Public
- Department of Health Human Services – Coronavirus Disease (COVID-19) Confirmed Case: What you need to know
- Royal Women's Hospital – Advice for Pregnant Women

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