Greg White

From: The Royal New Zealand College of General Practitioners <communications@rnzcgp.org.nz>
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To: Greg White
Subject: Medical Director update 21 October: A COVID-19 update

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This update provides you with the best information we have right now.

Over the last couple of days, some of our members in Auckland have suddenly started taking on COVID-19 management in the community. This feels sudden, but in someway is not surprising.

We have been working with the Ministry of Health at pace, but not fast enough, to get some documentation to help support this care. It is now available for our Auckland GPs on Healthpathways.

We have had some significant discussions this week with the Ministry and Ministers about the support surrounding this work, funding, and the issues with delays, protection and fit testing and IT systems to manage this and the way it has been communicated. Discussions have also started around ventilation in practices and the College will look at that with a Foundation Standard lens.

Forewarned is forearmed. Being prepared is helpful and having a strategy in place early is essential. We have reiterated that those of us on the ground doing the work should not find out ‘as it is happening’.

We will continue to work on the wrap around services that will help us to look after our patients in the community. We know them best and they trust us the most. This cannot however be a 24/7 gig and we need other services to be involved and smooth processes in place for escalating care when needed.

We also need to have a nuanced service that considers all the other issues that arise when we are dealing with rural communities, rural hospitals, larger whānau groups, homeless people, and those with complex health conditions. These are things we are working on. We are both on the Clinical Advisory Group for this and Sam is on the assurance group making sure that it happens.

Hopefully the communications out to GPs will be better and if not we will continue to work on this.

We want to acknowledge all the work you are doing every day to ensure your patients receive a high quality of care that we pride ourselves on. We have really shown our ability to pivot and adapt to whatever COVID-19 throws at us, and as it’s looking even more likely that COVID-19 will be with us for the foreseeable future, the information below will become part of our new normal.

The Pfizer third dose versus the booster shot

A third Pfizer third dose is not a booster shot.

An additional (third) dose is for people who may not have generated an effective response to the standard two doses of COVID-19 vaccine due to being severely immunocompromised. These people can now get a third dose as part of their routine vaccination series.

The Pfizer third dose

The Ministry of Heath recommends that consumers with severe immunocompromise be offered a third primary dose of the Pfizer/BioNTech vaccine. The criteria are tight and likely to apply to about 100 people nationwide.

Pages 5-7 of the Ministry's policy document outlines in table form the reasons a patient would receive this third dose. The third primary dose must be administered at least 8 weeks following the second dose.

The third primary dose must be prescribed by a medical practitioner, in accordance with Section 25 of The Medicines Act 1981, as it is considered off label use, and informed, written consent must be obtained prior.

Other information

- The Ministry is still working on the funding structure for GPs for dose three. Patients should never be charged for COVID-19 vaccinations
- The third primary dose can be administered at all vaccination clinics
- The standard two-dose course of vaccine should be offered to all eligible unvaccinated household contacts aged 12 and over, of severely immunocompromised individuals.

The Pfizer booster shot

Booster doses are aimed at addressing waning immunity over time. Antibody levels wane for most adults over time, although the level of antibody needed to protect against infection is a lot higher than needed to protect against severe disease if infected. This means that protection against any infection, especially infection with minimal or no symptoms, wanes relatively quickly (within a few months), but protection against severe disease lasts longer, even against the delta variant.

Based on overseas experience of waning in protection against severe disease, we expect booster shots will be at some point needed for highly vulnerable people such as the frail, elderly or those with significant comorbidities and have had their second dose more than six months ago.

The other group for whom boosters need to be considered soon is people with continued occupational exposure to SARS-CoV-2 and/or caring for people with COVID-19 disease, such as health care workers. The rationale for this group is because they are more likely to be exposed to SARS-CoV-2 infection and have higher potential to transmit infection to people at risk of severe disease.

Boosters are likely to ultimately be needed more widely (e.g. in the UK being given for all over 50 years), but timing is less urgent, still under discussion in New Zealand and will vary depending on risk profile.

IMAC is producing a more detailed document which will be on their website in the next day or two.

Vaccine exemption certificates

The College is being asked to clarify who can receive a vaccine exemption as patients are requesting them. The College has been working with IMAC on a statement about vaccine exemptions however the Ministry of Health has asked us to pause this work until they provide further clarification.

In the meantime, our advice is not to write vaccine exemption certificates until we receive the Ministry's guidance.

Principles of Care: unvaccinated patients

As a general practice you may have concerns about patients entering the practice who are not vaccinated. Although these people present a potential clinical risk to themselves, practice staff and other patients, **you have a duty of care to provide medical services to all patients registered with you, even if they are not vaccinated.**

However, you are justified in minimising the risk that unvaccinated patients may pose to staff and other patients.

Where possible these patients should be triaged before they arrive in the practice and their vaccination status determined. If the patient is unvaccinated or refuses to say, then they should be:

- Offered a tele consult in the first instance to manage their medical problems remotely
- If a face-to-face consultation is considered clinically necessary, then the practice needs to arrange for the patient to be seen face-to-face by a clinician. This clinician may or may not be the patient's regular GP.
- The patient should be treated as a 'red' stream patient according to practice procedures and appropriate precautions taken including:
    - separation in the waiting room, or waiting outside the practice (e.g., in the carpark)
    - the use of appropriate PPE by clinical staff interacting with the patient.

Principles of care: patients who refuse to wear a mask

Patients who refuse to wear a mask (or have an exemption), may not be identified until they reach the practice. Again, there is a duty of care to see these patients if they are unwell. These patients should be managed by:

- If they present without a mask, they should be asked to wait outside.

- The patient can be assessed outside (subject to privacy considerations), or they need to be offered a telehealth consult to manage their medical problems remotely.
- However, if a face-to-face consultation is deemed necessary, or the patient refuses the telehealth consult, then the patient will need to be seen by a clinician, who may or may not be their usual GP.
- The patient should be treated as a 'red' stream patient according to practice procedures and appropriate precautions taken including:
    - separation in the waiting room, or waiting outside the practice (e.g., in the carpark) from other patients
    - the use of appropriate PPE by clinical staff interacting with the patient.

The practice is entitled to make an appropriate charge for the extra work this may entail for both situations detailed above, but the charge must be reasonable (not punitive), and the patient must be notified of that charge when they initially present. It is important that the practice processes do not adversely affect the equity of access to General Practice services.

Kia kaha!

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