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CONFERENCE ABSTRACT

The Alfred Health Covid Community Pathway (AHCCP): development of a multidisciplinary, collaborative, and integrated model of care for supporting covid positive patients in the community during the Covid-19 pandemic.

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Background: The second wave of Covid-19 in Victoria in July 2020 revealed health system vulnerabilities including access to primary care and community readiness to provide care in the home to large numbers of Covid-19 positive patients. The health system risked being overwhelmed, and patients risked deteriorating at home with unmet clinical and psychosocial needs. The requirement for isolation of positive cases necessitated a rapid switch to remote and virtual models of care. In response to a successful pilot in Northwest Melbourne [1], the Department of Health (DH) implemented the Covid Positive Pathways program, which directed health services to provide a similar service in their local catchment areas.

Purpose of this report: To describe the design, implementation and evolution of the AHCCP, including challenges, lessons learnt and opportunities for use of such an integrated model of care in future epidemic/pandemic situations, as well as to support broader health and social care needs beyond covid.

Methods: This descriptive study describes the model of care developments and changes, and commentary with descriptive statistics from the cohort of patients who were referred to the pathway, and key learning points.

Service aim, stakeholders and implementation: In September 2020, the AHCCP was established with the aim of providing comprehensive care to patients in isolation with Covid-19. The service was established as a partnership between several stakeholders, including:

•Alfred Health, a quaternary hospital in south-east Melbourne.

•Connect Health and Star Health, community health orgsanisations.

•South East Melbourne Primary Health Network.

•Victorian DH, and the South East Melbourne Public Health Unit.

•South East Melbourne Health Service Partnership, Monash Health and Peninsula Health.

Patients referred from the Victoria DH were triaged and risk-stratified. Clinical monitoring was provided by the health service (medium pathway) or community health team in partnership with GPs (low pathway), with clear escalation pathways for management of acute deterioration. Support for psychosocial needs was also provided, including for those unable to safely meet isolation requirements.

Results: 91 patients were referred in the first nine months of the pathway's operation, however subsequent surges in cases have resulted in 172,306 referrals as of 31st August 2022. Rapid upscaling, changing public health directives, and the availability of vaccination and treatments led to major challenges and need for constant redesign. Significant developments included: the introduction of web-based symptom surveys, risk stratification modifications incorporating vaccinations and variants of concern, streaming lower-risk patients to usual care outside the pathway, and use of logistics services to aid distribution of monitoring equipment and medications. Significant opportunities for hospital avoidance were observed, along with minimal adverse outcomes and a high level of acceptability for patients and carers as well as staff.

Learnings: Collaboration across the partner organisations, including daily huddles with a non-hierarchical structure, was key to the success of the program. Virtual care, including use of information systems (Covid Monitor platform) emerged as essential to scalability. The pathway was successfully decentralised and integrated within community health and Alfred Health's core models of care in September 2022 to ensure sustainability.