Te Whatu Ora
Health New Zealand

FAQs – COVID-19 Primary Care Model of Care

These FAQs support changes to the national funding framework for COVID-19 management in Primary Care and Community Pharmacy and should be read in conjunction with the document *"Guidance for Primary Care Model of Care for COVID-19 FINAL"* and the '*Guidance for Community Pharmacy Funding for COVID-19 Feb 2023'*. They have been derived from feedback following engagement with Primary Care Leads, District Health Leads, and District COVID-19 Senior Responsible Officers during December 2022 - January 2023. It is expected that this document will evolve as funding changes are implemented.

Background

The 2023 funding reflects the move from a pandemic response to a targeted intervention response for those at higher risk of poorer health outcomes from COVID-19 including priority and vulnerable populations.

This funding model aligns with the current COVID-19 testing plan, public health measures and current policy settings.

COVID-19 funding is time-bound through to the end of June 2023 and as such we need to focus our efforts on supporting priority populations and those disproportionately affected as a result of COVID-19. COVID-19 healthcare for people outside of these priority populations will be provided on the same basis as other illnesses.

Criteria for funding

Q How is eligibility for funding 'rural and remote' defined?

A 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.

Q What criteria will be used to consider someone as disabled, to qualify for this funding?

A According to the United Nations Convention on the Rights of Persons with Disabilities (UNCRPD), 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. 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.

Q Are those living in Quintile 5 / Community Service Card holders considered part of 'other inequitably impacted population groups'?

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

Q The new criteria for funding for initial assessment includes priority groups OR those eligible for antiviral therapy. Does that mean all Māori and Pacific people are funded (not just those over 50)?

A Yes. According to the new guidance, priority populations include Māori, Pacific peoples, disabled people, people with mental health and addiction issues, people aged 65 and over, and other inequitably impacted population groups.

Q Are those patients who are considered clinically high risk but do not fall into the priority/vulnerable/anti-viral group eligible for any form of funded clinical support?

A There are now three funded categories: a) those who meet antiviral access criteria; b) priority population groups; and c) vulnerable population groups. Appendix B of the guidance document gives definitions of these categories. In addition, those who are assessed at the initial assessment as being clinically high risk **AND** eligible for anti-viral medications, are funded for regular review. Therefore, if someone is assessed as being clinically high risk and is outside of the three priority groups (eligible for antiviral medication, priority or vulnerable group) then they are not eligible for funded COVID-19 care in the community services. They would continue to have a consultation but would pay a co-payment, in line with the management of other diseases.

Q Why are there three separate but overlapping groups: priority, vulnerable, and those eligible for antiviral therapy? Could they be simplified into one group?

A While there are some overlaps in these categories, the funding does not apply universally to all three categories. For example, those who are in the vulnerable group receive fully funded care if they self-escalate, but not for proactive assessments.

Q Is a proactive initial clinical assessment funded only for those who meet antiviral access criteria **or** priority populations (i.e. not those in the vulnerable population)?

A Correct. Appendices B and C in the guidance document outline who falls into the categories of priority and vulnerable.

Q Do any of these changes affect Evusheld funding?

A No. The funding for Evusheld continues as per the 27 September 2022 *Evusheld – Claiming Guide for Primary Care*. We would expect the use of in primary care to be relatively rare due to the recent guidance from the Ministry of Health Therapeutics Technical Advisory Group (Therapeutics TAG) which is available here: https://www.tewhatuora.govt.nz/assets/For-the-health-sector/COVID-19-Information-for-health-professionals/COVID-19/Use-of-Evusheld-for-the-Prevention-and-Treatment-of-COVID-19.docx

Q Why is funding for regular review tighter than funding for patient-initiated clinical escalation?

A If an initial clinical assessment reveals that a patient falls into one of the funded groups (i.e., meets antiviral access criteria, or is in a priority or vulnerable group), then the practitioner can advise when and how to reach out for a funded clinical consult, if their condition worsens (with advice around what signs/symptoms to look for). So, it's about encouraging those patients to self-escalate if they need to and giving them the education to do it.

Q Targeting funding for regular reviews to only those who meet criteria means we are ignoring those patients who may not meet the criteria but may still be considered high risk by the practitioner. What about that cohort of people who don't proactively reach out for care?

A Most health conditions are escalated to health services by the patient, and this brings COVID-19 funding more into line with business as usual. The emphasis is on providing information to patients about when and how to self-escalate.

Q Does this funding cover assessment and/or management of Long COVID?

A No. This funding is for management of the acute phase of COVID-19. Funding for patients with Long COVID-19 is being supported through routine general practice consultations that are funded by capitation and patient co-payments.

Claiming

Q Can practices claim a co-payment from the patient in addition to making a claim under this framework?

A No. If a claim is made under this framework, an additional co-payment from the patient cannot be claimed.

Q Proactive clinical initial assessments are often time consuming and generally not able to be completed in 15 minutes, but this is not accounted for in this funding. Also, working out if someone is eligible will take additional time, so why is this not funded?

A The funding changes reflect the first step in the transition in the model of care from an emergency response to a more business as usual approach targeting those who are more vulnerable. Advice from the sector has been that proactive assessments are now averaging closer to usual appointment times, with longer appointments often being balanced by others requiring less time.

Q If a nurse conducts the proactive initial clinical assessment, the patient is confirmed eligible and requests antiviral therapy, and the patient is escalated to a GP for a discussion/prescribing, can this be dual claimed as both a proactive initial clinical assessment AND a clinical escalation?

A No. Patient-initiated clinical escalation is where a patient initiates contact with the healthcare provider because they require additional care. In this instance, the patient can be referred to pharmacy for an assessment for antivirals by the Pharmacist-Only Supply route. In the instance where a nurse conducts a regular review and escalation is

required, this can be dual claimed, if the patient meets the vulnerable population criteria.

Q Why is chart review no longer funded?
A Chart reviews are now included within the proactive assessment and this change reflects the first step in the transition in the model of care from an emergency response to a more business as usual approach, targeting those who are more vulnerable.

Q Is there a national expectation that funding will continue to be available for vaccine hesitancy, exemptions, adverse reactions, and 3rd vaccine dose?
A Funding for vaccination is outside the scope of the changes being introduced for COVID-19 Primary Care funding in this framework.

Q Is there an expectation that primary care practices conduct a proactive initial assessment for everyone that is funded for that service?
A There is no expectation that all patients who are eligible will need a proactive initial assessment. It is expected that clinicians will determine who requires a proactive initial clinical assessment based on clinical need.

Q Why is a pharmacist funded for an eligibility review that does not meet the criteria but a GP is not?
A Pharmacists do not have an enrolled population and associated funding. This funding recognises the additional time required for patients who are new to them and for whom they have little or no background history.

Q For a person who is eligible for funding, has a symptomatic consult but tests negative and then has a positive test the following day, is there the option to retrospectively claim that consult and refund the patients co-payment?
A Yes, if they would have met criteria for funding by being in either the priority, vulnerable or eligible for antiviral medications groups.

After hours and weekends

Q Is there an after-hours pharmacy eligibility assessment fee?
A No. There is one fee for an eligibility assessment regardless of the time of day.

Q Is there the expectation that practices continue to monitor their inboxes afterhours and on weekends?
A Practices will determine how best to manage their inboxes out of hours. Patients will be encouraged to self-manage and seek help proactively if they are at risk. This includes encouraging them to seek antiviral therapy direct from a pharmacy. In addition, patients will receive an SMS message after they have uploaded their positive test result about advice on where and when to seek help if needed.

Q Is it expected that primary care providers conduct and claim for a proactive initial clinical assessment for each individual household member?

A No, there is no expectation for an initial assessment to be carried out for every individual in a household, if there is no clinical need for this.

Public and Sector Communications

Q What is the time frame for public comms, and what will that consist of?

A Comms to the general public began on 8 February 2023, and include social media posts, a news item on United Against COVID-19 website, promotional material (e.g. Tiles, posters) made available for primary care practices and pharmacies to display. The United Against COVID-19 and Tu Whatu Ora websites will be fully updated on 13 February 2023A Ministerial announcement is planned for 14 February 2023.

Q Will there be a webinar for providers?

A Yes, a webinar for the primary care sector and pharmacy on these changes was held on the evening of Wednesday 8 February 2023. A recorded version is available on the Te Whatu Ora Vimeo page.

Q Managing public expectation around free consults will increase confrontation for front line staff.

A A public-facing communications programme began on Wednesday 8 February 2023, aimed at explaining the funding changes to the public. We encourage practices to further support communication of this change and are creating material to aid in this approach.

Q When will these changes take effect?

A The new changes will take effect from Monday 13 February 2023.

Q Who in the primary care sector has been consulted, and how have these changes been communicated to the sector?

A Sector engagement started in November 2022, following Cabinet decisions regarding COVID-19 funding. This included representatives from Te Whatu Ora, Te Aka Whai Ora, Primary care Leads – including College of GPs, GPNZ, Genpro, Urgent Care College, Rural health, and Māori Health providers.

The new framework has been developed by primary care clinicians working in Te Whatu Ora. The guidance and FAQs were circulated to PHOs on 27 January 2023, following a series of engagement meetings with sector leads where feedback was sought and incorporated into the final guidance. It is expected that PHOs will ensure their GP and pharmacy networks have received these documents. Sector communications will also be circulated through usual channels including Colleges, Health pathways etc.

Testing

Q How is a reduction in the current funded amount for PCR/RAT testing an eligible patient from $120 to $90 justified when the additional work required to identify eligibility for the test is arguably more than it was historically?

A The new Primary Care Funding document (with regards to Testing) is for a consultation and testing and has been reduced to align with the initial clinical assessment in the table under the CitC funding.
The latest Testing Plan and guidance is promoting the use of self-test RAT results as per the guidance, COVID-19: Testing Plan and Testing Guidance – Te Whatu Ora - Health New Zealand with the exception being those of high clinical concern, from the priority or vulnerable population groups and/or those that test negative when symptomatic.

Q The Testing Guidance changes according to level of community transmission. How should practices determine what level of transmission we are in? ie low/medium/high.

A The three categories respond to the level of burden on the health system and other sectors associated with each level of transmission. It has been proposed in the Testing Plan that determination of the transmission status at a national level will be assessed through the Public Health Risk Assessment process.

As of the release of this document on 10 February 2023 at a national level, the medium transmission level would apply.

The transmission status and recommended testing/public health measures in a ***specific setting or facility*** can be assessed by local IPC experts and/or Public Health Service to provide guidance (in conjunction with the Testing Plan and guidance).

Q Who will I be funded for conducting a RAT or PCR test during a consultation if a patient has not done a self-RAT test?

A Patients with COVID-19 like symptoms that meet one of the following:

- Antiviral access criteria
- Priority population group
- Vulnerable population group

A RAT can be conducted and claimed for on patients that meet the above criteria, if positive. If RAT negative and there is clinical concern a PCR can be undertaken and can be claimed for regardless of the result. There needs to be a clinical reason why the clinician needed to conduct the test, for example a disability limiting the person from self-testing.

Q What if a symptomatic patient does not meet the antiviral, priority or vulnerable population criteria? Am I funded to test them?

A As per testing guidance, if the patient has not done a self-RAT, clinically assess and test if high concern. This, however, will not be funded as the patient does meet the eligibility criteria, therefore funding does not apply, and a co-payment would be required. A PCR test can still be conducted but consult time cannot be claimed for this.

Q Are RATs only ever funded if the patient tests positive?

A A RAT conducted by a clinician will only be funded if it is positive and the patient meets the criteria for antivirals OR is in a priority or vulnerable population group.

The guidance states that if the RAT is negative and as the patient has COVID-19 like symptoms and is in a priority or vulnerable population group:

- a PCR should be considered (which can be claimed) OR
- a PCR test should be conducted if high clinical concern (which can be claimed) OR
- a PCR test may be conducted for more complex patients (for example, immunosuppressed patients where symptoms may indicate prolonged persistent infection)

Q With the amended guidance is there an expectation of doing a lot more PCR testing?

A No, as PCR tests are for the clinically vulnerable only. The guidance, states that **if the RAT is negative** and as the patient has COVID-19 like symptoms and is in a priority or vulnerable population group:

- a PCR should be considered OR
- a PCR test should be conducted if high clinical concern OR
- a PCR test may be conducted for more complex patients (for example, immunosuppressed patients where symptoms may indicate prolonged persistent infection)

Q Can treatment for COVID-19 commence without a test?

A As per the testing guidance, clinical discretion can be used at the time of consultation if the patient is deemed high risk, has COVID-19-compatible symptoms, and has a high pre-test probability (for example, known positive contact) 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.

Q Who else conducts PCR tests and RATs apart from General Practice?

A **PCR TESTING:**

General Practice:

- PCR test conducted at the practice as per testing guidance

Community testing centres (CTCs): (not to be confused with collection sites)

- PCR test – for incoming travellers to NZ who have tested RAT positive and are encouraged to do PCR for WGS (whole genome sequencing)
- PCR testing for general public
- If referring to a community testing centre please check Healthpoint to ensure in operation

Community providers:

- Not contracted to do PCR testing

Pharmacies:

- Not contracted to do PCR testing

RATs:

General Practice:

- RAT conducted at the practice as per testing guidance
- Can distribute RATs and masks free to the general public from a practice

Community testing centres:

- RAT **no longer** conducted, only PCRs, please check Healthpoint what service the CTC is providing

Community Providers:

- RAT (assisted) on those unable to do themselves (not listed on Healthpoint)

Pharmacies:

- No longer contracted to do RATs (assisted)

COLLECTION SITES:

- Districts (ex DHBs)
- Participating Pharmacies only
- Only distribute RATs and masks free to the general public – no testing – check Healthpoint

General

Q Is it still important to use CCCM for all patients who are eligible for antivirals, or is it only for people who need active monitoring?

A CCCM enables continuity of care, especially during weekends and after-hours when the clinician may not be the patient's usual healthcare provider. Therefore, it is important to continue to enter patient details into CCCM, if you are currently using this system.

Q Are the COVID-19 Hubs' services to continue in current capacity?

A Funding for COVID-19 Hubs is outside the scope of the changes being introduced for COVID-19 Primary Care funding in this framework. Separate work is occurring to support COVID-19 Hubs.

Q Will PPE and RATs continue to be provided free of charge?

A Yes, the changes in this framework do not affect the supply of PPE and RATs that will continue to be provided at no cost to general practices and community pharmacies, through the online portal.

Q How should we manage "red stream" patients? Ie. Potentially infectious illness, but RAT negative.

A It is expected that primary care providers and pharmacies will continue to determine how to best manage potentially infectious patients, according to usual infection, prevention and control practice as well as health and safety requirements. This is at the discretion of practices and their advisory bodies.

Pharmacy

Q Is the provision for extended pharmacy consults still going to be available? Many take more than 30 minutes.

A Yes. Where clinically indicated, in exceptional circumstances, providers may claim multiple service fees if an extended consultation is needed.

Q Many pharmacy services that are provided to COVID-19 positive patients aren't listed in the Primacy Care Model of Care for Covid -19 service schedule or guidance. Are they still funded?

A The Primary Care Model of Care for COVID-19 FINAL document only contains a summary of the pharmacy services which have been added or changed. 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.

Q Are home deliveries and prescription co-payments for regular medicines still funded for people with COVID-19 who do not meet the Pharmac eligibly criteria for antivirals?

A Yes, these services continue to be funded for people who are confirmed or probable COVID-19 cases who required them, for example, due to isolation requirements.

Q Can symptomatic household contacts of a positive case who are eligible for antivirals but not testing positive be given antivirals under pharmacist-initiated supply?

A Yes, 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 eligibly criteria.

Q Can you give the examples of when we would claim for a COVID-19 Antivirals Eligibility Review or Medicines Management Consultation even though no medicines were supplied.

A We expect providers to claim the COVID-19 Antivirals Eligibility Review if a consultation is needed with a Service User to determine whether they meet the Pharmac eligibility criteria for funded COVID-19 antivirals and through this consultation it is discovered they do not meet the Pharmac eligibility criteria.

For example, a 45-year-old of New Zealand European ethnicity is on holiday in Nelson and phones a pharmacy seeking Paxlovid because she has COVID-19 and takes multiple regular medicines. The pharmacist needs to phone her regular GP in Auckland to determine what long-term conditions she has and confirm what her regular medicines are. Through this conversation with her regular GP the pharmacist discovers she only has two long term conditions and therefore doesn't meet the Pharmac Eligibility Criteria.

We expect providers to claim the Medicines Management Consultation Fee if a consumer meets the Pharmac eligibility criteria but for clinical reasons is not appropriate for pharmacist initiated Covid 19 antivirals.

For example, a 75-year-old with severe renal impairment who wishes to take Paxlovid. The guidelines for pharmacist-initiated antivirals require people with severe renal impairment that wish to take Paxlovid be referred to their GP.

Capacity to target vulnerable and priority populations

Q Will there be any audit of how much of this work is done after-hours, and will there be any accompanying commentary around why some general practices are not able to do all this work in-hours?

A Yes, there will be an audit, which will be via reconciliation. The purpose will be understanding and explaining the context for why the work of one general practice differs from the work of another and allow for early recognition that a general practice may need additional assistance or strategies for resourcing.

Q General practices that deal with large numbers of casual patients will be unfairly disadvantaged by this funding schedule.

A Casual patients who qualify for funding for COVID-19 treatment under these criteria will not pay co-payments. Those who aren't in any of those high-risk groups, the priority and vulnerable groups or don't qualify for antivirals, would pay a co-payment, or casual patient fee, as per business as usual.

Q Until now the approach followed the clinical imperative that everyone who is eligible for antivirals should get them. Does this signal a change in that stance?

A No. The approach remains that everyone who is eligible for antiviral medicines should have the opportunity for a clinical assessment to establish suitability for them. The change is that there is more of an emphasis on educating patients when and how to reach out rather than expecting someone to contact them, in a transition to a more business as usual model.

Q Funding for regular review is now quite narrow. Is this a barrier to care for vulnerable patients?

A Our approach is to emphasise the need to provide information to patients about when and how to reach out for help. This aligns with our campaign to increase anti-viral supply direct from pharmacies, encouraging people to seek out antivirals if they test positive. Those in the vulnerable and priority groups can still have funded care if they self-escalate. The need for this may, in exceptional circumstances, be identified through the regular review.

Appropriate use of advance prescriptions

Q Should advance prescriptions be used cautiously, and why is there a funding difference between the initial issuing of an advance script, and its subsequent renewal?

A Advance prescriptions for COVID-19 anti-viral medicines can be used in limited circumstances when a patient who is eligible for antivirals may not have access to them in a timely way (e.g. living rurally, no ease of transport, limited access to communications, or nearing a weekend).

As with any prescription, consultation is required to exercise the clinical judgement necessary to issue an advance prescription in relation to the patient's clinical needs. Consultation in advance provides an opportunity for an in-person or virtual conversation about oral therapeutics and education on the oral antiviral therapies and potential side effects. The funding for an advance prescription is aimed for when this is the sole focus of the consult. It also provides an opportunity to undertake any tests that would support the safe use of oral COVID-19 antiviral medicines, such as renal function, and discuss possible interactions, when clinically indicated. Therefore, the initial issue of the advance script requires more work than subsequent renewal after the 3-month expiry period.

Timelines

Q When will these changes take effect?
A The changes in this funding framework will be implemented on 13 February 2023.

Q What will be the duration of the new funding arrangements?
A These changes are the first part of a staged transition to a business-as-usual model for primary care management of COVID-19. They will be accompanied by stronger monitoring and reporting processes to enable regular and timely review of expenditure. This guidance is provided until 30 June 2023 with advice on the approach after 30 June still being sought through usual government processes.

Funding delays

Q One of the changes is to strengthen monitoring and reporting processes for the flow of funding to Primary Care. Where in the system have these delays been occurring?
A There have been system-wide issues with timely invoicing and payment across the system. Funding relies on all parts of the system being responsive. We have, and continue to streamline and simplify funding systems and processes to enable more timely payment of invoices.

Accountability within the system

Q What level of monitoring will occur, and will it be across the sector?
A Local District processes are being updated to enable a nationally consistent centralised management, monitoring and reporting system. This will better track expenditure, activities and outcomes of our COVID-19 response.

As part of this process, we will introduce a primary claims reporting template that will need to be completed and submitted with invoices. Collated information will be reported to Government.

Q Does this funding recognise the costs of providing primary health care for priority patients who have a COVID-19 infection.

A Funding has recognised the cost of standing up and supporting a pandemic response over and above business as usual primary care. The response funded a universal level of care that is outside the ability of existing primary health care funding to support.

The funding model is shifting to a targeted response to support those in our communities who are at the most risk of poor outcomes if they contract COVID-19. We are moving to a business-as-usual model to treat COVID-19 for those outside of the eligible population groups, with usual funding for general practice and pharmacy being part of a larger piece of system-wide work within Te Whatu Ora.