Te Whatu Ora
Health New Zealand

Guidance for Primary and Community Care Model of Care for COVID-19

1 July 2023

Purpose

The purpose of this guidance document is to:

1. Update the primary care funding guidance for COVID-19 clinical assessments.
2. Provide clear concise guidance for the primary and community care sector.
3. The aim for our system of care for the start of 2023 is a targeted approach to support those most in need of care, ensuring that we do not lose the gains we have made in addressing the disproportionate impact of COVID-19 on Māori, Pacific people, disabled people, and other populations identified as at risk of poorer outcomes from COVID-19.
4. Those who are not identified as most in need of care from within this guidance document, can still access care for COVID-19 through usual-care mechanisms, with co-payments.

Background

Primary care funding for COVID-19 was last reviewed in February 2023 and continued to support the alignment of access criteria for COVID-19 anti-viral medicines with funding for pro-active initial clinical assessments. This recognised that those populations have a higher risk for serious health outcomes from a COVID-19 infection.

The model of care continues to reflect the move from a pandemic response to an equity-based approach targeting those at higher risk of poorer health outcomes from COVID-19 including priority and vulnerable populations (see appendix B). This model of care aligns with the current COVID-19 testing plan, public health measures and policy settings, and keeps within the budgeted forecast for COVID-19 funding until 30 September 2023.

Eligibility for Funding

The chart below outlines the current funding package.

This brings funding for COVID-19 management in Primary and Community care into closer alignment with other respiratory conditions.

Funding for regular review and in-home care remains in place for those who are recognised by the clinician as clinically high-risk and meet other funding eligibility criteria.

Table 1: Funded Services

Service	Description	Current Funding Cost
Proactive initial clinical assessment	Those who meet anti-viral access criteria **OR** who are in the priority population	$90 (standard) $135 (after hours/ weekends)
Regular review - monitoring timing and frequency are clinically determined at initial assessment and clinical escalation	Those who meet anti-viral access criteria **AND** For those identified to be clinically high risk	$34 (standard) $51 (weekends only)
Consultation and testing (PCR/RAT) – based on updated guidelines	Those who meet anti-viral access criteria **OR** are in the priority or vulnerable groups	$90 (standard) $135 (after hours/ weekends)
Clinical escalation – patient initiated	Those who meet anti-viral access criteria **OR** are in the priority or vulnerable groups	$90 $135 (after hours/ weekends)
Primary care Prescriber support for pharmacist-initiated supply of anti-virals. Provision of advice or additional information when a pharmacist needs support for a complex patient.	Those that meet anti-viral criteria, **OR** eligibility review that doesn't meet criteria	$37.50
Urban In-home care	Those who meet anti-viral access criteria **OR** are in the priority or vulnerable groups **AND** are identified to be clinically high risk and needing in-person review.	$180 + travel ($0.83 per kilometre) $270 + travel (0.83 per kilometre) after hours/weekend
Rural and Remote In-Home Care	Those who meet anti-viral access criteria **OR** are in the priority or vulnerable groups **AND** are identified to be clinically high risk and needing in-person review.	$250 + travel (0.83 per kilometre) $375 + travel (0.83 per kilometre) after hours/weekend

In person care in clinic – face-to-face review when clinically required.	Those who meet anti-viral access criteria **OR** are in the priority or vulnerable groups **AND** are identified to be clinically high risk.	$90 $135 (weekends)
Advance prescription for COVID-19 anti-viral medication	Those who meet anti-viral access criteria	$90 – initial prescription $60 – initial prescription consult for someone eligible that doesn't result in a prescription $45 – for further advance prescription when initial prescription has expired
Pharmacy cost (i.e., assessment, dispensing and delivery)[1]	Those that meeting anti-viral access criteria Eligibility review that doesn't meet criteria	$75 $37.50

- All costing quoted in this chart are GST exclusive.
- After-hours on weekday is between 8pm-8am Monday – Thursday. Weekend rate covers Friday 5pm - Monday 8am and any public holiday. Most standard COVID-19 care and regular reviews are intended to be undertaken during business working hours (weekdays) with after hours and weekend reviews based on clinical need.

Additional notes

- A claim can be submitted for each person in a household who is COVID-19 positive, including probable cases.
- Claiming is limited to one type of claim per person, per day, per practice, except for cases where the patient has required clinical escalation after a regular review has already been completed. In this instance a clinical escalation can be claimed as an additional claim for that day.
- A proactive clinical assessment which is then escalated to a prescriber or other clinician can only be claimed once as a proactive clinical assessment. It cannot be claimed as a proactive clinical assessment and a clinical escalation.
- Claims can be made for consultations undertaken by any virtual means including telephone/video/text/patient portal.
- To qualify for a funded regular review, a patient must meet the anti-viral criteria **AND** be identified by the clinician as clinically high risk.
- Pharmacy-initiated anti-viral assessment and supply is supported by a funded consultation between the pharmacist and a primary care prescriber. This enables

[1] The full schedule of COVID-19 Care in the Community – PHARMACY SERVICES can be found in the 'Guidance for Community Pharmacy Funding for COVID-19 February 2023' document.

safe pharmacy-initiated supply in situations where there is limited access to patient information and can help avoid the need to re-direct the patient to a prescriber.

Advance prescriptions

Advance prescriptions for oral COVID-19 antiviral medicines will not be clinically appropriate for some patients that otherwise meet the eligibility criteria. There is no obligation for a clinician to issue an advance prescription.

Situations where advance prescriptions may be particularly useful are:

- for people who are at very high risk of becoming infected with COVID-19 in the near future e.g., patients who meet eligibility criteria, and who are household contacts but not yet symptomatic or COVID-19 positive, but may become a case soon
- for people who are travelling to other regions within New Zealand who may struggle to contact their usual health provider at that time.
- for people who live in remote and rural areas with limited availability of primary care or pharmacies that can provide anti-viral medication without a prescription.

Primary care clinics will be able to identify those people who would gain most benefit from an advanced prescription. It is anticipated that there is likely to be a short intervening period between the issuing of the advance prescription and when it is dispensed. It is not expected that advanced prescriptions will be issued for all those eligible for anti-viral medication, it is to be targeted for those most clinically appropriate, at the discretion of the prescriber.

When a consultation takes place with the sole purpose of discussing anti-viral medication, but the advance prescription is either declined or contra-indicated there is a lower fee to acknowledge that the extra work of the prescription is not required.

See the separate Advance prescription guidance document for further details.

Clinical Assessment and Testing

Testing

Patients should be encouraged to do a self-test RAT at home wherever possible, with support from household members if living with others, before attending a primary care facility. It is important for general practice to reinforce this message with patients and accept a self-reported RAT when making decisions regarding a patient's clinical management.

Symptomatic household contacts of a positive case who are eligible for antivirals, can be prescribed these, without a positive test result.

Patients should be encouraged to upload their result via My Covid Record, prior to presenting at general practice or pharmacy. If a patient can't do this, the case needs to be reported either by facilitating the upload or through CCCM.

Points to note:

- A COVID-19 clinical assessment can be undertaken by a nurse, nurse practitioner or general practitioner for symptomatic patients, which also includes a COVID-19 test – in accordance with the testing guidance (in Appendix C) – this is either a RAT or PCR.
- A claim for funding cannot be made for self-test RAT that was completed at home.
- A claim for funding can be made for a RAT and/or PCR (ie: one claim for either a RAT, OR a PCR test, OR for both a RAT and PCR test in the same consultation) in accordance with the testing guidance in Appendix C.
- If there is a requirement for a RAT to be carried out by a clinician for an in-person consultation, this will only be funded if it is positive, **and** the patient meets criteria for anti-virals **or** is in a priority or vulnerable population group. This is allocated under one funding stream only; ***claims cannot be made separately for testing and initial assessment***.
- If the patient tests negative on a RAT as per the testing guidance and they meet criteria for conducting a PCR test, this will be funded even if the PCR is negative.
- All funding and claiming will be made through existing payment mechanisms with Te Whatu Ora Districts and PHOs.

Pharmacy guidance

- Pharmacist-initiated assessment and supply of COVID-19 anti-viral medication continues with the current funding model.
- The full schedule of COVID-19 Care in the Community – PHARMACY SERVICES can be found in the 'Guidance for Community Pharmacy Funding for COVID-19 February 2023' document.
- If an extended pharmacy consult is required due to clinical indications, providers may claim multiple service fees.
- Home deliveries for regular medicines continue to be funded for people who are confirmed or probable COVID-19 cases.
- Pharmacists can initiate supply of COVID-19 antivirals without a positive test result for symptomatic household contacts of a positive case who meet the other Pharmac eligibility criteria.

Clinical High Risk Guidance

With the dominance of Omicron, higher level of immunity and anti-viral medication becoming available, there are fewer people who become severely unwell with COVID-19. The focus is to provide funded follow-up care for those most in need and allow all other patients to self-manage and escalate as required. Those patients in the eligible groups, who are most likely to be at higher risk when unwell with COVID-19 will include but are not limited to:

- people with underlying severe respiratory disease
- people who require O2 monitoring during their COVID-19 illness
- socially isolated (lives alone, unable to connect with others through technology, little or no social network support)
- lack of caregiver support if needed, e.g., the other member of the household may also be unwell and/or have underlying health conditions that means they would be unable to care for the person
- symptoms/signs of dehydration (due to diarrhoea, vomiting, and/or poor fluid intake)
- challenges with health literacy or ability to understand treatment recommendations.

It is important to use clinical judgement and there may be examples that aren't listed above.

Note that those who are considered clinically high risk but are outside of the three priority groups (eligible for antiviral medication; priority group; vulnerable group) are not eligible for funded COVID-19 primary or community care services. They would pay a co-payment for their consultation, in line with the management of other diseases.

Appendices

Appendix A: Definitions

Rural and remote: Rurality is defined according to the Geographic Classification of Healthcare, and based on location of the patient's home address. Those in locations designated R2 and R3 will be eligible for funding.

Disabled people: Disabled people are people who have long-term physical, mental, intellectual, or sensory impairments which in interaction with various barriers may hinder their full and effective participation in society on an equal basis with others[2]. We acknowledge that this is a broad category and will not be easy to identify these people within the PMS. It is not an expectation that General Practice will necessarily proactively contact these people for an initial assessment if it is not clinically indicated, but it is important for General Practice to be aware that this funding is available where it is clinically indicated.

Migrant ethnic communities: This refers to refugees and asylum seekers.

[2] United Nations Convention on the Rights of Persons with Disabilities (UNCRPD),

Appendix B: Priority and vulnerable (high risk) populations

Anti-viral access criteria (in full on Pharmac website)

Symptomatic cases, within first five days of symptom onset and not requiring supplemental oxygen, who are also:

- 65 and over, OR
- Māori and Pacific peoples 50 and over, OR
- 50 and over and not completed primary vaccination, OR
- immunocompromised, OR
- Down Syndrome, OR
- Sickle cell disease, OR
- 3 or more high-risk medical conditions

Priority populations

- Māori and Pacific Peoples
- Disabled people
- People with severe mental health and addiction issues
- Older people (65 and over); and
- Other inequitably impacted population groups, including[3]:
    - migrant ethnic communities (see Appendix A),
    - remote and rural people (see Appendix A),
    - rough sleepers,
    - people in transitional housing, and
    - those not enrolled in primary practices.

Vulnerable populations

- people with high-risk medical conditions (long-term health conditions and/or immunocompromised)
- older people (65 and over)
- Māori and Pacific people with co-morbidities; and
- people who are pregnant.

Clinically High Risk

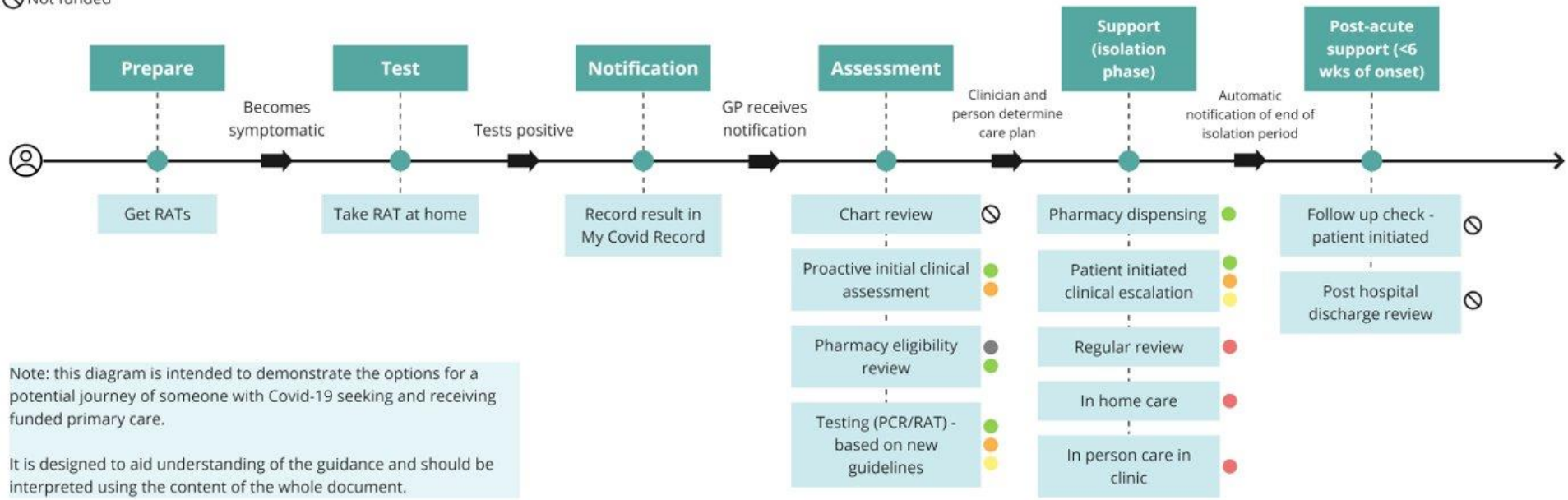
Includes but is not limited to:

- people with underlying severe respiratory disease
- people who require O2 monitoring during their COVID-19 illness
- socially isolated (lives alone, unable to connect with others through technology, little or no social network support)
- lack of caregiver support if needed, e.g., the other member of the household may also be unwell and/or have underlying health conditions that means they would be unable to care for the person
- symptoms/signs of dehydration (due to diarrhoea, vomiting, and/or poor fluid intake)
- challenges with health literacy or ability to understand treatment recommendations.

[3] Note Community Service Card (CSC) holders are not considered to belong to the 'other inequitably impacted population groups' categories by virtue of the CSC alone.

Covid-19 case journey map - primary care funded services

- Funded for any eligibility review
- Funded for people who meet anti-viral access criteria
- Funded for people in priority populations
- Funded for people in vulnerable populations
- Funded if clinically deemed to be very high risk (and within one of the above groups)
- Not funded



Note: this diagram is intended to demonstrate the options for a potential journey of someone with Covid-19 seeking and receiving funded primary care.

It is designed to aid understanding of the guidance and should be interpreted using the content of the whole document.

Appendix C: COVID-19 Testing Operational Guidance: General Practice and Urgent Care

RELEVANT INFORMATION
Current testing guidance: general population is to conduct a self-test RAT if symptoms develop.
It should be noted that asymptomatic (screening) testing for COVID-19 with the exception of close household contacts to a known case is no longer generally recommended in community, healthcare settings or facilities. Where appropriate, measures including adherence to Public Health IPC practices and vaccination and hybrid immunity are considered sufficient under the current settings.
Purpose of testing: enable access to antiviral treatment for those at greatest risk, within the recommended treatment window or where a result will change clinical management. The need to, and the choice of, test is a clinical decision based on need and the urgency of the test result. It may depend on local testing services available.
Patients with COVID-19 compatible symptoms who require in-person care either at home or at an urgent or primary care clinic should be encouraged to do a self-test RAT at home wherever possible, before attending a primary care facility.
A self-reported RAT from a patient should be accepted, when making decisions regarding a patient's clinical management.
During winter and with the re-emergence of a range of pathogens that cause similar symptoms to COVID-19, consideration of alternative diagnoses is particularly important especially for Māori, Pacific people and those at higher risk of severe illness from COVID-19. For example, confirmation of a COVID-19 diagnosis may lead to different treatment for someone who otherwise would have been treated for influenza. Note that people can be co-infected with more than one pathogen.
A GP may use clinical discretion at the time of consultation if the patient is deemed high risk, has COVID-19-compatible symptoms, and has a high pre-test probability during high transmission, (for example, known contact of a case) as to whether to commence treatment without a test result/or negative RAT if they deem appropriate, and may cease treatment dependent on a subsequent negative PCR result if undertaken.

COVID-19 TEST RESULTS	
Positive test result for COVID-19	Isolate at home for seven days from the date of positive test or onset of symptoms, whichever is earlier
Negative test result for COVID-19	If symptoms worsen, repeat the self-test RAT in 24 and 48 hours, and contact the healthcare provider.
Household contacts (of positive case)	Complete a daily **self-test RAT** for five days after the first case in the household tests positive or develops symptoms.
Case definition and clinical testing guidelines for COVID-19 here	
DEFINITIONS	
Priority people	• **Māori, Pacific people, Elderly (65 years and older), Disabled people, people with severe mental health and addiction** • **other inequitably impacted populations - including refugees and asylum seekers, remote and rural[1] people, rough sleepers and those in transitional housing, and other groups experiencing disadvantage, and those not enrolled in primary practices.**
Those at higher risk of severe illness from COVID-19 (vulnerable people)	• **People with long term or chronic health conditions and/or who are immunocompromised are inequitably impacted due to increased susceptibility to COVID-19 infection and/or complications.** • **Pregnant people**

[1]'Rural' is defined according to the Geographic Classification of Healthcare, based on the location of the patients home address, in defined regions R2 and R3.

Target Group	Recommended Testing
Priority people and those at higher risk of severe illness from COVID-19 (vulnerable) **Symptomatic**	RAT self-test at home OR assisted RAT in clinic (if unable to) • if positive result - treat accordingly • if negative result and COVID-19 symptoms persist – repeat RAT in 24 and 48 hours (consider alternative diagnosis of other respiratory pathogens). • PCR where a result can influence treatment options for priority people and those at higher risk of severe illness fromCOVID-19 (vulnerable) Note that people can be co-infected with both COVID-19 and another infectious disease.
General population **Symptomatic**	RAT self-test at home • if positive test result - treat accordingly • if negative result and COVID-19 symptoms persist – repeat RAT in 24 and 48 hours (consider alternative diagnosis of other respiratory pathogens). • Note that people can be co-infected with both COVID-19 and another infectious disease.
Asymptomatic - household contacts	All household contacts of known COVID-19 cases are recommended to test daily for five days from the day when the first case in the household tested positive or developed symptoms (whichever is earliest).
Testing on arrival to New Zealand: for more information, please visit: Travelling to New Zealand; Travel to New Zealand by Air	
Symptomatic international arrival	If RAT result is positive, they are encouraged to get a PCR test to enable WGS for variant surveillance purposes.
Asymptomatic (household contact) international arrival	Recommended to test daily for five days from the day when the first case in the household tested positive or developed symptoms (whichever is earliest)
REINFECTION	At 28 days or less after the onset of a previous infection (Day 0 is the day of symptoms onset or positive test, whichever is earlier), testing for reinfection is discouraged, as it is uncommon and difficult to confirm without specialist input. People at a higher risk of severe outcomes, or becoming more unwell, should seek advice from the healthcare provider or Healthline. People who have recently been a case within the last 28 days are not considered household contacts, and testing is not recommended.
	At 29 days or more after the onset of a previous infection, individuals with new symptoms consistent with COVID-19 or household contacts are encouraged to take a RAT and upload all positive or negative results to My Covid Record. Isolation requirements are the same as for the first COVID-19 infections, and household contact testing guidance applies. All people who develop COVID-19 symptoms at 29 days or more are recommended to take a RAT, and if positive, they can be treated in the same manner, as if it was their first. Healthcare providers still have discretion to do a PCR test, where a person is symptomatic but RAT negative, to inform clinical management in either case (first or new infection).