Te Whatu Ora
Health New Zealand

Primary Care and Other Clinic-Based Settings

This guidance document is divided into three sections covering:

- Testing information for primary care and other clinic-based settings
- COVID-19 Testing Operational guidance for General Practice and Urgent Care table
- Guide for diagnosis and table for COVID-19 reinfection, rebound, persistent infection, and long COVID-19

Testing information for primary care and other clinic-based settings

Testing in primary care and clinic-based settings is aimed at protecting priority people and those who are at higher risk of severe illness from COVID-19 (vulnerable people), reducing transmission within facilities, and ensuring that a sustainable healthcare workforce is maintained.

These settings include:

- Primary Care
- GP
- Community pharmacies
- Outpatient clinics; and
- Other health professional clinics (for example, dentist, chiropractor, physiotherapist).

The purpose of testing is to enable access to antiviral treatment for those at greatest risk, within the recommended treatment window or where a result will change clinical management. Testing also supports recommended COVID-19 public health and infection prevention control measures. The need to, and the choice of, test is a clinical decision based on need and the urgency of the test result:

- for those with symptoms compatible with COVID-19
- for priority people and those at higher risk of severe illness (vulnerable people) where the result can influence treatment options.

Priority access to COVID-19 Testing

Priority people are defined as those who are inequitably impacted by COVID-19. People in this group are eligible for targeted assessments regarding additional clinical and social support. The COVID-19 pandemic has exacerbated existing inequities for specific groups, including:

- **Māori** who experience greater inequity and disadvantage due to COVID 19 resulting in poorer outcomes.
- **Pacific People** who have had the highest age-standardised hospitalisation rates for COVID-19, and experienced age-standardised mortality rates 2.4 times greater than European and other population groups.

Other priority groups within our population who may also experience inequity due to poorer health or social outcomes and/or barriers to accessing testing include:

- **Elderly (65 years and over)** experience inequity as this age group collectively has the highest rate of poor outcomes including total numbers hospitalised, average length of stay and/or death from COVID-19. Māori and Pacific people are overrepresented in case numbers for the 65 years and over age group as well as other age groups.
- **Disabled people** including tāngata whaikaha Māori and Pacific disabled people who experience inequities due to greater barriers to access, and for some increased susceptibility to COVID-19 infection and/or complications.
- **Elderly (65 years and over)** experience inequity as this age group collectively has the highest rate of poor outcomes including total numbers hospitalised, average length of stay and/or death from COVID-19. Māori and Pacific people are overrepresented in case numbers for the 65 years and over age group as well as other age groups.
- **People with severe mental health and addiction**.
- **Other inequitably impacted populations** including refugee and asylum seekers, remote and rural[1] people, rough sleepers and those in transitional housing, and other groups experiencing disadvantage.

The following group are those at higher risk of severe illness from COVID-19 **(vulnerable people):**

- **People with high-risk medical conditions (long-term health conditions and/or immunocompromised)** are **inequitably impacted due to increased susceptibility to COVID-19 infection and/or complications**
- **Pregnant people**

Note this group includes Māori, Pacific people and the elderly over 65.

[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.

Testing of patients

The purpose of testing is to 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.

Current testing guidance is for the general population is to conduct a self-test RAT if symptoms develop. Asymptomatic testing is generally not recommended.

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.

Testing of healthcare staff

It is essential that the workforce is maintained at the level adequate for ensuring ongoing care of all people. If workforce is significantly negatively impacted by COVID-19, service providers may undertake risk assessments to ensure safety of residents and the workforce.

Guidance has been established for workers, with the following general advice:

- In general, asymptomatic testing of healthcare workers is not recommended if they are using risk assessment tools and applying systematic IPC measures which significantly reduce the risk of workplace exposure. It is essential that healthcare workforce is maintained to ensure ongoing care of people.
- If the healthcare workforce is significantly affected by COVID-19, service providers may undertake their own risk assessments to ensure safety of patients and the workforce which may include a testing protocol.
- Additional precautions beyond the public guidance to test daily for five days from the day when the household case tests positive may be advised for staff who were household contacts and who work with those residents who may be at higher risk of severe illness from COVID-19, as per **Healthcare Worker Guidance**;

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

- 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.

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[2] 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**

[2] '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.

Recommended Testing:

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).

Guidance for diagnosis of COVID-19 reinfection, rebound, persistent infection, and long COVID-19

The latest evidence shows that reinfection with COVID-19 can occur within a short period of time. Reinfection will become more likely as new variants spread in the community.

When someone uploads a positive RAT result in My Covid Record, if it is 29 or more days since the last infection, it will be categorised as reinfection (same advice and support as for a new infection).

Evidence on reinfections is evolving rapidly. We will continue to monitor emerging information and update this advice accordingly.

Some people experience a range of ongoing symptoms after the initial COVID-19 illness. The type of symptoms may change over time. Long COVID-19 is a general term for describing symptoms that continue or develop after the initial COVID-19 diagnosis and cannot be explained by any other condition. In New Zealand, long COVID-19 is divided into:

- ongoing symptomatic COVID-19: signs and symptoms of COVID-19 four-to-twelve weeks after the initial infection; and
- post-COVID-19 syndrome: signs and symptoms that develop during/after an infection, consistent with COVID-19, continue for more than 12 weeks, and are not explained by any other condition.

Long COVID-19 can affect any system of the body, and the severity of symptoms may fluctuate over time. Symptoms will often gradually improve over time.

Currently, there is no diagnostic test available for long COVID-19.

Primary care guide on COVID-19 reinfection, rebound, persistent infection, and long COVID-19

This table is intended to be a helpful guide for the primary care sector to provide some definitions and general advice about reinfection, rebound, persistent infection and long COVID (post-COVID-19 condition)

It provides high-level information only and when applying this to individual cases, clinicians need to use clinical judgement and consider overall circumstances for patients, their whānau and the public health setting at the time. This document does not override current advice on the Te Whatu Ora website on any of the topics mentioned here.

Studies are still evolving around all of these topics, both locally and internationally, and therefore advice is likely to change as more evidence emerges.

	Definition	***At Risk Population***	***Timeline***	***Testing***	***Infectious***	***Specialist referral***
Reinfection	Second (or more) infection with SARS-CoV-2 (usually different variant)	All – more likely in younger, unimmunised	29 days or more from onset of previous infection	RAT or PCR where clinically indicated	Same as primary infection	**If severe or worrying symptoms, not improving or if severely immunocompromised**
Rebound infection	Recurrent symptoms after initial recovery, usually within 2 weeks of onset, up to 4 weeks - can occur with or without antiviral use	All – more common in women, unimmunised and those with severe acute infection	Suggested definition is positive test within 2 weeks of testing negative or finishing	Further testing not recommended unless clinically indicated, specialist guidance may be required for immunocompromised patients	Recommend isolation for patient until 24 hours of symptoms resolution and encourage	**If severe or worrying symptoms, not improving or if severely immunocompromised**

			antiviral, recognising there is no requirement for a negative test at end of isolation		standard protective measures for household contacts	
Persistent infection (PSI)	Ongoing viral replication indicated by persistently positive RAT or PCR result, usually but not always with symptoms, without a robust serological response, beyond 20 days from onset, in an immunosuppressed person	Those who are severely immunocompromised	>20 days from onset of previous infection	Either RAT or low-Ct PCR that is persistently positive. Severely immunocompromised as per specialist guidance: • Regular monitoring by PCR/RAT • Serology baseline and follow-up monitoring in consultation with specialist	Recommend ongoing personal IPC measures for the patient's protection and others they come into contact with (especially in healthcare settings), and encourage standard protective measures for	**If severe or worrying symptoms, not improving or if severely immunocompromised - discuss with specialist re monitoring, ongoing support and serological testing and result interpretation**

					household contacts	
Long COVID (Post-COVID-19 condition)	**Symptoms which develop during or after acute COVID-19 infection and persist**	**All - more common in older, female, co-morbid, unimmunised, severe acute infection**	**>12 weeks from onset of previous infection**	**Exclude other causes of symptoms – no diagnostic test available for long COVID at the current time**	**No**	**If severe or worrying symptoms, not improving or if severely immunocompromised**