

## Series 9 – Quick COVID Clinician Survey Summary (Australia)

Series 9 of the Quick COVID-19 Clinician Survey was fielded from the 17<sup>th</sup> to the 24<sup>th</sup> of September 2020 and received 48 responses. Confirmed cases of COVID-19 in Australia increased by 204 over this period to 26,983. The tough lockdown measures imposed in Victoria have continue to yield results, with case numbers in that jurisdiction decreasing to less than 30 per day on average during this period.

**Demographics** All 48 participants were general practitioners, of whom 19 (40%) were practice owners. One respondent identified as a GP practice owner and practice manager. 11 participants (23%) worked in a rural practice. All jurisdictions were represented in this survey: NSW 33%; Vic 19%; Qld 17%; SA 15%; WA 1%; Tas 2%; NT 2%; ACT 10%.

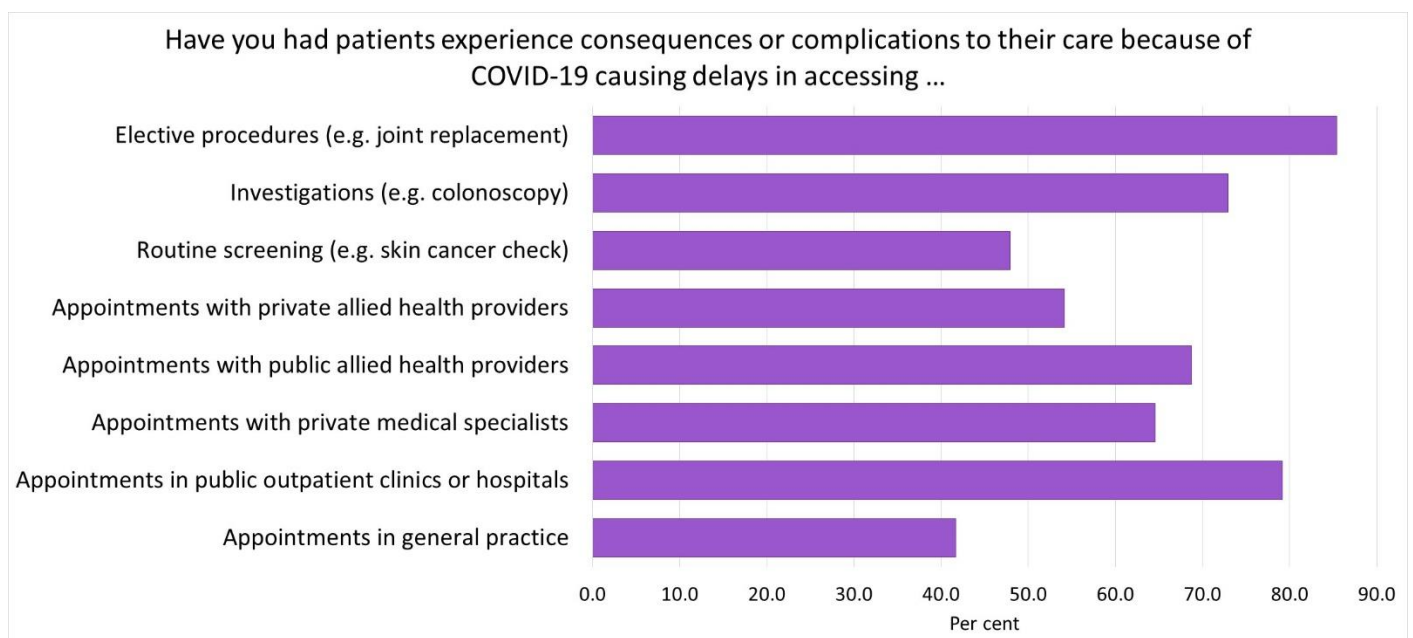
**Consequences of delayed access** Respondents' were asked about whether they had observed consequences or complications to their patients' care due to delays caused by the COVID-19 pandemic.

The biggest impact reported was for elective procedures, with 85% reporting consequences or complications from their delay.

Concerningly 79% reported consequences or complications from delayed public outpatient clinic appointments, and 73% from delayed investigations. Around two thirds reported effects from delayed appointments with private medical specialists.

Impacts from delayed allied health appointments varied between the public and private sectors. Respondents noted negative effects in 69% from delayed public appointments and 54% from delated private appointments.

Less than half reported consequences or complications from delayed GP appointments.



**Open Text Questions:** We asked clinicians about the consequences or complications that arise from missed appointments, investigations, or procedures. 48 clinicians responded citing themes of (i) More advanced disease, (ii) Prolonged pain, anxiety and deterioration (iii) Decline in mental health, (iv) Increased workload for GPs, (v) Increased hospital presentations, and (vi) Telehealth as a contributor to delayed care. Most consequences or complications were experienced at a greater rate, or were more impactful, for vulnerable patients, particularly elderly patients and economically disadvantaged patients who have lower access to care than the general population. Patients relying on public care were more often experiencing delays than those accessing private care.

**More advanced disease** due to delayed screening and diagnosis.

- *More advanced skin cancers, dental problems, mental health issues*
- *Delay in diagnosing possible covid (ground glass opacities on CXR which developed during a wait for the cardiologist), during which time the patient did not think to see me*
- *Late diagnoses of lung cancer*

**Prolonged pain, increased anxiety, and deterioration** caused by delayed diagnosis and treatment.

- *Delays in starting treatment and therefore persisting symptoms and pain*
- *longer waits for treatment of painful conditions in public hospitals (e.g. endometriosis, osteoarthritis)*
- *Pain prolonged because of inability to have joint surgery. Extra steroid injections and higher dose analgesics required*
- *Mood disorder secondary to failure to resolve symptoms*
- *Clinical deterioration and hopelessness*
- *Delays in surgery causing increased pain and anxiety*
- *Delayed diagnoses and treatment, increasing psychological despair as a consequence of delay*
- *Increased chronicity of pain, prolonged time off work and increased severity*
- *Deterioration in physical symptoms and worsening of chronic pain*

**Decline of mental health** due to lack of access to supports including the social interaction provided by clinicians.

- *Those with existing mental health problems are unable to get support in a timely manner*
- *increasing mental health issues especially anxiety, social anxiety and dysthymia leading to depression; loneliness and isolation due to lack of social interaction*
- *worsening mental health in patients trying to access mental health services*

**Increased GP work-load** due to a greater reliance on GPs for care, and greater administrative load as GPs navigate the changing health landscape.

- *Maternal and Child Health Nurses asking patients to attend GPs for growth checks as they're not doing F2F visits*
- *The hits to the public sector with cessation of public OPD clinics has meant [GPs] have done more. I have done 6 minute walk test for respiratory and other tasks for specialists as they are not prepared to see people in person*
- *Many of our usual reliable pathways have changed and more time has been spent calling/chasing/checking to try and find how to get people seen*

**Increased hospital presentations** due to delayed care.

- *Delayed appointments with specialists leading to increased presentations to GP and ED*
- *Patients not being able to see their GP in person, having to go to the ED*
- *Delays to get ACAT a big problem causing bed block [in rural hospitals]*

**Telehealth** has contributed to delayed screening, treatment, and diagnosis.

- *Much less face to face consulting and therefore increased risk of missed diagnosis especially in vulnerable groups*
- *A major issue has been for patients accessing psychological therapy via telehealth. I have had several who either didn't have the logistical capacity of the emotional headspace to try and have therapy via a screen. Some actively chose to delay until their psychologist returned to face to face sessions which was detrimental to their mental health*
- *People being fobbed off by Telehealth appointments when they really needed to be seen*
- *Medication errors due to telehealth consultations and delayed commencement of e-Prescribing*

Delayed services quoted in responses included: joint replacement surgery; colonoscopies; colposcopies; antenatal care; fracture clinics; mental health services; physiotherapy; dietetics; podiatry; exercise physiology; and dentistry.

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## Series 10 – Quick COVID Clinician Survey Summary (Australia)

Series 10 of the Quick COVID-19 Clinician Survey was fielded from the 15<sup>th</sup> to the 22<sup>nd</sup> of October 2020 and received 68 responses. Confirmed cases of COVID-19 in Australia increased by 125 over this period to 27,466, an average of less than 16 per day. Victoria has achieved a remarkable reduction in cases, a tribute to the efforts of the Victorian community and their cooperation with lockdown measures. During the survey period, Victoria recorded just 18 new cases (<3 per day). In comparison, NSW reported 53 cases, however local transmission is contained.

**Demographics** Participants included three practice nurses, five practice managers, and 60 general practitioners (of whom 18 were practice owners). 15 participants (22%) worked in a rural practice. All jurisdictions were represented: NSW 24%; Vic 34%; Qld 13%; SA 10%; WA 6%; Tas 3%; NT 3%; ACT 7%.

**Impact** Practices still feel the strain of the pandemic, despite decrease in daily cases, with 69% reporting moderate to severe strain on their practice. The majority report loss of staff due to illness or self-quarantine: general practitioners out (61%); nursing staff out (54%); front desk staff out (54%).

**Consultations** A combination of reduced case numbers and financial recompense available for telehealth has seen a return to increased face-to-face consultations. During the survey period, only 40% of respondents reported care being handled via video, with almost all reporting only a little (< 20% of consultations). Most respondents reported ongoing telephone appointments, but most (77%) for less than half of all consultations. This corresponds to a clear majority (71%) having more than half of their appointments take place face-to-face.

**Open Text Questions** We asked participants about barriers to telehealth use with vulnerable patients, and solutions that have been implemented to increase telehealth use with vulnerable patients. The barriers identified were similar to those reported in Series 3. These results allow specific barriers to be identified for specific population groups and suggests potential strategies to support telehealth use.

**Barriers** to telehealth were mentioned by most participants. Some participants reported no barriers, and that telehealth is beneficial for patients as it allows increased access to healthcare (n=7). Still, reliance on digital solutions creates vulnerabilities in patient groups that face challenges in accessing technology. As such, barriers and solutions must be identified and managed.

**Communication challenges** over telehealth means that information is lost in translation or left unsaid (n=xx). Communication was particularly difficult for patients with hearing impairments, low English proficiency, speech impairments, or cognitive disability.

- *Communication is more difficult using telehealth for ESL patients, as the pronunciation and annunciation is less clear than in person*
- *If speech impairment, then phone consults are difficult/ unsafe hard to communicate without visual clues*
- *Difficult with people with cognitive impairment eg early dementia, head injury, autism or intellectual disability.*
- *The people I consult via telehealth often aren't mindful of the fact a face to face interaction isn't occurring... more repetition and clarifying is needed as compared to face to face.*
- *Patients with mental health issues are often poor communicators which make telephone consults difficult.*
- *I have some patients who find it difficult to hear over the phone for Telehealth consults.*

**Poor access to technology** that supports telehealth (such as videos, phones, adequate internet, and computers) makes it difficult for telehealth consults to happen (n=27). Poor access was particularly noted for elderly patients, rural and remote patients, low income patients, and patients experiencing homelessness.

- *Not having access to reliable computer/laptop/computer workstation or access to reliable internet*
- *My older remote patients don't even have internet access*
- *People living with economic disadvantage [have] no access to internet*
- *We have issues with telehealth because the signal coverage in rural WA is often patchy and unreliable, especially for farmers from our small surrounding communities*



- *Some of our clients don't have phones*
- *Hindered by having no credit on their mobile phone plan*

**Low technology literacy** means patients may not want a telehealth appointment (n=14). Low technology literacy was particularly noted among patients with psychosocial disabilities and elderly patients

- *For my patients with intellectual disability, the process of logging on to a video consultation is too difficult*
- *People living with psychosocial disability have found it harder to use video platform*
- *Older patients and patients with disabilities have found Telehealth more difficult.*
- *Difficulty comprehending the concept of phone or video appointments in elderly patients...*

**Lack of safe, quiet and private space** to conduct telehealth consults makes discussing personal and medical information difficult and was particularly noted for low income patients and patients experiencing homelessness (n=4).

- *Often want to have consultation in a less than ideal spot - like when they are on the train and don't want to reschedule*
- *Video Telehealth [is] beyond organisational capabilities and often extra responsibilities - never have a moment to themselves*
- *...difficulty with background noise of car traffic noise, or dogs barking, or, commonly, children crying*

**Solutions** for telehealth use with vulnerable populations were suggested by 42 participants. The most common solution was for consults to be conducted face-to-face, especially in cases of no technology access, no connection and severe communication challenges.

**Solutions for poor internet connection and lack of appropriate internet or credit** involved a mixture of phone and face-to-face consultations:

- *Providing phone consults instead of video consults or turning the video off a few minutes into a video consult.*
- *Telephone consultations are much more accessible than Telehealth to people of low socio-economic background and those with disability.*
- *Sending a txt message with computer software to inform them GP has been trying to call them*

**Solutions for communication difficulties** included extra supports on the patient end and using video.

- *Support from a family member or carer.*
- *Flexibility around using video vs telephone. FaceTime with the right patients has been good at breaking down some of the barriers.*
- *If we can have in person interpreter booking for specific hours can then call the clients directly without going through telephone interpreter service.*
- *Ensuring presence of healthcare worker or support worker to assist patient during Telehealth.*

**Solutions for technology illiteracy** included face-to-face consults, extra time for consults, and extra support on both the practice-end and patient-end.

- *We have skilled up a staff member and developed easy English resources and provided 1:1 support for clients/patients to build capacity and confidence.*
- *Trying Telehealth with client in another room to get the used to idea and Telehealth workings*
- *Suggested client service officers contact video clients the day before to ensure they can use the system.*
- *In-person appt to meet, discuss and agree on further telehealth (phone) once ice broken. Tech support via sister organisation closer to patient (other headspace branch).*
- *Created a simple link on our practice website homepage to our HealthDirect video consultation page.*
- *Creating promotional materials for video consults*
- *Engagement of family members and carers to assist*
- *Taking the time to explain the concept of telehealth and it's uses to patients*

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## Series 11 – Quick COVID Clinician Survey Summary (Australia)

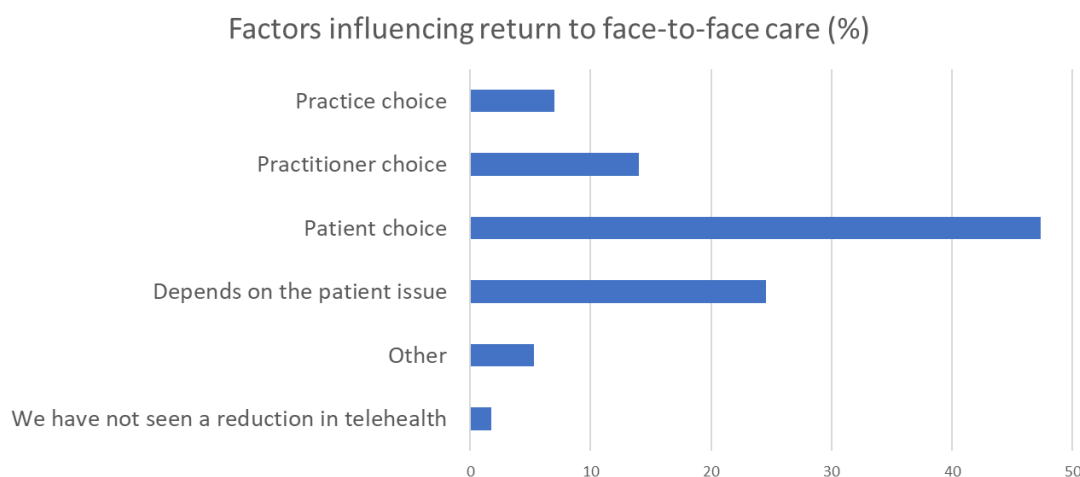
Series 11 of the Quick COVID-19 Clinician Survey was fielded from the 11<sup>th</sup> to the 19<sup>th</sup> of November 2020 and received 57 responses. Confirmed cases of COVID-19 in Australia increased by 106 over this period to 27,784; over three-quarters of new cases were overseas acquired. Victoria has effectively eliminated community transmission; there were no new cases of COVID-19 in Victoria during the survey period. South Australia has reported a cluster of cases where there may be community transmission.

**Demographics:** Participants included three practice nurses and 54 general practitioners (of whom 13 were practice owners). Nine participants (16%) worked in a rural practice. Responses were received from: NSW 21%; Vic 11%; Qld 9%; SA 11%; WA 2%; ACT 47%. There were no participants from Tasmania or the Northern Territory in this survey.

**Impact:** Strain on practices persists, but the proportion reporting moderate-to-severe strain has decreased to 54%. Loss of staff due to illness or self-quarantine continues (general practitioners out - 61%; nursing staff out – 53%; reception staff out – 63%).

**Consultations:** During the survey period, 37% of respondents reported care being provided via video. Telephone appointments were offered by most respondents, but for less than 20% of consultations by 49%, and for 20-50% of consultations by 41%.

**Consultation format:** We asked participants about changes in the balance of telehealth and face-to-face care in the previous 3-months, and what factors influenced reductions in telehealth where that occurred. Patient choice was the perceived driver in nearly half of responses.



**Open Text Questions:** We asked participants why they think face-to-face consultations have increased. We received 39 responses, from which three themes could be identified.

- Patients feel safe** to return to in person visits with their GP, and often appear to prefer face-to-face consults.
  - “People seem to be feeling safer to come in especially older pts who seem to prefer F2F so long as they feel it’s safe.”*
  - “As less cases in ACT more confidence with patients coming into the surgery.”*
  - “Overall, patients are more confident to come back to face-to-face consultation.”*
  - “Our practice is small and I think patients felt safe to come in.”*
  - “A lot more patients (and practitioners) are happy with F2F consults, especially in light of the low COVID cases locally.”*
  - “Many patients feeling safe in our area with little cases. Masks in practice helped confidence initially.”*

2. **Patients are more confident identifying when telehealth is appropriate** and book appointments accordingly.
  - *“Patients are becoming more literate with telephone and telehealth options. They have become much more discriminating about what consults are appropriate to do remotely.”*
  - *“Patients who have symptoms of concern are keen for FTF consults but most who simply need scripts, referrals, results for example are requesting phone consults.”*
  - *“... they still choose teleconsult for consultations that they perceive feasible on teleconsult such scripts renewal, results follow up, routine referrals.”*
3. **Telehealth remains viable for infection control.** Awareness of social distancing for infection control is observed as coming from practice, clinician, and patient levels.
  - *“We are continuing to encourage patients to take up the option of telehealth...to manage the waiting room.”*
  - *“Being in metro Melbourne we are just starting to increase our face to face consultations, but keeping a mix of telehealth to manage waiting room numbers etc.”*
  - *“We have some clinicians who are working from home for whom telehealth remains the preferred option.”*
  - *“Patients still prefer telephone consults to avoid coming [in] and sitting in waiting room full of sick people.”*

We asked participants what was appropriate and what was inappropriate for telehealth consultations.

**Appropriate consults for telehealth** (n=57) included known patients with simple presenting problems (that did not require examination), administrative procedures and reviews, and consultations with patients that may otherwise not attend.

- *“[Telehealth] has been fantastic for simple results. It has also been good for routine care plan reviews, a lot of which doesn't need face to face review.”*
- *“Telehealth via whatever format works better with patients I know well. I suspect [patients] feel more confident about it with a doctor they know well too.”*
- *“Issues requiring administration, likely renewed referrals, some renewal of prescriptions or discussing most types of results are largely suitable to Telehealth. Whereas most other consults work better when done F2F.”*
- *“Very good for rural patients who live far away from town.”*

Conditions identified as appropriate for telehealth varied by practitioner, but included: some basic pregnancy counselling, basic mental health counselling, palliative care, identification of skin issues (by video), reviews for chronic disease management when patients have access to home equipment (e.g., sphygmomanometer), mild respiratory issues, suspected COVID-19.

**Inappropriate consults for telehealth** (n=57) included anything requiring an examination or procedure, new conditions or new patients, and sensitive counselling sessions.

- *“Anything requiring a physical examination that is not immediately recognisable in a photo, e.g. new musculoskeletal injuries, skin checks, women's health checks, shortness of breath. Procedures of course, or anything that may require a procedure on the day (e.g. vaccination).”*
- *“Complex older patients should be seen at least every few months face-to-face I believe, because they are not always aware that they are deteriorating.”*
- *“New patients. Routine patients not seen for say 6 months.”*
- *“Acute presentations, potentially serious conditions e.g., chest pain”*
- *“Breaking bad news.”*

Conditions identified as inappropriate for telehealth varied, but included: Acute pain/distress, pain management (e.g., opioid prescriptions), baby and infant checks, musculoskeletal injuries, complex mental health counselling (especially high-risk patients), skin issues that require examination, abdominal pain, chest pain, pregnancy care >20 weeks, procedures (e.g. IUD placement), domestic abuse.

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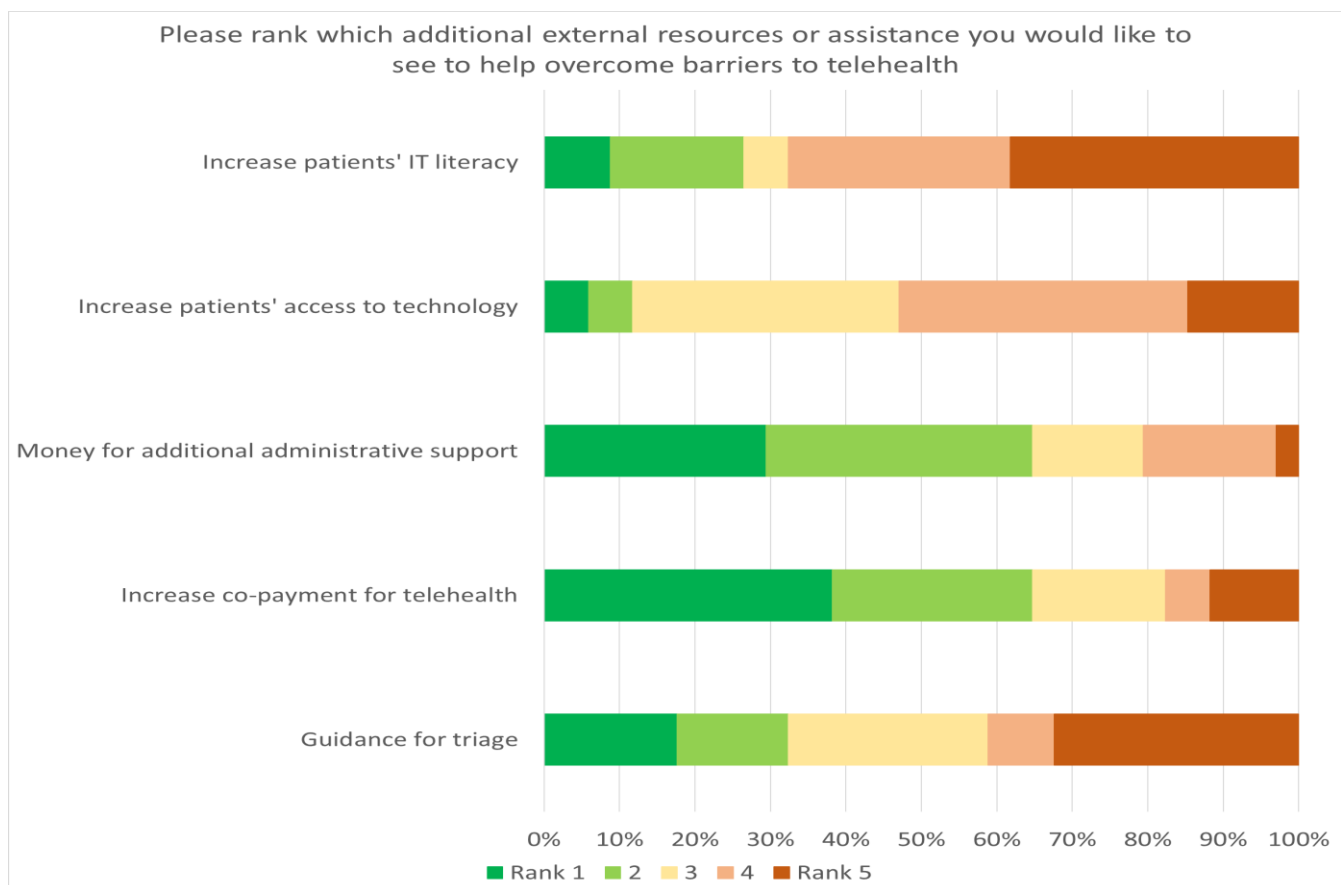
## Series 12 – Quick COVID Clinician Survey Summary (Australia)

Series 12 of the Quick COVID-19 Clinician Survey was fielded from the 9<sup>th</sup> to the 17<sup>th</sup> of December 2020 and received 34 responses. Confirmed cases of COVID-19 in Australia increased by 85 over this period to 28,072, of which 54 were active cases. There were no deaths in Australia due to COVID-19 during the survey period.

**Demographics** Participants were all general practitioners (of whom 10 were practice owners). Eight participants (24%) worked in a rural practice. Responses were received from: NSW 24%; Vic 27%; Qld 21%; SA 15%; WA 3%; NT 3%; ACT 9%. There were no participants from Tasmania in this survey.

**Consultations** Face-to-face consultations was the predominant format, with 88% reporting that more than half conducted in this format.

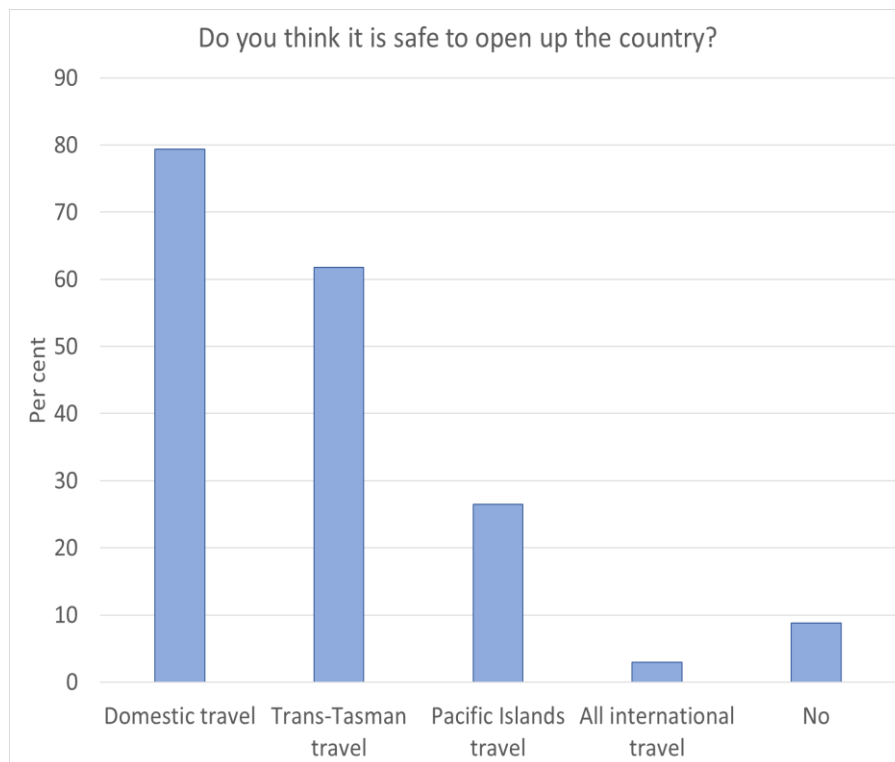
**Incentives for telehealth** We asked our participants to rank which additional external resources or assistance they would like to see to help overcome barriers to telehealth. The majority of respondents ranked financial support as priority 1 or 2: increasing the co-payment for telehealth, and money for additional administrative support.





**Travel** We asked respondents about whether they thought it was safe to open up the country. Domestic travel and trans-Tasman travel were generally considered safe (79% and 62% respectively).

Qualitatively, respondents echoed comments from previous surveys. Domestic travel and trans-Tasman travel was considered mostly safe due to low COVID-19 case numbers and minimal reports of community transmission. Still, respondents re-iterated ongoing monitoring, testing, quarantining, and rapid lockdowns to be necessary, even during holiday periods, to prevent COVID-19 spread. International travel remained 'unsafe' due to ongoing COVID-19 cases and community transmission.



**Open Text Questions:** We asked participants to justify their ranking of external supports or to provide other external supports that may be helpful to support long term sustainability of telehealth. Of the responses (n=16), most related to the desire of financial support to account for (i) telehealth equipment and set up, and (ii) increased time associated with telehealth.

Financial support was requested to cover the provider and practice costs of set up for telehealth, including laptops, video cameras and internet usage.

- *“Payments to cover practitioners’ costs or make it worthwhile for practices to cover practitioners’ costs for video...costs of setting this up and ongoing increased data costs etc which I would have to cover personally to say nothing of IT support etc make [telehealth] not really practical...”*
- *“A lot of staff have shared family computer which the kids use during home learning. They do not have exclusive use computer but rely on mobile phone. They also do not have multifunction printer with fax/scan capacity for home telehealth. Also cost of mobile calls and internet download is exorbitant. In the event of work from home primary care staff including GP/Nurse/Admin, the question then becomes who pays for the tech equipment/mobile phone bills and internet bills?”*

Financial supplement was requested to cover the extra time investment (administrative and practitioner time).

- *“There is an extra admin time burden from triaging patients, explaining booking options and taking payments. It is more time consuming to take payment over the phone than to tap a card in person.”*
- *“Patients very frequently do not pick up the phone for telehealth, leading to them trying to call through later, which is an extra administrative burden.”*
- *“Admin are doing lots more work and we are now being paid less.”*

Other suggestions for support included telehealth consultation guidelines and better internet quality.

- *“Clear guidelines for [telehealth] consults”*
- *“Helping patients and staff work out what can be done via Telehealth can be really tricky. I feel like I am forever answering questions about this.”*
- *“Improve upload speed on nbn - the difficulty with ALL online visual conferencing tools!!!!”*

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## Series 13 – Quick COVID Clinician Survey Summary (Australia)

Series 13 of the Quick COVID-19 Clinician Survey was fielded from the 11<sup>th</sup> to the 18<sup>th</sup> of February 2021 and received 33 responses. Confirmed cases of COVID-19 in Australia increased by 41 over this period to 28,912. At the close of the survey period, there were just 41 active cases of COVID-19, with 11 people in hospital, and no people in an intensive care unit. Australia has continued to successfully contain small clusters of COVID-19 cases. Since the previous survey was conducted, NSW, Qld, WA and Victoria have all had lockdowns in response to cases in the community.

The first COVID-19 vaccinations were administered on 21 February 2021, with the immunisation program for those in the highest priority group (1a) commencing on 22 February. This survey asks participants about preparing for the rollout of the next priority group (1b). Accredited General Practices were invited by the federal government to submit expressions of interest for providing vaccines to the community

**Demographics** All participants were general practitioners (of whom 11 were practice owners). Eight participants (24%) worked in a rural practice. Responses were received from: NSW 30%; Vic 27%; Qld 12%; SA 12%; WA 6%; Tas 3%; ACT 9%. There were no participants from the Northern Territory in this survey.

**Consultations** Almost all respondents (94%) reported the majority of their consultations being conducted face-to-face during the survey period, corresponding to the very low numbers of community COVID-19 cases.

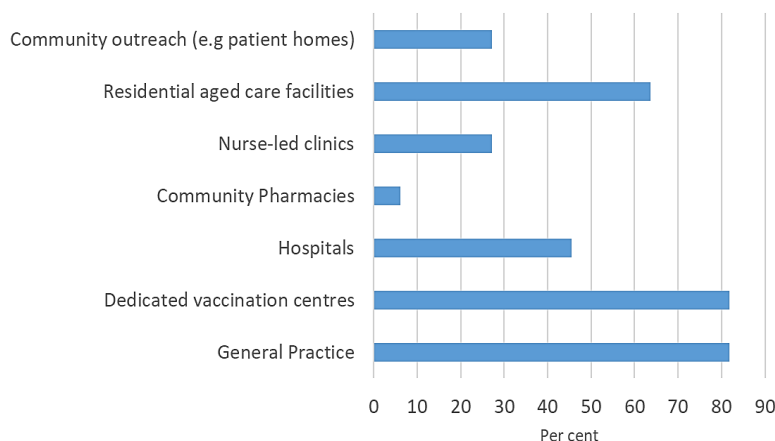
**Phase 1b vaccination program** Eighty-two per cent of participants indicated that their practice had submitted an expression of interest to be part of the phase 1b COVID-19 vaccination rollout. They were not aware of whether their applications were successful at the time of the survey. While uncertain of the outcome of vaccination EOI's, several participants expressed concern around their practices' eligibility based on: current practice software, low capacity to take new patients, and inadequate space to ensure physical distancing during post vaccine observation.

- *“Risk government booking system would crash our software and destroy our business”*
- *“Taking unknown patients and not being able to telehealth for past medical history is not something I am really prepared to do”*
- *“Our staff are already pretty burnt out and we couldn't ask them to do more than they have been and for a long term.”*
- *“Our main limitation will be the need for social distancing during the post vaccine observation period.”*

Participants were asked where vaccines should be delivered and who should administer them. There was strong support for vaccines to be delivered in general practices, dedicated vaccination centres, and residential aged care facilities. Participants expressed concern over vaccine delivery outside of general practice due to limited access to patient records, medical history, and vaccine eligibility information:

- *“Community pharmacies are not trained/set up to do this e.g., no comprehensive patient history/database e.g., NOK, past medical history and no training to manage severe anaphylactic shock in pharmacies. Furthermore, no ongoing follow-up”*

Where should the Phase 1b COVID-19 vaccine rollout be delivered?

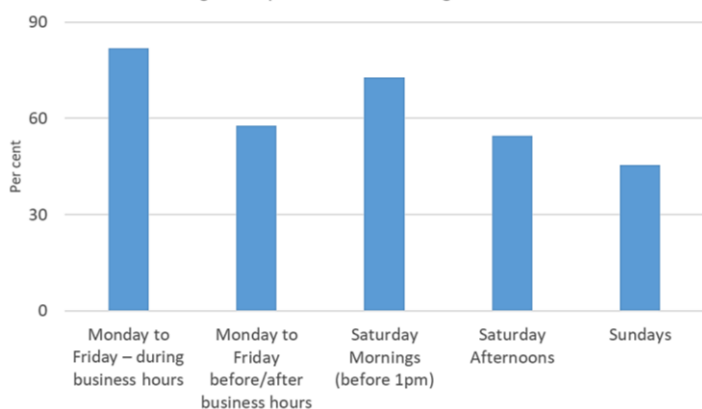


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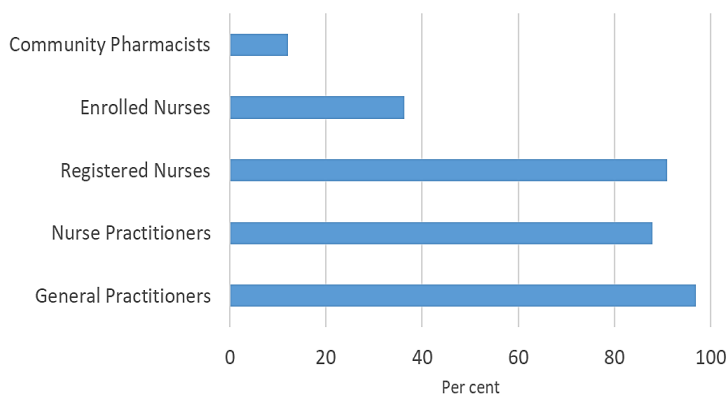
Respondents generally thought that GPs, NPs and RNs were best place to administer the vaccines. Open text ‘other’ responses included: medical specialists, practice nurses, and medical students (under supervision). Again, participants expressed hesitance over pharmacy vaccinations:

- *“Pharmacists should not be giving vaccines without a Dr standing by. What about anaphylaxis? And immunocompromised patients who may not be aware of it? Or a knowledge of medical history etc?”*

When should general practice be delivering COVID-19 vaccines?



Who should administer COVID-19 vaccines as part of the Phase 1b rollout?



We also asked about what times of the day and week would be suitable for delivering the vaccines. Open text responses all advocated for practice level flexibility depending on staff capacity and usual opening hours of the practice.

**Open Text Questions:** We asked participants what information they need to safely and effectively deliver the vaccine. Of the responses (n=33), three key themes were identified.

1. Participants want to be prepared on what to expect in terms of adverse reactions, contraindications for vaccination, and management.
  - *Contraindications, side effects, anaphylaxis management*
  - *Clear recommendations of how long to observe patients following the vaccine and how they need to be monitored.*
  - *If we are going to rely on records about anaphylaxis or ask each patient separately and how we are going to record that. I'm very vague about the recording of adverse reactions.*
2. Participants are concerned about continuity of care for patients, how and where to access patient records.
  - *What to do about patients from other practices coming to our practice for a vaccine, where we do not know their medical history, with the risk they are claiming to be eligible when they are not.*
  - *how are we going to manage people who don't understand what immunisation they have had already - will we be accessing myhealthrecord?*
  - *Are immunisation records linked to the AIR automatically?*
3. Participants want to be prepared on the vaccine roll out logistics, including how many vaccines to prepare for, how to appropriately draw and store the vaccines (especially in the case of multidose vials), how to time vaccinations appropriately, and want information on appropriate remuneration.
  - *The drawing up and how to manage the remaining stock in the vial at the end of the day*
  - *When vaccines will be available for COVID relative to influenza in order to plan the delivery of both especially given that they need to be given two weeks apart.*
  - *Information and appropriate monetary compensation for time and effort expended. Not a level A consult.*
  - *Does the GP need to see every patient to bill MBS item and how independently can nurse vaccinators operate?*

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