# BHS COVID Monitor Reference Guide RISK ASSESSMENT V2

**BHS at Home COVID monitoring team is available Monday – Sunday 0900 – 1700**

Please use the following guidance when completing a Risk Assessment

## Patient Allocation

Patients are allocated to the Grampians Healthdirect tab on the BHS SharePoint from GPHU.
Patients are allocated based on their home postcode. There are some exceptions to this which include

- Paediatric and obstetric patients that may be referred to BHS from outside the Ballarat catchment, if they need specialist care. So, at times some patients with an address outside of the Ballarat catchment maybe allocated to the SharePoint

The GPHU will populate as much information as possible/known e.g. vaccination status, symptom start date, pregnancy status (if applicable) and if they have comorbidities.

| 3341 | 3350 | 3351 | 3352 | | 3355 |
|---|---|---|---|---|---|
| Dales Creek | Alfredton | Berringa | Addington | Lal Lal | Lake Gardens |
| Greendale | Bakery Hill | Bo Peep | Blowhard | Lamplough | Mitchell Park |
| Korobeit | Ballarat Central | Cape Clear | Bolwarrah | Langi Kal Kal | Wendouree |
| Myrniong | Ballarat East | Carngham | Bonshaw | Learmonth | Wendouree Villiage |
| Pentland Hills | Ballarat North | Chepstowe | Brewster | Leigh Creek | |
| | Black Hill | Haddon | Bullarook | Lexton | 3356 |
| 3342 | Brown Hill | Hillcrest | Bungaree | Magpie | Delacombe |
| Ballan | Canadian | Illabarook | Bunkers Hill | Millbrook | Sebastopol |
| Beremboke | Eureka | Lake Bolac | Burrumbeet | Miners Rest | |
| Blakeville | Invermay Park | Mininera | Cambrian Hill | Mollongghip | 3357 |
| Bunding | Lake Wendouree | Mount Emu | Cardigan Village | Mount Bolton | Buninyong |
| Colbrook | Mount Clear | Nerrin Nerrin | Cardigan | Mount Egerton | |
| Durdidwarrah | Mount Helen | Nintingbool | Chapel Flat | Mount Mercer | 3358 |
| Fiskville | Mount Pleasant | Piggoreet | Clarendon | Mount Rowan | Winter Valley |
| Ingliston | Nerrina | Pitfield | Claretown | Napoleons | |
| Mount Wallace | Newington | Pitfield Plains | Clarkes Hill | Navigators | 3361 |
| | Redan | Rokewood junction | Corindhap | Pootilla | Bradvale |
| 3345 | Soldiers Hill | Ross Creek | Dereel | Scotchmans Lead | Carranballac |
| Gordon | | Scarsdale | Dunnstown | Scotsburn | Skipton |
| | | Smythesdale | Durham Lead | Springbank | |
| | | Smyths Creek | Enfield | Sulky | 3363 |
| | | Snake Valley | Ercildoune | Wallace | Creswick |
| | | Springdale | Garibaldi | Warrenheip | Creswick North |
| | | Springdallah | Glen Park | Wattle Flat | Dean |
| | | Staffordshire Reef | Glenbrae | Waubra | Glendaruel |
| | | Streatham | Gong Gong | Weatherboard | Langdons Hill |
| | | Wallinduc | Grenville | Werneth | Mount Beckworth |
| | | Westmere | Invermay | Windermere | Tourello |
| | | | | Yendon | |

# Healthdirect Risk Assessment

The aim of the Risk Assessment is to stream patients into a Care Pathway, that defines the type of care they will receive and who will provide that care. Details of each care pathway are in the below table:

| Care Pathway | Care Provider | Care Provided |
|---|---|---|
| BHS LOW | Safety Link | Telehealth Symptom Monitoring |
| Health Service MEDIUM | BHS at Home COVID Monitoring<br>Plus MC@H for paeds<br>Plus Obstetics for maternity | Telehealth from medical or nursing Symptom monitoring<br>Social / welfare |
| Health Service HIGH | BHS Inpatient Unit | Inpatient care, usually at the patient's closest hospital |

It is the Healthdirect assessor's role to complete the Risk Assessment for their allocate patients and decide which Care Pathway the patient should be streamed to. Clinical reasoning should be applied to ensure the patient receives the right care from the right provider, and that health service resources are reserved for the patients who need it most.

# Pending Risk Stratification Assessment List

Patients who require a Risk Assessment will appear on the Pending Assessment list.

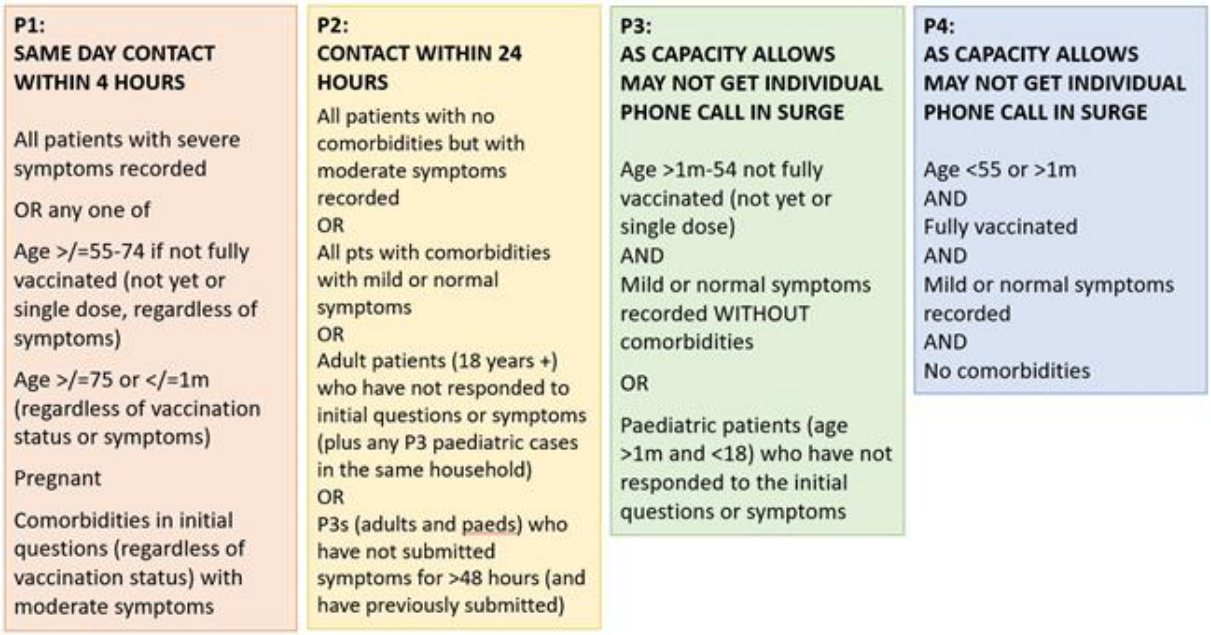
| COLUMN HEADING | FUNCTION |
|---|---|
| Priority | Gives ability to sort the list by priority (criteria on next page)<br>Type P1, P2 etc. in the box below the column heading to sort the list by priority |
| TREVI ID | This is the unique patient identifier |
| UR | This is the BHS UR number |
| First name / Surname / DOB / Address / Suburb | Self-explanatory – can be edited in the Patient Details screen if incorrect |
| Model of Care | Standard for majority of patients |
| Paediatric / Maternity | Yes/No– enables filtering for paediatric and maternity patients |
| Last Obs Date | When the patient last reported their observations |

| | |
|---|---|
| Symptomatic | NA/Normal/Mild/Moderate/Severe – enables filtering for symptom severity by typing the severity in the box below the column heading |
| SOB / Chest Pain | Key symptoms that patient reports |
| Self-symptom Onset / TREVI Symptom Onset | These will help identify the date on which a patient can be discharged from thepathway (Day 14 in most cases) |
| Day of Illness | This is dictated by the date of symptom onset or their first positive swab date |
| History Risk | If the patients have answered YES to the pre-intake comorbidities question, it means they have one or more of: respiratory disease, diabetes, |
| Vax Status | Vaccination status – Not yet, one dose, two doses. Specific detail will be captured in the assessment. |
| Clinical Pathway/ Pathway Severity | All new patients will default to Low. As part of the riskassessment, the pathway may be changed to BHS at Home COVID and maybeupgrade |
| Day of Allocation | The date upon which the patient was allocated to the Care Pathway |

Each Healthdirect Assessor will have a pre-defined list of patients on which to complete Risk Assessment.

# Risk Assessment Priority Criteria

P1-4 is automatically set in the Pending Assessment list based on the criteria in the below diagram:




P1 cases should be assessed ideally within 4 hours and P2 should be assessed within 24 hours.

Within the P1 category, sub-priority should be given as follows:

- P1 (severe symptoms),
- P1 (moderate symptoms with comorbidities),
- P1 (pregnant, no severe or moderate symptoms),
- P1 (very old, very young),
- P1 (all remaining).

Within the P2 category, sub-priority should be given as follows:

- P2 (moderate symptoms),
- P2 (adults who have not responded),
- P2 (adults or unvaccinated children over 12 years with comorbidities and mild/normal symptoms)

The prioritization is dynamic, so patients will move between levels depending on the symptoms they enter.

The following notes may need to be used in order to communicate any issues

| Issue | Used For |
|---|---|
| Edit Patient | If any of the patient details are incorrect |
| Left Message / No Answer | If a call to the patient to complete the Risk Assessment is not answered |
| Record Notes | To record something specific in addition to the Risk Assessment documentation |
| Change Care Pathway | Once the assessment has been completed you have completed your assessment, use this button to allocate the patient to the right care pathway – Low, Medium or High |
| Change Model of Care | This is only used by BHS at Home COVID Team |

# Exclusions

Patients in Residential Aged Care Facilities or patients in Hotel Quarantine are **excluded** from the COVID Positive Care Pathway. Please check this at the beginning of the Risk Assessment, and if patients are found to be in these settings, explain to patient that care is provided to them via other mechanisms, and discharge the patient as 'Ineligible for pathway' from within the Patient Details screen.

# Patient Information

Please check the patient information on the Patient Details screen, particularly their home address, to ensure we have up to date details for the patient. Please complete all sections in the Patient Information, especially the Next of Kin details so we have an alternative contact number in case we cannot contact the patient directly. Update any general demographics.

If there are any changes in patient details, particularly address and mobile number, please advise GPHU so they can update the central database (TREVI) with these details.

Note that all patients who are Refugees or Aboriginal / Torres Strait Islanders must be allocated to the **MEDIUM SEVERITY PATHWAY.**

# Patient History

The table below explains the relevance of the Patient History questions for adult patients. The following co-morbidities are risk-factors for severe COVID-19. Unless otherwise specified, patients who have one of the following comorbidities should be in the **MEDIUM SEVERITY PATHWAY**.

| **History Question** | **Definition** | **Explanation** |
|---|---|---|
| Pregnant | Pregnancy confirmed by biochemical test or ultrasound<br><br>Pregnant women who are less than 20 weeks gestation, fully vaccinated and willno medium severity comorbidities **can remain in the LOW SEVERITY PATHWAY** | Pregnant women are at increased risk of severe disease and may have increased frequency ofpreterm birth or Caesarean delivery. |
| Age | Age > 55 years | Older age is associated with severe disease and increased mortality. |
| Cardiac Disease | Previous Acute Myocardial Infarct<br><br>History of angina<br><br>History of cardiac failure<br><br>Cardiomyopathy<br><br>Ischaemic heart disease (+/- CABG/stents) | Patients with cardiovascular disease are at increased risk of a poor prognosis.<br><br>Patients with severe infection may require higher cardiac output, which may not be met in patients with pre-existing cardiac disease.<br><br>In some patients, COVID-19 may result inmyocardial injury. |
| High Blood Pressure | History of hypertension. Patients requiring a single antihypertensive medication with a well-controlled BP **can remain in the LOW SEVERITY PATHWAY** | Hypertension may be a risk factor for severe COVID-19. |
| Cancer | Patients with a diagnosis of active solid tumour cancer (excluding isolated skin cancers) OR haematological cancer e.g. lymphoma, leukemia, myeloma.<br><br>They may be currently receiving chemotherapy, radiotherapy or other treatments, or recently completed treatment in the last 6 months.<br><br>Patients that have been treated for cancer **more than 6 months ago** and now completely recovered **can remain in the LOW SEVERITY PATHWAY** | Patients with hematologic and non-hematologic malignancy maybe at increased risk of severe COVID-19. |

| | | |
|---|---|---|
| Liver Failure | Liver failure<br>Cirrhosis<br>Hepatitis B or C without liver disease **can remain in the LOW SEVERITY PATHWAY** | Patients with liver disease maybe at higher risk of severe COVID-19.<br>Patients with cirrhosis may have a higher risk ofmortality. |
| Diabetes | Patients with Type 2 Diabetes Mellitus on oral hypoglycaemic agents and/or receiving insulin therapy<br>Diet controlled Type 2 Diabetes<br>Patients with Type 1 DM | Patients with Type 2 diabetes are more likely to have serious complications, more ICU admissions and have higher mortality rates from COVID-19.<br>There is little data to inform whether poor glycemic control prior to COVID-19 infection impacts on the risk of severe infection.<br>Patients with Type 1 DM may be at higher risk of severe COVID-19. |
| Renal Failure | Patient with chronic kidney disease: eGFR<30 mls/min if known, or currently under review by a kidney specialist at least twice a year.<br>Patients with end stage kidney disease receiving haemodialysis or peritoneal dialysis. | Patients with chronic kidney disease are at increased risk of severe COVID-19.<br>Patients receiving haemodialysis at an outpatient facility will require specialised infection control measures when attending outpatient haemodialysis. |
| Respiratory Disease | Asthma<br>- Requiring blue puffer or reliever medication (such as Ventolin, Asmol, Airomir, Apo-Salbutamol or Bricanyl) multiple times per week<br>- Asthma symptoms which wake them up at night more than once/week<br>- Poor asthma control in the previous 4 weeks<br>- Childhood asthma that has resolved **can remain in the LOW SEVERITY PATHWAY**<br>COPD<br>Pulmonary fibrosis<br>Bronchiectasis<br>Cystic fibrosis Other<br>lung diseases<br>If patient is requiring home oxygen, please ensure to note this | Chronic lung disease has been associated with severe COVID-19. |

| | | |
|---|---|---|
| Immuno-suppressed | Patient is receiving medication that will suppress their immune system, often for autoimmune disease such as rheumatoidarthritis, SLE, RA, Crohn's Disease, ulcerative colitis. Common medications include but are not limited to:<br>- Prednisolone<br>- Methotrexate<br>- Azathioprine<br>- Cyclophosphamide<br>- Tacrolimus<br>- Biological therapies for arthritis<br>or patients with conditions<br>that cause immunosuppression such as HIV, hypogammaglobulinemia, congenital immunodeficiencies. | Patients receiving immunosuppressive therapy for rheumatic disease may be at risk for severe COVID-19, although this is not clear. |
| Transplant History | Patient has received a solid-organ transplant e.g. kidney, heart, lung, pancreas, liver<br>Patient has undergone a bone- marrow transplant (allograft or autograft) | Patients receiving immunosuppressive therapy may be at risk for severe COVID-19 and its complications.<br>Transplant recipients have been reported to have higher mortality rates in some studies. |
| Haema-tological disease | Blood disorders such as Thalassemia major, Sickle cell disease, ITP requiring ongoing treatment, myelofibrosis, splenectomy. | These conditions may be associated with severe COVID-19. |
| Recent or current Psychiatric / Mental Health Treatment | Psychiatric conditions receiving ongoing therapy by a psychiatrist.<br>Patients with a history of depression or anxiety disorders but well-controlled (including on medication) **can remain in the LOW SEVERITY PATHWAY**. | Among patients with psychiatric illness, deterioration may occur because routine visits are not available, or patients may have reduced access to medication. |
| BMI | BMI >/= 30 kg/$m^2$ | Obese or very overweight patients are at increased risk of severe disease. |

# Vaccination Status

A patient's vaccination status has been incorporated into the risk algorithm to determine their risk of severe disease. A patient must be 14 days post their second dose of vaccination to be considered fully vaccinated. Some patients remain at high risk of severe disease despite being fully vaccinated.

| **Vaccination status** | **Clinical Pathway** |
|---|---|
| Less than 75yo:<br>>14 days post 2nd dose | These patients will automatically be in the **LOW SEVERITY PATHWAY UNLESS** they have any of the following conditions, in which case they will remain in the Medium Pathway regardless of vaccination status:<br>- Pregnancy<br>- Respiratory disease<br>- Immunosuppressed (as defined in Table 1)<br>- Renal replacement therapy<br>- BMI >/= 30 mg/kg$^2$<br>- Diabetes mellitus |
| Older than 75yo:<br>>14 days post 2nd dose | Patients > 75yo will remain in the **MEDIUM SEVERITY PATHWAY** regardless of vaccination status |

For pediatrics, the vaccination status should be collected for the **patient**, and **not the parent**.

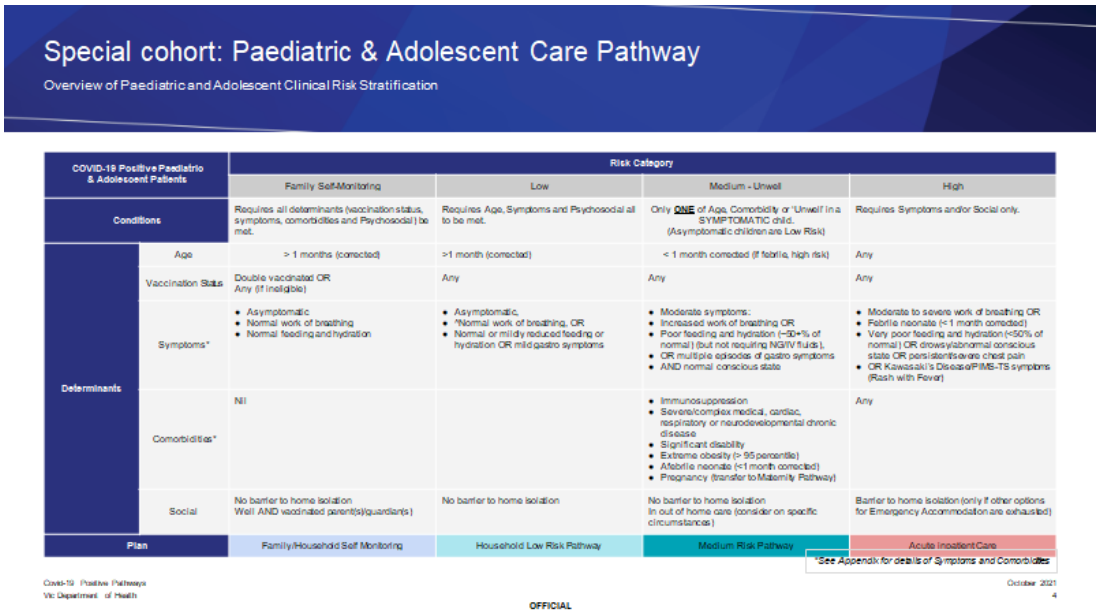
# Risk Screening Questions

The Risk Screening questions include both physical symptoms and social/welfare questions. Please answer **all questions** to ensure a complete set of data.

# Paediatric Patients

The Risk Assessment is modified automatically for all patients less than 18 years of age. Questions are phrased for a parent/carer to answer the questions about the child, however if the child is a teenager and able to answer the questions for themselves, the questions can be asked directly to the patient.

The following table indicates which clinical pathways suitable for paediatric patients based on age, vaccination status, symptoms and comorbidities.




Most children should remain in the **LOW SEVERITY PATHWAY**. From an age perspective, only babies **less than one month in age** will routinely be referred to the **MEDIUM SEVERITYPATHWAY**

Contact details for paediatric escalations will be thru the BHS at Home COVID Monitoring Navigator

# Maternity Patients

All pregnant patients should be classified as **MEDIUM SEVERITY, with the exception of women who are less than 20 weeks gestation, AND double vaccinated AND have no significant comorbidities (as per the above table), who can remain on the LOW SEVERITY pathway**.

# Submission of the Risk Assessment

Once you are finished all sections, enter data in Assessment finalization section of spreadsheet in Grampians Healthdirect SharePoint.

# Clinical Escalations

The below table and flow chart details criteria for clinical escalation based on reported patient symptoms.

| | | | |
|---|---|---|---|
| Symptoms | • Chest pain that is severe and new, excluding pain that is only associated with coughing<br>• Syncope<br>• Shortness of breath at rest, or unable to speak in sentences<br>• New confusion or disorientation | • Chest pain that is moderate intensity (except if only associated with coughing or resolves with simple analgaesia)<br>• Pre-syncope<br>• Increasing shortness of breath on exertion (e.g. whilst walking or dressing)<br>• Haemoptysis – repeated episodes of coughing up frank blood (without new chest pain or breathlessness)<br>• GI symptoms – repeated diarrhoea or vomiting if unable to tolerate oral fluids or concern for significant dehydration (e.g. minimal urine output, postural dizziness)<br>• Other clinical concern | • Mild chest pain or tightness, or chest pain that is only associated with coughing, or with chest wall tenderness<br>• No shortness of breath, or mild shortness of breath with significant exertion<br>• Haemoptysis – small flecks of blood or pink coloured sputum (without any new dyspnoea or chest pain)<br>• GI symptoms – diarrhoea or vomiting but tolerating fluids and no concern for significant dehydration (e.g. passing normal amounts of urine, no postural dizziness) |

**Consider a lower threshold for escalation of care in patients who are: elderly, frail, have multiple risk factors for severe disease, or who live alone or are otherwise vulnerable (e.g. low health literacy, cognitive impairment, co-existing significant mental health issues)

Medical staff on call daily for urgentescalations will be contacted via the BHS at Home Navigator

# Patients who Decline the Assessment

If the patient declines the Risk Assessment, offer to call back later in the day or the next day. Record this using the 'Record Notes' tab in the spreadsheet.

# Patients who Require an Interpreter

Health Direct can utilise their own internal interpreting arrangement or call TIS National Interpreting Service on 131 450.

# Uncontactable Patients

If attempting to complete a Risk Assessment and the patient cannot be contacted, mark as Left Message / No Answer. Leave a voicemail if possible. Do not discharge them as unable to contact at this point.

A repeat attempt should be made to contact them later in the day and then again on the following day

If after 2-3 attempts over 24 hours, they are still not-contactable, then an escalation to GPHU for referral to Vic Pol. **Do not discharge the patient**

# Wrong Number / Number Disconnected / No Phone Number

Where a patient's phone number is incorrect or disconnected, please remove the number from the spreadsheet so that staff do not continue to contact an incorrect number.

The admin team will regularly check the patient list for patients who do not have phone numbers and attempt to find alternative numbers where possible.

# Key Contacts:

| | | | |
|---|---|---|---|
| **Operations Directors** | | | |
| Craig Wilding | Executive Director Primary and Community Care | craig.wilding@bhs.org.au | 0427 204 473 |
| Michelle Veal | Operations Director Community and Sub Acute Ambulatory | michelle.veal@bhs.org.au | 0427 204 473 |
| Robyn Wilson | Operations Director Grampians Public Health Unit | robyn.wilson@bhs.org.au | 0425 764 209 |
| **BHS IT** | | | |
| Help Desk | | it-servicedesk@bhs.org.au | 5320 4786 |
| Bernhard Heemann | IT Systems Manager | bernhard.heemann@bhs.org.au | 5320 4789 |
| Andrew Brisbane | SharePoint Administration | andrew.brisbane@bhs.org.au | 0407 400 652 |
| **BHS at HOME** | | | |
| Rachel Fishlock | Operations Manager | Rachel.fishlock@bhs.org.au | ex 93085<br>0437 189 933 |
| Claire Milgate | COVID Navigator | Claire.milgate@bhs.org.au | 0477 988 770 |
| Sarah Beech | COVID Navigator | Sharh.beech@bhs.org.au | 0477 988 770 |
| BHS at HOME COVID | Group email | bhsathomecovid@bhs.org.au | N/A |
| | | | |
| **Emergency Numbers** | | | |
| Ballarat Police | 583366 6000 | Ballarat West Police | 5338 9200 |
| peter.McCormick@police.vic.au and BALLARAT-UNI-OIC@police.vic.gov.au | | | |
| Ambulance Victoria – a non-urgent ambulance can be arranged via the BHS at Home Navigator | | | |
| **Project Team** | | | |
| Jade Odgers | Project Manager | Jade.odgers@bhs.org.au | 0419 115 003 |
| Karen Higgins | Project Support | Karen.higgins@bhs.org.au | 0407 689 233 |