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Update on the use of Covid Clinical Care Module (CCCM) by primary care

This update is intended to clarify the use of CCCM during the current stage of the Omicronoutbreak

The use of CCCM has been promoted to enable integrated care across providers supporting people with COVID-19. It creates visibility of the care provided so that people with COVID-19 can access the care that they need, when they need it. It is also being used in some areas to support payment mechanisms.
We know the sharp increase in cases has caused a significant increase in workload for general practice, and that the concurrent implementation of a new digital system is challenging. This means that practices have little time for training and familiarising themselves with the tool.

We also understand that much of the workflow within CCCM is additional to healthcare professionals' requirements and, as a result, its use is seen by many primary care clinicians is limitedin its current configuration.

It also takes 2-4 hours from when a new positive test result is reported to generate a CCM record.We are reducing this time as quickly as we are able, but it is likely in the medium term rather than immediately.

We are working hard to improve the system, to make it more user friendly and add to its value. In the meantime, while use of CCCM is not compulsory, we would like to highlight several areas whereuse is desirable.

We recommend that CCCM is used where a person is not enrolled with a general practice and has no other primary care medical record. It is also desirable to use CCCM when a person is under active medical care and/or when out of hours care is or is likely to be provided by another provider to support continuity of care.

Where a patient is under active clinical management, ideally, the following data should be enteredinto CCCM:

- marking the person for active management
- setting an acuity rating for the person.

This can be entered very quickly on Page 5 of the regular review.

This gives visibility at the care coordination hub that a clinical assessment has occurred, reduces duplication of effort, and supports national reporting without having to implement additional manual processes for the sector.

Regarding patients requiring Manaaki/Welfare support, general practice is reminded that referrals tothe Ministry of Social Development who are the lead agency for welfare needs, can be created directly out of CCCM in the regular review section. If the record is not available, the patient can use the MSD 0800 512 337.

With most cases having only mild to moderate illness, most people can self-manage, and no active contact is expected. However, clinical teams may choose to send a message to some patients to reassure them that assistance is available if needed. Practices would be funded at a rate of $34 (excl. GST) for chart review and contact (via text, email, patient portal– not bulk text messaging) forpatients that are higher risk but do not require a full initial assessment.

General practice, Primary Health Organisations and other healthcare providers should continue to work with their local care coordination hubs to develop processes that enable us to focus clinical care on individuals with COVID-19 who are likely to have higher risk of mortality and morbidity, referencing the published pathways and utilising local datasets.

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