Metro Auckland COVID-19 Care in the Community (Whānau HQ): Additional Funding Information

21 March 2022

The aim of this document is to provide further information to support you with claiming for case management (Whānau HQ) activity. There are two sections to this document:

1. Frequently asked questions, and
2. A description of the COVID-19 Care in the Community funding changes over time (since the Delta Outbreak).

Frequently Asked Questions:

1. ***What if the patient care spans over a fee change period?***

   Choose the fee claim according to the date of the care episode. If claiming under Packages of Care this is only available for care starting on or after 10 February 2022.

2. ***What if our practice doesn't use CCCM?***

   You can still claim. However, we encourage use of CCCM because it is a shared care record which is accessible by other healthcare providers across the system who may need to provide care for your patient, including Healthline which may receive overnight calls from your patients, the Red Plus urgent care clinics, the hospitals across Auckland, and the Whānau HQ hub which provides weekend clinical calls for cases needing weekend review (indicated by raising a yellow flag). This is also the way you request an oximeter for your patient.

3. ***What if the Māori or Pacific Regional Coordination Hubs do an initial assessment, can I still claim?***

   Yes. Even if a hub has done an initial assessment, because of the large numbers of cases the majority of Māori and Pasifika at higher risk will still need to be picked up by primary care and you may claim for the care that you provide. You cannot claim for a second initial assessment in the same practice.

   The Māori and Pacific Coordination Hubs may have done an initial assessment (visible in CCCM) if the patient's name is on their list of higher risk patients and you have not yet raised the blue flag to indicate that you have taken on care.

   If a patient has been offered and consented to care from a Māori or Pacific provider you will see the care documented in CCCM, and you will not provide routine COVID-19 follow ups. However, the patient may reach out to you for care and you can claim for the episode of care provided. This would be on a fee for service (FFS) basis.

4. ***Low risk, low acuity patients – how is a desktop review +/- a text message or email funded, or a prescription for symptom management?***

It is reasonable to claim a FFS COVID-19 Regular Review Standard in this situation. Please note that it is not expected with current large case volumes that all low risk cases get a desktop review. Each positive case now receives a text message from the automated system and a self-serve web form link, and patients without a valid mobile phone number are provided with this information in other ways. Therefore, it is not necessary for the practice to text or email a low risk patient.

The Ministry of Health and the metro Auckland view is that care should in most cases be directed towardsthose at highest risk and more moderately unwell. Practices should now be receiving a *COVID-19 Triage Tool risk of hospitalisation New Case List* from the PHOs twice daily to assist with stratifying risk, though please note this tool does not currently pick up if a patient is pregnant.

5. ***Packages of Care (POC) - what is the minimum number of regular reviews required to claim each package?***

    - **Package 1**: all should have a documented initial assessment (an Initial Assessment requires both filling out of the initial assessment and a Regular Health Check to complete symptoms on CCCM), and 0-2 or more further regular reviews.
    - **Package 2:** all should have a documented initial assessment (an Initial Assessment requires both filling out of the initial assessment and a Regular Health Check to complete symptoms on CCCM), and 1 or more regular reviews.
    - **Package 3 & 4**: all should have a documented initial assessment (an Initial Assessment requires both filling out of the initial assessment and a Regular Health Check to complete symptoms on CCCM), and 4 or more regular reviews.

    This mechanism of claiming is intended to reduce the administration burden. It operates as a high trustmodel on the understanding that sometimes the care episodes will require more input, sometimes less.

6. ***Can a practice use both a FFS and POC approach?***

    Yes, though it is preferable that the practice takes a consistent approach. Please be aware that this claiming is subject to audit. Note that you may only use one approach (FFS *or* POC) for each full COVID-19 treatment episode for any individual patient.

7. ***Is the public health notification e-referral required to be submitted with the POAC claim?***

    No.

8. ***Do practices that have used CCCM need to submit notes with their POAC claim?***

    No, as your notes will be available for audit in CCCM. Please just indicate on the claim that clinical notes are in CCCM.

9. ***Can I continue to use CCCM for to record activity provided and still be paid via POAC without the need to complete a separate POAC Claiming Form?***

    No. You can continue to use CCCM. This is ideal for patients who are moderately unwell as it is a shared record across the system.

Unfortunately, at this stage, we are unable to pull the data from CCCM to inform payments. Completing retrospective claims using POAC claiming will be the quickest way to secure payment. Retrospective Bulk Claiming Options are also being investigated and will be advised shortly.

10. ***What if we decide as a practice to move to full use of CCCM only, can we be paid for this recorded activity by POAC?***

    Yes. Payment for treatment activity for COVID-19 positive patients will require the completion of the POAC claiming form.

    Please note that the CCCM system is now more stable. There is a time lag of 2-4 hours to creation of a CCCMrecord from positive test result in the afternoons. We recommend you use your risk -stratified New Case List from your PHO as your list for each session; all these should have a CCCM record available as they are generated from positive tests entering the system at least 4 hours prior. Funding for combined testing (by RAT or PCR) and assessment remains in place at this time, which is suitable for symptomatic people being assessed and tested at the same time.

11. ***If a 'high risk' patient (as per COVID Triage Tool report) has not been assessed by the clinic within 24hrs and has notbeen picked up or an assessment made by a Whānau HQ hub, if the clinic catches up with their workload and are able to make an assessment outside of that 24hr period (and within the 7 days in isolation) will this be funded?***

    Yes, it will be funded. The Whānau HQ team receives lists 3 times per day of high risk patients who have not been contacted within 24 hours, and will usually pick up these patients for initial assessment. However, practices are very welcome to assess their own patients at any stage, and raisethe blue flag so that Whānau HQ knows they are doing the care. If an initial assessment has already been completed by WHQ, a practice cannot claim for another initial assessment, but they may take over care and claim for subsequent reviews including clinical escalations.

12. ***If the high risk patient was picked up by WHQ for the initial assessment (e.g., over the weekend orafter 24hrs), can the clinic then go on and 'flag blue' and take over care for the regular health checks/welfare needs etc.?***

    Yes, though only if the patient needs ongoing active management.

13. ***If practices are entering initial assessments several days after the positive case notification, would you advise them to fill in the assessments and then document in the notes section that the assessment was made outside of the 24hrs?***

    In most cases starting an initial assessment more than three full days after test notification is unnecessary unless there is a good justification i.e. the person's symptoms have become significantly worse; this will be shown by use of Acuity 5-6. We will accept three days' delay as this allows for weekend delays in getting to the assessment. If a specific type of care is required but not the initial assessment, then just claim FFS for the service provided.

14. ***Some clinics are finding that over time they are able to catch up and assess the patient, or they***

find that Manaaki needs etc. have not been met for Māori and Pacific (if they don't fall into the high risk category), and therefore clinics go ahead and provide care. Will it be funded if clinics come in like this, later on down the track of the patient's isolation period?

Yes, they can provide care – most patients won't need initial assessment but may just need a short call and sorting of an issue (claim for a regular review). Phoning the MSD COVID welfare line on 0800-512-337 is the quickest way to get welfare needs met.

15. ***Once the 7-day isolation period is complete and there is still care being provided, is the claiming still available****?*

    Yes, for moderately symptomatic patients (acuity 5-6) it is reasonable to continue care if needed for up to 14 days. Please ensure clinicians are marking patients' CCCM files as "active management", so that the files do not get automatically closed. The COVID Care in the Community funding is not intended to be used for funding management of Long COVID.

16. ***Is COVID Care in the Community funding available for non-residents?***

    Yes, all COVID testing, vaccination and COVID Care in the Community is funded for non-residents.

17. ***Is the package of care 1 initial assessment for 2 different interactions with an acuity 1-4 patient?Please clarify. This would then obviously be reflected in all the other packages of care.***

    For POC claims, an initial assessment claim refers to the first contact with a patient, during which an initial assessment *and* a regular health check are completed sequentially.

18. ***When claiming a package of care, I am sending the invoice immediately after doing the first callto avoid creating an additional workload to come back to at the end, when it may be missed. I am unsure what the "Outcome" is for these COVID calls.***

    If only doing an initial assessment, then it is not appropriate to claim a POC as you only intend to do an initial assessment, rather claim FFS initial assessment. The outcome is that it is 'completed'. This is not a mandatory step. Please note POC 1 refers to an initial assessment and at least one regular review.

COVID-19 Care in the Community Funding Changes Over Time: 20 October 21- 09 February 2022

1. Delta Outbreak Through to Early Omicron

The majority of routine care for COVID-19 cases were managed by Māori and Pacific Regional Coordination Hubs and Whakarongorau Healthline. General practice contributed to care as and when requested by the patient, Public Health, or the Coordination Hubs.

Requirements at this time for billing: supply with POAC claim a statement or copy of the request for GP care from Public Health, Coordination Hubs or patient request for care. This did not require the Public Health Notification to be submitted with the POAC form.

2. 10 February – 27 March 2022

Omicron outbreak implementation of the 22 December Ministry of Health Framework

Primary care is actively encouraged to provide COVID-19 Care in the Community by using the COVID Clinical Care Module (CCCM) to provide care. The reasons for using CCCM for a patient are:

1. This creates a shared care record so that Whakarongorau Healthline and the Whānau HQ Coordination Hub have a continuity of care record for patients who need after hours or weekend clinical care when the GP is not available.
2. It enables visibility across the system (by raising a blue flag) to see who is caring for the patient, thereby avoid duplication of care.
3. It provides centralised oximeter requesting process.
4. The provision of clinical call at weekends to be covered by the Whānau HQ hub (raise yellow flag) for moderately unwell patients.

The intention was also to extract data from the CCCM use to determine payment for the activity completed in the patients CCCM record. Payment parameters were to be applied to these data and then practices paid via Buyer Created Tax Invoice (BCTI) through the POAC payment processes, thereby alleviating the need to generate POAC claims. We are still working to enable this system and ensure we can successfully use it as a consistent and accurate payment method.

The CCCM has had unanticipated problems, mainly in time delays in creating CCCM records from a positive test entering the system. Increasing case pressure in practices has meant that clinicians have resorted to managing patients within their own practice management systems (PMS). Therefore, metro Auckland general practices have ended up with a combination of practices or clinicians using either CCCM or PMS or both. Some practices have maintained spreadsheets of COVID-19 activity. Because of the problems with CCCM and the extensive feedback from the sector, we have revised the plan to provide a fair claiming process for the period between 10 February and 13 March.

On the 22 February a further Ministry of Health Funding Framework was released. Subsequent to this another document has been circulated indicating $34 for desktop review +/- text message. This figure does reasonably cover an activity that is reported to be occurring in practices and is more appropriate than a full initial assessment for low risk/low acuity cases.

On 8 March the claim category “COVID PC Regular Review weekend claims GP/NP” was removed from metro Auckland funding in line with the Ministry of Health Funding Framework Update on 22 February 2022. The “COVID PC Regular Review weekend” (clinician not specified) remains.

The MEDINZ message of Friday 11 March communicated to the sector two options for itemising the COVID care provided, and two ways of invoicing for COVID-19 care:

Two ways of itemising care:

a. *Packages of Care (POC)*
    - The aim of this option was to reduce the administration burden of itemising every aspect of care and to use a package of care approach.
    - It takes an averages approach – sometimes the care required will be more, sometimes less.
    - Cases are categorised as low acuity or high acuity, and as standard or high needs.
    - Additions to Packages of Care are permitted - itemised Fee For Service (FFS) claims for extra activities such as clinical escalations and in-person assessments.

b. *Fee for Service (FFS)*
    - Full itemised list of fees for clinical care provided.

Two ways of invoicing:

a. *Retrospective POAC Claiming*
    - Requires:
        i. STEP 1 Case creation as per normal POAC case creation.
        ii. STEP 2 Either
            - Package of care selection with FFS Additions if required, or
            - FFS itemised claim.

b. *Bulk Claiming*
    - Solutions are currently being investigated to allow bulk claiming to be submitted for POAC claiming purposes, for services delivered from 10 February to 28 March 2022.
    - For practices that have itemised every COVID-19 clinical care episode on a spread sheet or can generate a spreadsheet. Practices will need to enable access to records if required for audit.
    - Practices that have exclusively used CCCM to deliver and record COVID-19 care for patients. CCCM records are auditable by NRHCC.

3. 28 March 2022 Onwards

From the 28 March:

- One way of itemising care: Fee for Service (FFS).
- One way of claiming: POAC claiming.