12th Biennial

"Are You Remotely Interested...?"

AYRI CONFERENCE 2025

Conference Proceedings Booklet

Keeping on Track for Health Equity in the Bush

12th Biennial "Are You Remotely Interested...?" Conference

Tuesday 15th to Thursday 17th July, 2025

JAMES COOK UNIVERSITY AUSTRALIA

MURTUPUNI CENTRE FOR RURAL & REMOTE HEALTH

The Murtupuni Story

The name "Murtupuni" (pronounced: mer/da/pun/e) was suggested by Kalkadoon elder Clive Sam in 2015 who has since passed. Local Kalkadoon artist, Glenda McCulloch, was commissioned to paint the story of “Murtupuni” and provided the following narrative for this painting which now hangs in the foyer of the Centre for Rural and Remote Health in Mount Isa:

This piece titled Murtupuni is inspired by my traditional homelands Kalkadoon country, the land where new journeys begin or are continued. A place where we come together to learn and share stories; this place is welcoming and warm. The rocky ridges are depicted here and the spinifex that grows wild on the hills. I have depicted here the red dust, the red and orange rock faces. This place is rough and rugged but also soft and pretty - this Kalkadoon land. The hibiscuses growing wild in the gulf country, the Cape York lilies, the Channel

SPONSORS

We acknowledge and appreciate the ongoing contribution of our funding body, the Australian Government Department of Health and the support from the following organisations for making this conference remotely possible:

Australian Government
Department of Health

North West
Hospital and Health Service

phn
WESTERN QUEENSLAND
An Australian Government Initiative

SPECIAL THANKS TO

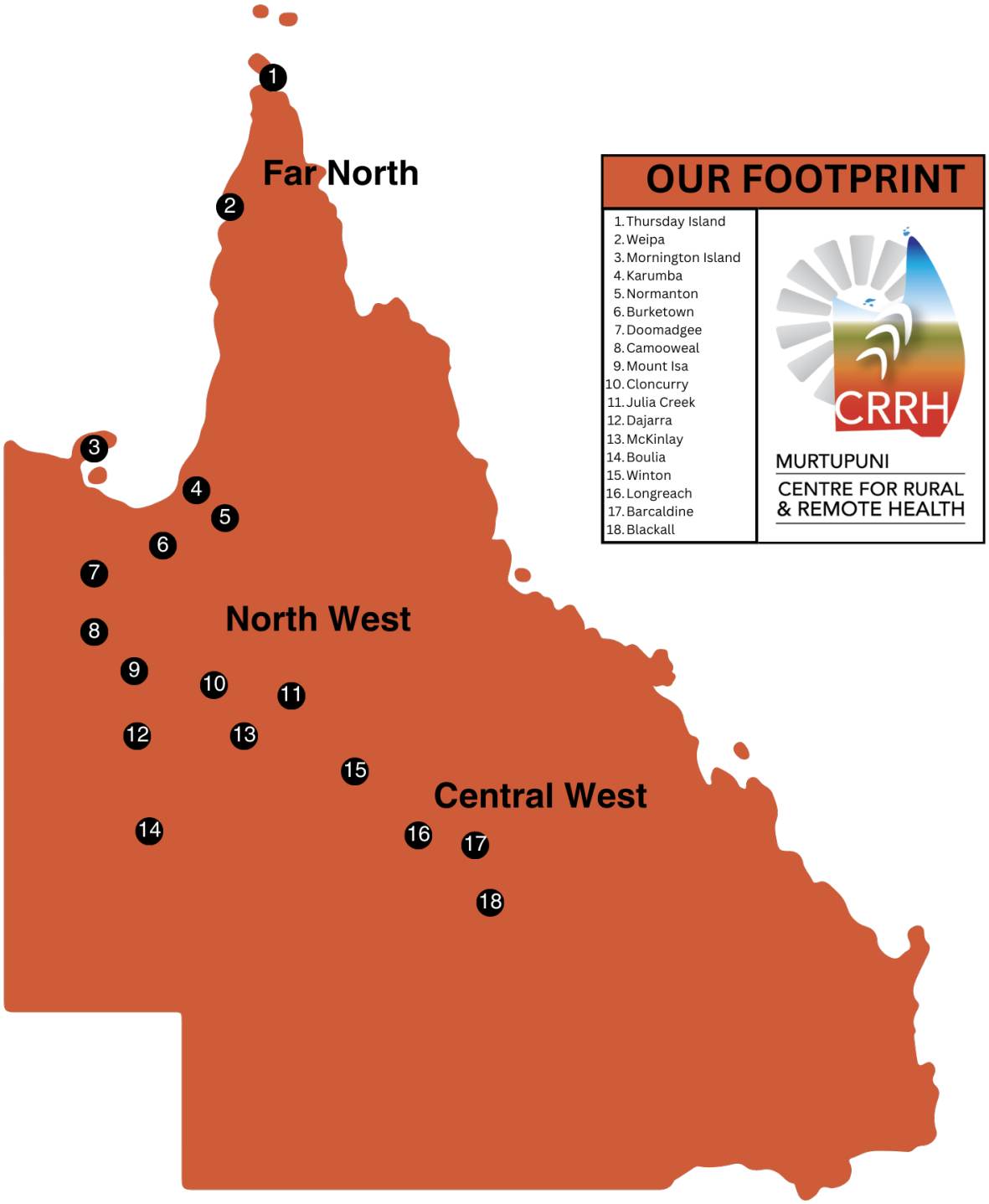
Mount Isa Water Board

MOUNT ISA
CITY COUNCIL

ZONTA
CLUB OF
MOUNT ISA INC
MEMBER OF ZONTA INTERNATIONAL
EMPOWERING WOMEN
THROUGH SERVICE & ADVOCACY

We acknowledge and pay our respect to Australian Aboriginal and Torres Strait Islander people as the first inhabitants of the nation and acknowledge traditional owners of the lands where our staff and students live, learn and work.

OUR FOOTPRINT



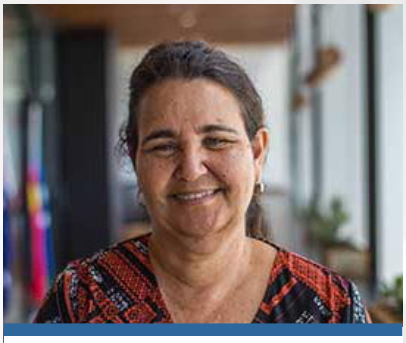
OUR FOOTPRINT

1. Thursday Island
2. Weipa
3. Mornington Island
4. Karumba
5. Normanton
6. Burketown
7. Doomadgee
8. Camooweal
9. Mount Isa
10. Cloncurry
11. Julia Creek
12. Dajarra
13. McKinlay
14. Boulia
15. Winton
16. Longreach
17. Barcaldine
18. Blackall

CRRH

MURTUPUNI
CENTRE FOR RURAL
& REMOTE HEALTH

Director's Welcome



ASSOCIATE PROFESSOR
CATRINA FELTON-BUSCH

BA, MPH, GRAD CERT PHC RES, PHD (CANDIDATE)

James Cook University Director

Catrina Felton-Busch, Director, Murtupuni Centre for Rural & Remote Health, James Cook University

Welcome to the 12th Biennial Remote Health Conference "Are you remotely interested....?" as we gather once again on the beautiful lands of the Kalkatungu. A gathering grounded in connection, collaboration and deep caring for community across our north and western Queensland footprint, AYRI brings together key stakeholders, academics, policy makers, health professionals and most importantly our community, whom keep it real, to grapple with the health challenges facing our rural, remote and Indigenous communities. Building on the work of AYRI 2023's theme "Health Equity for the Bush" this year's conference will harness the strength and diversity of our health sector, to challenge assumptions, to share knowledge, and to cultivate the next generation of health heroes for keeping on track with health equity for the bush.

Though this may be a small conference in size, we punch above our weight. AYRI is one of only two national remote health conferences and the only one consistently held in a remote regional centre. It builds on a proud tradition commenced by the founding University Department of Rural Health (UDRH) in Queensland – the Mount Isa Centre for Rural and Remote Health (MICRRH). Renamed "Murtupuni" a name gifted to James Cook University by Kalkatungu traditional owners, our centre is one of a national network of twenty federally funded UDRHs established to improve rural and remote health workforce.

AYRI celebrates the work we have done together for many decades: shaping rural, remote and Indigenous health policy through research, education, workforce development and community engagement. The conference comprises of both general and peer reviewed presentations and posters. It includes keynotes, panel discussions and paper presentations with supported opportunity for first time presenters and students. All accepted abstracts have undergone a rigorous review process.

There's something special about coming to Mount Isa in July. The outback air is crisp and cool, the skies vast and impossibly blue, and the red earth stretches out in quiet welcome. It's a time when the land breathes a little easier, inviting us to slow down, to listen, and to feel the rhythm of country. To journey into remoteness but also into connection: with place, with people, and with purpose. Whether it's your first time or a return visit, Mount Isa offers a grounding presence and a backdrop like no other for reflection, exchange, and inspiration. AYRI 2025 has something for everyone. Whether you're an old friend or a new face, we're glad you're here. This is a space for serious conversations, practical insights, and spirited exchange.

I hope you enjoy your time with us and I look forward to the outcomes of this 12th Biennial "Are You Remotely Interested...?" Conference.

Warm regards,

Catrina

Conference Opening Address

PROFESSOR NGAIRE BROWN

BMED, MPHTM, FRACGP

James Cook University Chancellor

James Cook University Chancellor, Professor Ngiare Brown

Professor Ngiare Brown is a senior Aboriginal medical practitioner and the first female and first Indigenous Chancellor of James Cook University. She is a proud Yuin nation woman from the south coast of NSW, with a passion for Aboriginal and Indigenous health, child safety and adolescent development.

She has made extensive contributions to research process, bioethics, policy, translation, and practice within Aboriginal and Torres Strait Islander health and worked over the past two decades to develop an extensive international network in Indigenous health and research.

One of the first Aboriginal medical graduates in Australia, Professor Brown completed her medical degree at the University of Newcastle in 1991 before obtaining a Master of Public Health and Tropical Medicine from JCU in 2000. She was named an Outstanding Alumna in 2012 and is a Fellow of the Royal Australian College of General Practitioners.

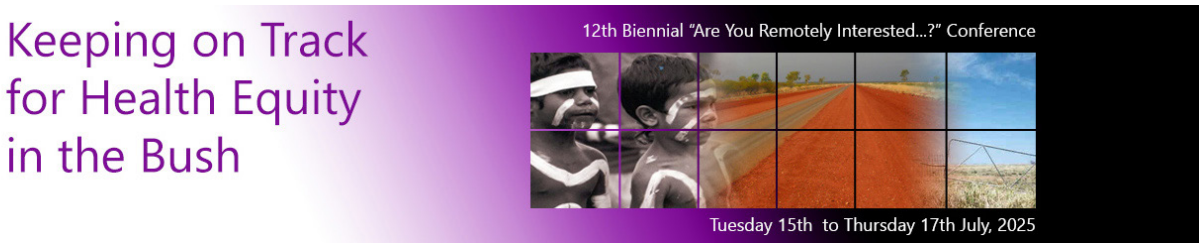
Professor Brown has held a variety of positions in education, mentoring, clinical practice, research, and advocacy as the:

- Founding member and foundation Chief Executive Officer of the Australian Indigenous Doctors Association
- Founding member of the Pacific Region Indigenous Doctors' Congress
- Associate Professor and Foundation Director of the Poche Centre for Indigenous Health at the University of Sydney
- Founding Director of Ngaoara, a not-for-profit committed to child and adolescent wellbeing
- Commissioner with the National Mental Health Commission.

PROGRAM - TUESDAY 15TH JULY 2025

Time	Session
9.00 -9:45am	**Registrations**
9:45 -10:30am	**CONFERENCE OPENING** **Welcome to Country** William Blackley & Cameron Leon **Professor Ngiare Brown** BMed, MPHTM, FRACGP James Cook University Chancellor **Director's Welcome** Associate Professor Catrina Felton-Busch **Housekeeping**
10:30 -11:30am	**PLENARY - KEEPING ON TRACK WITH HEALTH EQUITY IN THE BUSH** **Session Chair: Mr Shaun Solomon** Head of Indigenous Health, Murtupuni Centre for Rural and Remote Health **Panel members:** • Gary Torrens – Assistant Director of Nursing Kidney Services, North West Hospital and Health Service • Susan Sewter – Ngarnal Aboriginal Community Controlled Health Service, Mornington Island • Uncle Guy Douglas – North West Hospital and Health Service Rheumatic Heart Disease Indigenous Liaison Officer & Community Leader - Doomadgee • Dr Scott Davis – Executive Director, Tropical Australian Academic Health Council
11:30 – 12:15pm	**PANEL – INTEGRATING DISABILITY, REHABILITATION AND LIFESTYLE SERVICES IN RURAL AND REMOTE AUSTRALIA** **Session Chair: Ms Kylie Stothers** Deputy Chief Executive Officer, Indigenous Allied Health Australia **Panel members:** • The Hon. Jan McLucas – Former Senator for Queensland; Shadow Minister for Ageing, Disabilities and Carers 2004 - 2007; Parliamentary Secretary for Disabilities and Carers 2010 - 2013; Minister for Human Services 2013 • Katrina Bird – Principal Research Officer – Projects, Murtupuni Centre for Rural and Remote Health • Rahni Cotterill – Executive Manager – Allied Health and Community Services, North and West Remote Health • Professor Ruth Barker – Principal Investigator, FNQ Connect, James Cook University
12:15 -1:00pm	**Lunch**

1:00 -2:30pm	Session 1A/1B Scientific Program	
	Tjirtamai Hall Session Chair: TBC	**Lecture Room 1** Session Chair: Rahni Cotterill, North West Remote Health
	The Baribunmani Wanyi Ngay Youth Program *Marcelle Townsend-Cross* 15-min	**Transforming Care: Exploring Consumer and Pharmacist Perceptions of Expanded Practice in Rural and Remote Communities** *Dr Selina Taylor* 15-min
	What worked in women's groups: The bigger picture in Indigenous Australia *Nalita Nungarrayi Turner* 15-min	**Social Work contributions to General Practice in Northern Queensland** *Rebecca Lee* 15-min
	Empowering First Nations Nurses and Midwives: The Tjurtu Leadership Program *Professor Roianne West* 15-min	**FNQ Connect: Connecting people with care** *Ruth Barker and Katrina Bird* 15-min
	Implementing 'Ironbark Fall Prevention' in Mount Isa: A student-led quality improvement project *Kylie Bower* & Madeline Mills** 5-min	**The furthest corner. The finest care. – Delivering on a promise** *Dr Geoff Clark* 15-min
2:30 -3:00pm	**Afternoon tea**	



<table>
<tr><td>3:00 -4:30pm</td><td colspan="2">Session 2A/2B Scientific Program</td></tr>
<tr><td></td><td>Tjirtamai Hall
Session Chair: TBC</td><td>Lecture Room 1
Session Chair: Sarah Jackson, JCU</td></tr>
<tr><td rowspan="5"></td><td>Experiences of staff and consumers with the Cape York Kidney Care team
Dr Alice Cairns
15-min</td><td>Remote versus rural placements...And the winner is....
Aaron Hollins
15-min</td></tr>
<tr><td>Embedding Aboriginal and Torres Strait Islander Knowledges and protocols into our workplace
Sandra Levers and Shaun Solomon
15-min</td><td>Innovative Remote Allied Health Education and Training Hub
Steve Woodruffe
15-min</td></tr>
<tr><td>Medications During Healthcare Transitions: Utilising Grounded Theory to Improve First Peoples Experience
Michelle Rothwell*
15-min</td><td>The Keeping on Track, Leading with Strength: 10 Years of the IAHA Ultimate Student Leadership Challenge
Kylie Stothers
15-min</td></tr>
<tr><td>Evaluating training opportunities for improving community-led health workforce: Past, present, and future considerations from community
Roslyn Rowen
5-min</td><td rowspan="2">Confidence, heat, uncertainty; Student experiences in remote service-learning placements
Dr Alice Cairns
15-min</td></tr>
<tr><td>On track: Co-designed strategies to strengthen Northern Queensland's First Nations Health Workforce
Lisa Gibson*
5-min</td></tr>
<tr><td>4:30pm</td><td colspan="2">End of Day 1</td></tr>
<tr><td>4:45 -7:00pm</td><td colspan="2">Lake Moondarra Sunset Meet and Greet

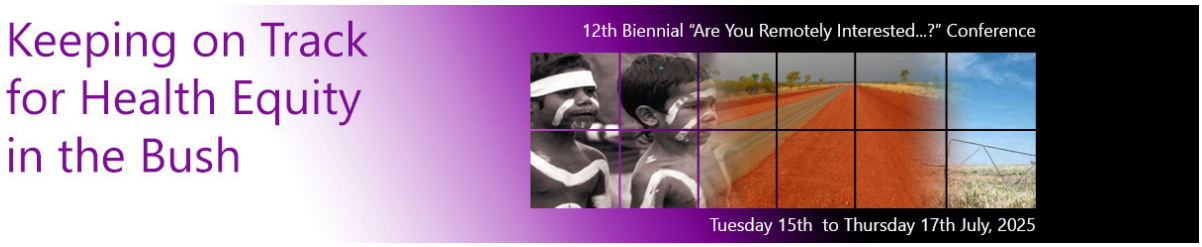
Join us for this social activity, and an opportunity to meet and network with other conference delegates.

Transport, canapes and drinks provided.</td></tr>
</table>

PROGRAM - WEDNESDAY 16TH JULY 2025

<table>
<tr><th>Time</th><th colspan="2">Session</th></tr>
<tr><td>8.00-9.00am</td><td colspan="2">Registrations</td></tr>
<tr><td>9.00-10.30am</td><td colspan="2">PLENARY – DEVELOPING THE NURSING WORKFORCE TO KEEP ON TRACK FOR HEALTH EQUITY IN THE BUSH
Session Chair: Professor Sabina Knight
Director, Central Queensland Centre for Rural and Remote Health, James Cook University
Panel Members:
• Professor Roianne West - Chief Executive Officer, First Nations Nursing and Midwifery Consulting
• Adjunct Professor Shelley Nowlan - Chief Nurse Officer for Queensland Health
• Madeline Ford - Head of Indigenous Health, Central Queensland Centre for Rural and Remote Health, James Cook University
• Sammy-Jo Kupfer - Project Manager, Workforce & Training, Western Queensland Primary Health Network</td></tr>
<tr><td>10.30-11.00am</td><td colspan="2">Morning Tea</td></tr>
<tr><td>11.00-12.00pm</td><td colspan="2">Session 3A/3B Scientific Program</td></tr>
<tr><td></td><td>Tjirtamai Hall
Session Chair: Amanda Mackay, JCU</td><td>Lecture Room 1
Session Chair: Kirsten Russell, Murtupuni JCU</td></tr>
<tr><td rowspan="3"></td><td>Experiences and perceptions of rural and remote nurses caring for pregnant women
Michelle McElroy*
15-min</td><td>Clinical Supply Online Shopping Solution
Melony Heaver & Andrea Mann
15-min</td></tr>
<tr><td>Pilot: Enhancing care for Chronic Disease patients in Dajarra through inter-organisational collaboration
Casey McDermott
15-min</td><td>Developing implementation strategies for the implementation of a remote context guideline
Sally West*
15-min</td></tr>
<tr><td>Advancing Remote Nursing Practice: Optimising Scope Through Protocol-Driven Education
Kylie Fischer*
5-min</td><td>Interdisciplinary Student-Led Allied Health Group Therapy Clinic
Taegen Pascoe & Melanie Sisavanh*
15-min</td></tr>
</table>

12.00-1.30pm	**Lunch & Poster sessions** **Poster titles:** • Distribution and Severity of Road Crashes in Queensland, *Dr Kehinde Obamiro* • Skin Cancer Early Detection in Rural and Remote Queensland, A Dual Approach, *Mary-Anne Quilter* • Data-driven approach to improve PI risk assessment and classification for all skin, *Rachel Walker** • Persistent Opioid Use After Cardiothoracic Surgery in Regional Queensland, *Izza Zahid*, Mahi Dhillon** • Beyond the Pain: Investigating the Psychosocial Impacts of Adenomyosis, *Sarah McDonnell** • Moving Minds: Exercise as Mental Health Care in Rural Communities, *Kirsten Russell** • Rural and remote stroke survivors driving their own recovery using technology, *Sarah Jackson**
1.30-3.00pm	**PANEL – STRENGTHENING RURAL HEALTHCARE DELIVERY THROUGH VALUE-BASED ALLIED HEALTH RURAL GENERALISM** **Session Chair: Professor Richard Hays** Professor of Remote Medicine and Health, Murtupuni Centre for Rural and Remote Health, James Cook University **Panel members:** • Andrew Quabba - Senior Pharmacist - Chief Operating Officer, North West Hospital and Health Service • Gabrial (Gabe) Arnold - Clinical Dietician and proud Palawa man - First Nations Allied Health Graduate program, North West Hospital and Health Service • Dr Alice Cairns - Senior Occupational Therapist - Rural Research Coordinator, Office of the Chief Allied Health Officer, Clinical Excellence Queensland, Queensland Health; Senior Research Fellow, Murtupuni Centre for Rural and Remote Health • Danielle Rodda - Senior Occupational Therapist - Rural Generalist in the Weipa Allied Health team for Torres and Cape Hospital and Health Service, conjoint with Murtupuni Centre for Rural and Remote Health • Dr Sharon Varela – Senior Psychologist - Deputy Director, Murtupuni Centre for Rural and Remote Health; Rural Generalist in Private Practice
3.00-3.30pm	**Afternoon tea**

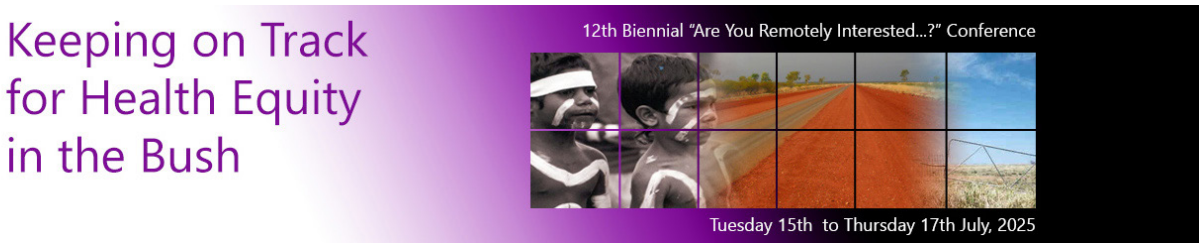


3.30-5.00pm	**Session 4A/4B Scientific Program**	
	Tjirtamai Hall Session Chair: Dr Anthony Bell, North West Hospital and Health Service	**Lecture Room 1** Session Chair: Penelope McArthur, Murtupuni JCU
	Role of Allied Health Professionals in Fertility Care: A Scoping Review *Amanda Mackay** 15-min	**Avoidable cancer-related deaths due to spatial disparities in survival across Australia (2010-2019)** *Dr Lizzy Johnston* 15-min
	Health, Partners, and Periods: What we miss in Australian Women's Health Survey *Dr Kris McBain-Rigg* 15-min	**Improving Access to Ultrasound in Remote Cape York Communities** *Steve Wallin* 15-min
	Caring in Nursing: Insights from Collective Narratives *Tanya Park* **15-min**	**Bridging the Gap: Delivering Mobile Dental Care in Rural Queensland** *Dr Stevie Dilley* **15-min**
	Facilitators and barriers to improving survivorship care for rural cancer survivors *Dr Lizzy Johnston* 15-min	**Sustainability in Healthcare: Investigating oral nutrition supplement wastage in the hospital system** *Gina-Maree Teixeira* 15-min
	High Burden and Low Access: Sexual Health Care in Mount Isa *Savannah Grudzinski** 5-min	**Barriers to evidence-based paediatric burn care within rural, remote healthcare settings** *Kylie Fischer** 5-min
5.00pm	**End of Day 2**	
7.00-11.00pm	**Conference Dinner** **In memory of Professor Dennis Pashen, Founding Director of the Mount Isa Centre for Rural and Remote Health** *In celebration of his life and career* MC: Professor Richard Hays Including the inaugural Dennis Pashen Oration by Dr Louis Peachey **Dress theme: 'Sheila Beige' or 'Tropical Depression'**	

PROGRAM - THURSDAY 17TH JULY 2025

<table>
<tr><th>Time</th><th colspan="2">Session</th></tr>
<tr><td>8.00-9.00am</td><td colspan="2">Registrations</td></tr>
<tr><td>9.00-10.30am</td><td colspan="2">PLENARY – SUSTAINABILITY IN RURAL MEDICINE
Session Chair: Professor Richard Hays
Professor of Remote Medicine and Health, Murtupuni Centre for Rural and Remote Health, James Cook University
Panel Members:
• Dr David Rimmer - Central West Hospital and Health Service
• Dr John Douyere - Australian College of Rural and Remote Medicine
• Associate Professor Michael Clements - Royal Australian College of General Practitioners
• Mr Phillip Kemp – Mount Isa local community representative & consumer</td></tr>
<tr><td>10.30-11.00am</td><td colspan="2">Morning Tea</td></tr>
<tr><td>11.00-12.30pm</td><td colspan="2">Session 5A/5B Scientific Program</td></tr>
<tr><td></td><td>Tjirtamai Hall
Session Chair: Deborah Spanner, Western Queensland Primary Health Network</td><td>Lecture Room 1
Session Chair: Chris Foley, Murtupuni JCU</td></tr>
<tr><td rowspan="4"></td><td>Home delivery ENT Diagnostics: Transforming Paediatric Sleep Apnoea Care in Regional Australia
Sue Hammoud
15-min</td><td>An analysis of student placements in Weipa 2017-2024: setting the future vision
Danielle Newsome
15-min</td></tr>
<tr><td>Technology-based teaching to support rural students' stroke clinical skills: A scoping review
Kylie Bower*
15-min</td><td>Service-learning placements in regional, rural and remote contexts: A realist review
Catherine Seaton*
15-min</td></tr>
<tr><td>Pharmacist recruitment and retention on the Darling Downs: Driving sustainable solutions
Lucy Parker & Louisa Handyside
15-min</td><td>Innovative student placement model in Far North Queensland: bringing allied health to Weipa
Erin Weekes
15-min</td></tr>
<tr><td>Collaboratively developed domestic violence training resources to strengthen rural dental workforce capability
Alex Dancyger
5-min</td><td>Understanding staff preferences for retention interventions in remote primary health care services
Deborah Russell
5-min</td></tr>
</table>

12.30-1.30pm	**Lunch**	
1.30-3.00pm	**Session 6A/6B Scientific Program**	
	Tjirtamai Hall Session Chair: A/Prof Rae Thomas, Tropical Australian Academic Health Council	**Lecture Room 1** Session Chair: Kylie Bower, Murtupuni JCU
	Primary care workforce gaps in remote QLD: perceptions of practitioners/ managers *Melissa Brimelow & David Stanyer* 15-min	**Culturally safe workplaces: supporting social-emotional wellbeing of First Nations health staff** *Rhiannon Dooley* 15-min
	Developing a framework to support the delivery of high quality Australian rural clinical placements *Catherine Seaton** 15-min	**Case Study: Place-based health planning in a remote NQ community** *Dr Karen Johnston* 15-min
	Getting them to train rural – initiatives and policy levers that have impact *Dr Michael Clements and Dr Cindi Jackson* 15-min	**Short term fixes, long-term gaps: rural health workforce policy in Queensland and Australia** *Thu Nguyen* 15-min
3.00-3.30pm	**Afternoon tea**	
3.30-4.30pm	**Conference closing statement** Murtupuni JCU Director, Associate Professor Catrina Felton-Busch	
4.30pm	**Conference close**	



Plenary Session

TUESDAY 15TH JULY 2025

Keeping on track for health equity in the bush

Across rural and remote Queensland, persistent health inequities continue to impact Aboriginal and Torres Strait Islander peoples. In response, Hospital and Health Services are now required to develop and implement a First Nations Health Equity Strategy—a significant step toward structural reform. But how do we move beyond plans into meaningful action, especially in places where geographic isolation, limited infrastructure, and workforce shortages remain chronic barriers?

Primary health care for First Nations peoples must be community-led, culturally safe, and sustained—not just delivered. Yet, recruiting and retaining a skilled and culturally capable workforce in these settings remains difficult. The intersection of mainstream services, Aboriginal Community-Controlled Health Organisations, and visiting specialists is complex, and coordination is often fragmented.

This session will explore the implementation of health equity plans with a focus on workforce models and culturally responsive primary care in remote contexts. It will raise questions about how systems and services can better align with Indigenous leadership, values, and expectations. The discussion will include insights from those working within the system and a voice from community who experiences its impacts firsthand.

SESSION CHAIR - Mr Shaun Soloman

HEAD OF INDIGENOUS HEALTH, MURTUPUNI CENTRE FOR RURAL AND REMOTE HEALTH

Shaun was appointed Head of Indigenous Health at the Murtupuni Centre for Rural & Remote Health in 2012. This role involves teaching, industry engagement and working with MCRRH academics across program areas to support the inclusion of Aboriginal and Torres Strait Islander Health content and issues in the centre's goals and activities.

Shaun brings to this role senior project officer experience through his previous positions in the Office of Aboriginal and Torres Strait Islander Health (Department of Health and Ageing) and his cultural affiliation with the Birri and Ewamain peoples of Northern Queensland.

Shaun's interests include supporting Aboriginal Health Workers, chronic disease care and rural and remote health in outback Queensland.

Panel members:

- Gary Torrens – Assistant Director of Nursing Kidney Services, North West Hospital and Health Service
- Susan Sewter – Ngarnal Aboriginal Community Controlled Health Service, Mornington Island
- Uncle Guy Douglas – North West Hospital and Health Service Rheumatic Heart Disease Indigenous Liaison Officer & Community Leader, Doomadgee
- Dr Scott Davis – Executive Director, Tropical Australian Academic Health Council

Panel Session

TUESDAY 15TH JULY 2025

Integrating Disability, Rehabilitation and Lifestyle Services in Rural and Remote Australia.

What's the issue?

People living in rural and remote areas often experience fragmented, under-resourced, and disconnected services across the disability, rehabilitation, and lifestyle sectors. These challenges are amplified by workforce shortages, geographic isolation and siloed funding and service systems. Aboriginal and Torres Strait Islander communities are disproportionately impacted, further entrenching health and social inequities.

We will discuss opportunities and challenges for integrating care and support including:

- place-based, people-centred approaches
- bridging siloed funding models across disability, health, and aged care systems
- leveraging joint mechanisms (e.g., data, funding) to support integration of care and support.

Who would be interested:

This panel is relevant to policy makers, service providers, researchers, community leaders, and advocates working across disability, health and aged care, particularly those focused on regional, rural, and remote Australia. It will also be of interest to those exploring place-based reform, systems integration, or Aboriginal and Torres Strait Islander health and disability equity.

SESSION CHAIR - Ms Kylie Stothers

DEPUTY CHAIRPERSON, INDIGENOUS ALLIED HEALTH AUSTRALIA

Kylie Stothers is a young mother of two children; she is a Jawoyn woman who was born and raised in Katherine, NT. Kylie comes from a large extended family with strong ties in Katherine and surrounding communities. Kylie is a social worker and has worked throughout the Northern Territory for over 15 years. Kylie currently works for the Centre for Remote Health and Flinders NT in the Katherine Campus. Her current role is as a lecturer and she (along with her colleagues) delivers training across the NT. Kylie is also involved in many local, regional and national committees and boards. She is the current Deputy Chairperson of Indigenous Allied Health Australia.

Kylie's interest areas are in child and maternal health, working with families, health promotion and health workforce issues. Kylie is passionate about education and issues that relate to remote and rural Australia.

Panel members:

- The Hon. Jan McLucas – Former Senator and Co-Chair of FNQ Connect Consumer Reference Group
- Katrina Bird – Principal Research Officer – Projects, Murtupuni Centre for Rural and Remote Health
- Rahni Cotterill – Executive Manager – Allied Health and Community Services, North and West Remote Health
- Professor Ruth Barker – Principal Investigator, FNQ Connect, James Cook University.

Plenary Session

WEDNESDAY 16TH JULY

Developing the Nursing Workforce to Keep on Track for Health Equity in the Bush

Nurses are the most distributed health profession in rural and remote areas. Ensuring these have the knowledge, skills and supports to provide high quality care underpins achieving health equity. Despite their critical role, rural and remote nurses face persistent challenges related to workforce development, retention, and access to professional support.

This session will examine strategic approaches to strengthening the rural and remote nursing workforce within the broader context of health system sustainability and equity. Key areas for discussion include policy levers, education and training pathways, service design, and culturally safe models of care that reflect the needs of diverse communities.

SESSION CHAIR - Professor Sabina Knight AM

DIRECTOR, CENTRAL QUEENSLAND CENTRE FOR RURAL AND REMOTE HEALTH, JAMES COOK UNIVERSITY

Professor Knight comes from an extensive background in remote and Indigenous primary health care, public health, and education. Originally a Remote Area Nurse (RAN) in NSW, Professor Knight gained her Master of Tropical Health from the University of Queensland and has held various remote health practice, service and academic roles, including extensive work as a RAN in very remote communities of Central Australia.

Professor Knight has served on numerous national, state and regional committees and advisory councils. Her leadership roles have included foundation roles with the Council of Remote Area Nurses of Australia; the National Rural Health Alliance, the Central Australian Rural Practitioners Association and as a commissioner with the National Health and Hospitals Reform Commission.

Panel Members:

- Professor Roianne West - Chief Executive Officer, First Nations Nursing and Midwifery Consulting
- Adjunct Professor Shelley Nowlan – Chief Nurse Officer for Queensland Health
- Madeline Ford - Head of Indigenous Health, Central Queensland Centre for Rural and Remote Health, James Cook University
- Sammy Jo Kupfer - Project Manager, Workforce & Training, Western Queensland Primary Health Network

Panel Session

TUESDAY 15TH JULY 2025

Strengthening rural healthcare delivery through value-based allied health rural generalism.

What's the issue?

Growth and sustainability of allied health (AH) workforce in rural and remote Queensland has been an ongoing challenge, contributing to reduced health service access and increased burden and financial costs on the rural health system. The Allied Health Rural Generalist (AHRG) pathway plays a critical role in supporting an integrated model of health service delivery, across both hospital and community-based care.

We will discuss:

- Concept of Rural Generalism and scope of practice
- Professional identity
- Training pathways
- Impact and value of Allied Health Rural Generalism
- Integrated care model and Interprofessional collaboration

Who would be interested:

The panel will be relevant to allied health professionals, allied health students, policy makers, academic and researchers, health service managers and executives, Primary Health Networks (PHNs) and Local Health Districts staff and community health advocates in rural and remote areas.

SESSION CHAIR - Professor Richard Hays

PROFESSOR OF REMOTE AND RURAL HEALTH & POSTGRADUATE MEDICAL EDUCATOR, MURTUPUNI CENTRE FOR RURAL AND REMOTE HEALTH, JAMES COOK UNIVERSITY

Richard Hays was a rural medical generalist in northern Queensland before becoming a teacher and education researcher, gaining further qualifications in educational psychology and medical education. He has had roles in the development of several medical education programs, including new medical schools in Australia, the United Kingdom, Ireland, Canada and South-East Asia. In 2017 he returned to rural practice in North-West Qld and South-West Tasmania and resumed roles supporting registrars training for rural and remote medicine. His research profile includes about AUD 5 million in competitive research and development grants and publication of about 270 peer-reviewed papers, 19 book chapters and 12 books.

Panel members:

- Dr Alice Cairns- Senior Research Fellow, Murtupuni Centre for Rural and Remote Health
- Danielle Rodda- Senior Occupational Therapist - Rural Generalist in the Weipa allied health team for Torres and Cape Hospital and Health Service
- Andrew Quabba- Chief Operating Officer, North West Hospital and Health Service
- Dr Sharon Varela- Deputy Director, Murtupuni Centre for Rural & Remote Health

Plenary Session

THURSDAY 17TH JULY

Sustainability in Rural Medicine

In North West Qld we are experiencing another round of changes in the structure, service mix, roles and ownership of medical services, both public and private. The Mount Isa Base Hospital, general practice and local community-controlled Aboriginal and Torres Strait Islander medical services all struggle to recruit and retain an appropriate workforce. The RFDS provides some itinerant primary medical services in addition to its excellent emergency services. But - how should these services work together to provide the service mix needed and wanted by local communities?

This brings into focus the '4 As' of healthcare delivery - availability (present in the community), accessibility (are appointments available?); affordability (at point of care); and 'affability' ('niceness') and how they should be addressed in organisational structures, training pathways and employment models that include resident and visiting clinicians. This session will present for discussion a range of issues relevant mostly to small town/remote primary medical care delivery, including a contribution from a representative of the local community who relies on local services.

SESSION CHAIR - Professor Richard Hays

Panel Members:

- Dr David Rimmer - Central West Hospital and Health Service
- Dr John Douyere - Australian College of Rural and Remote Medicine
- Associate Professor Michael Clements - Royal Australian College of General Practitioners
- Mr Phillip Kemp – Mount Isa local community representative & consumer

Scientific Program, Session 1A

The Baribunmani Wanyi Ngay Youth Program

Presented by Marcelle Townsend-Cross

UNIVERSITY CENTRE FOR RURAL HEALTH NORTHERN RIVERS, THE UNIVERSITY OF SYDNEY

List of authors

Marcelle Townsend-Cross[1], Tracey Piccoli[1], Emma Walke[1]

Author Institution/s

1. University Centre for Rural Health Northern Rivers, The University of Sydney

Abstract:

Background: Increasing Indigenous Australian participation in the health workforce has been identified as a key factor for improving health outcomes for Indigenous peoples. Consequently, university outreach programs for Indigenous young people that aim to build career aspirations, influence career intentions and contribute to professional pathway uptake are a crucial strategy for building the Indigenous health workforce. The Baribunmani Wanyi Ngay Program (the Program), designed and developed by the Aboriginal Health Education Team at the University Centre for Rural Health Northern Rivers, has been delivered to local Indigenous high school students since 2017.

Aims: The aims of the Program are to inspire and encourage Indigenous young people to consider a career in health, to provide positive Indigenous health role models, to highlight pathways to health careers and ultimately, to strengthen cultural safety in health care provision by increasing the Indigenous health workforce. The Bundjalung language name, 'Baribunmani Wanyi Ngay' meaning 'I dreamed about you', reflects the key message of the Program that careers in health are attainable for Indigenous young people.

Methodology: Between two and four half-day Program sessions are offered each year. Indigenous high school students meet with local Indigenous community health champions as well as medical and allied health university students who are undertaking rural placements. Hands-on simulation and virtual reality activities provide the opportunity for students to learn practical health related skills such as CPR, suturing, pharmacy and first responder skills.

Results: Since 2017, participants have completed evaluation surveys that have been used for quality improvement purposes. Survey feedback has consistently indicated that participants found the Program to be effective in familiarising students with a tertiary learning environment and inspiring students to consider pursuing a career in health.

Conclusion: The innovative Program can be considered an exemplar worthy of replication in other locations.

What worked in women's groups: The bigger picture in Indigenous Australia

Presented by Nalita Nungarrayi Turner

JAMES COOK UNIVERSITY

List of authors

Nalita Nungarrayi Turner[1], Catrina Felton-Busch[2], Sarah Larkins[1], Stephanie King[1,2], Veronica Matthews[3], Yvonne Cadet James[4], Lynore Geia[1,5], Talah Laurie[1], Michelle Redman-MacLaren[1], Judy Taylor[1], Robyn Preston[6], Rebecca Evans[1], Karen Carlisle[1]

Author Institution/s

2. James Cook University
3. Murtupuni Centre for Rural and Remote Health, James Cook University
4. University of Sydney
5. Apunipima Cape York Health Council
6. Edith Cowan University
7. Central Queensland University

Astract:

Culture: The WOMB (Women's Action for Mums and Bubs) story began in 2018 across 10 communities around Australia. The research emphasis was on how Aboriginal and Torres Strait Islanders can incorporate a Mums and Bubs group in their community and whether this would improve health of Mums and Bubs. The WOMB group became an important process to explain what happens within Indigenous Australia.

Throughout the process of the WOMB groups, it became apparent that culture became the essence of existence. The concept of culture was ambiguous over the 10 sites as some understood that they were practicing culture and others didn't think they were. The flow of culture within each site was the element that held the strong foundation, interweaving the facilitator, mums, bubs and all those who attended the meetings. The culturally holistic approach enabled the WOMB journey to enhance the oldest living culture to thrive in contemporary settings.

The Journey: The important aspect for the groups was to support the balance of the individual 'self' in relationship with the community. This process of finding the "right" people or peoples to facilitate the group was a journey within itself. There were individuals nominated by their health centre and others were considered by their community. The process became a holistic approach of doing.

Indigenous people were not always the first face of the WOMB meeting. In early stages some sites had non-Indigenous people to facilitate and without their help and support some of the groups would not have got off the ground.

In the groups the strong sense of relationship emerged. In the remote communities, there was evidence that kinship plays an important role. Kinship was a way to establish how people were connected in a culture way. The connections in the groups helped establish a standing where the outcome was balanced. Everyone knew their position and could have a say in the groups.

In the urban and other sites, family groups became a strong indicator of knowing. Due to the Stolen Generation era, people became lost and culture was taken away from families. However, all who attended WOMB began the journey of self-identity as Indigenous peoples. The healing began. So, family groups began to form within each mums and bubs meeting with nanas, aunties, nieces, and daughters. All belonged and all held an important role within the WOMB meeting. No one was left behind. The essence of culture was woven within the journey of the groups.

Relationships with each other: The respect of each other within the WOMB mums and bubs meetings enabled the meetings to run safely. Each site continued the practice of culture, knowingly or unknowingly. Knowing one's position in the WOMB group became relevant and valued. Identifying the elders in the meetings was vital and age became an essence of respect. The issue of age and how WOMB group members connected with each other is indeed the essence of the cultural practices from the past.

Empowering First Nations Nurses and Midwives: The Tjurtu Leadership Program

Presented by Professor Roianne West

FIRST NATIONS NURSING AND MIDWIFERY CONSULTING

List of authors

Professor Roianne West[1], Susan Anderson[1], Nicole Tukana[2], Melina Connors[2]

Author Institution/s

1. First Nations Nursing and Midwifery Consulting
2. Queensland Health

Abstract:

Background: First Nations nurses and midwives remain underrepresented in senior leadership roles within the healthcare system, despite their critical role in improving outcomes for Aboriginal and Torres Strait Islander peoples. Structural inequities, systemic racism, and culturally unsafe work environments continue to impede their career progression. There is an urgent need for leadership programs that centre cultural identity, self-determination, and community accountability.

Aims: This presentation introduces the Tjurtu First Nations Nursing and Midwifery Leadership Program—a culturally grounded initiative aimed at building strategic, ethical, and resilient leadership capabilities among First Nations nurses and midwives across Queensland.

Methodology: Co-designed and delivered by First Nations Nursing and Midwifery Consulting (FNNMC), the Tjurtu Program embeds Kalkadunga Knowledge Systems and Relational Leadership across five culturally informed modules: Thurdu (resilience), Ngurru (emotional sovereignty), Kurrka (land-based leadership), Malkarri (intergenerational legacy), and Yumurru (holistic wellbeing). Delivered in blended mode over 16 weeks, the program incorporates yarning circles, mentorship, community-based projects, and two residential blocks.

Results: The Tjurtu Leadership Program will officially commence in April 2025. It has attracted widespread interest, with eligible applications received from across 15 of the 16 Queensland Hospital and Health Services including 11 participants from Rural, Remote and Regional HHS's. This strong response affirms the demand for culturally grounded, First Nations-led leadership development in nursing and midwifery. While the program has not yet been delivered, early engagement from prospective participants, supervisors, and community leaders reflects high expectations for impact. The program design has already demonstrated value in centring First Nations knowledges, and upcoming delivery will offer further insight into culturally safe and sustainable leadership development within Queensland Health.

Conclusion: The Tjurtu Program offers a decolonising model for nursing and midwifery leadership development rooted in First Nations sovereignty and community responsibility. It not only strengthens the First Nations health workforce but also models how healthcare systems can shift toward culturally safe and self-determined governance.

Implementing 'Ironbark Fall Prevention' in Mount Isa: A student-led quality improvement project

Presented by Madeline Mills[1] & Kylie Bower[2]

GRIFFITH UNIVERSITY(1); MURTUPUNI CENTRE FOR RURAL AND REMOTE HEALTH, JAMES COOK UNIVERSITY (2)

List of authors

Madeline Mills[1], Kylie Bower[2], Richard Violette[2]

Author Institution/s

1. Griffith University
2. Murtupuni Centre for Rural and Remote Health, James Cook University

Abstract:

Background: Ironbark is a fall prevention program developed with and for Aboriginal Elders and evaluated in urban and regional NSW and WA. Its content aligns with an existing student-led program in Mount Isa, which focuses on yarning and exercise for Indigenous Elders' healthy ageing. It was unknown whether Ironbark's evidence-based, culturally responsive model was acceptable and feasible for this group, and for a student-led approach.

Aims: To pilot and adapt the Ironbark program with an Indigenous Elders healthy ageing group, in an acceptable and feasible manner, for participants and student facilitators.

Methodology: A quality improvement approach was applied, using iterative cycles of plan-do-study-act. 'Planning' involved participant yarning, formal training and student orientation. 'Doing' involved twice-weekly sessions of exercise and yarning. 'Study' involved keeping a student reflection journal, weekly informal participant feedback, and a final evaluative yarn. 'Acting' involved iterative modifications to yarning and exercise approaches.

Results: Four to 10 participants attended 17 sessions (mean attendance = 6), with 6 student facilitators and 6 guest speakers across 9 weeks. Participants in an evaluative yarn (n=7) rated program enjoyment at 9/10 and confidence in preventing falls at 7/10. Strongest behaviour changes related to exercise participation (71%), vision checks (57%), appropriate footwear (57%), and optimising the home environment (57%). Student challenges included managing blood pressures, exercise targets and yarning duration, and adapting to fluctuating cultural support and participant attendance. Students valued learning how to support yarning and behaviour change with cultural sensitivity.

Conclusion: Implementing the Ironbark Program in Mount Isa involved adaptations to the standard exercise and yarning processes to suit the individuals involved, and a student-led approach. Participant and student feedback indicates that this has been acceptable and feasible, despite challenges encountered. This pilot project will inform future research to explore the experiences of students and participants in adapting the Ironbark program.

Scientific Program, Session 1B

Transforming Care: Exploring Consumer and Pharmacist Perceptions of Expanded Practice in Rural and Remote Communities

Presented by Selina Taylor

MURTUPUNI CENTRE FOR RURAL AND REMOTE HEALTH, JAMES COOK UNIVERSITY

List of authors

Selina Taylor[1], Shelby Joyce[2], Ruby Schembri[2], Josh Swain[2], Rachael Turiano[2], Prof Beverley Glass[2]

Author Institution/s

1. Murtupuni Centre for Rural and Remote Health, James Cook University
2. College of Medicine and Dentistry, James Cook University

Abstract:

Background: Accessing essential healthcare services presents a challenge for consumers living in rural and remote communities, often leading to higher rates of chronic disease and poorer health outcomes. Community pharmacists are well positioned to address this lack of access through expanded service delivery.

Aims: This study aimed to explore rural and remote consumers' and pharmacists' perceptions of community pharmacists expanding their services in these communities.

Methodology: Qualitative, semi-structured interviews were undertaken with consumers and pharmacists recruited from community pharmacies in far north, north west and central west Queensland. The Consolidated Framework for Implementation Research guided question development, with the responses deductively coded and thematically analysed.

Results: Thirteen pharmacists and 23 consumers were interviewed with both groups citing benefits such as convenience and reduced wait times. Key barriers identified included pharmacist workload, time constraints, inadequate infrastructure, and limited consumer awareness of services. Pharmacists highlighted the need for better reimbursement models and professional collaboration, while consumers valued accessibility and convenience, but were concerned about the costs of services.

Conclusion: This study has highlighted the benefits of expanded pharmacy services as perceived by the key stakeholders, the consumers and pharmacists. However, future research is needed to ensure the successful implementation of sustainable funding models to deliver better access and health outcomes for consumers in these communities.

Social Work contributions to General Practice in Northern Queensland

Presented by Rebecca Lee

NOMINATED PRESENTER INSTITUTION

List of authors

Dr Albert Kuruvila[1], Dr Grace Jefferson[1], Rebecca Lee[1]

Author Institution/s

1. Institution 1

2. Institution 2

Abstract:

Social determinants of health significantly influence patients' overall health and wellbeing. General practitioners (GPs) often lack the time and resources to address the psychosocial or systemic issues affecting patients' health. Social work is well-positioned to enhance population health and wellbeing by considering the complex factors impacting patients with its focus on social justice, human rights and holistic well-being. However, few social workers currently provide services in GP clinics in Australia. This presentation outlines the context of social work in GP settings and shares interim findings from Australian research on placing social workers in these environments.

The project investigated the benefits and challenges of integrating social work practice into GP clinics. GP clinics in North Queensland were supported to hire and integrate social workers and social work students into their practices. Data Collection included recorded social work interventions, applied a pre- and post-wellbeing scale, and gathered patient feedback. An evaluation survey was conducted at the end of the 1-year implementation phase.

The findings highlight the value of social work in regard to:

- Holistic Health Approaches: Integrating social workers into GP clinics addresses the complex psychosocial and systemic issues affecting patients' health, leading to more comprehensive care;
- Positive Interventions: Social workers provide services such as advocacy, emotional support, and goal setting, which are crucial for managing chronic health, aging, mental health, families, and disability;
- Collaborative Benefits: A collaborative approach between social work and general practice can improve health outcomes, although more evidence is needed to support these interventions' effectiveness;

Recommendations include the development of sustainable funding pathways and this model of care being offered in rural and remote settings. Insights into the broad range of health areas and interventions that social workers engage in within GP settings will be crucial for developing sustainable pathways for social work practice in GP settings.

FNQ Connect: Connecting people connecting care

Presented by Professor Ruth Barker & Katrina Bird

FNQ CONNECT, THE CAIRNS INSTITUTE, JAMES COOK UNIVERSITY

List of authors

Ruth Barker[1], Katrina Bird[1,2]

Author Institution/s

1. FNQ Connect, The Cairns Institute, James Cook University
2. Murtupuni Centre for Rural and Remote Health, James Cook University

Abstract:

Background: People with lived experience of disability, families, communities and service providers across Far North Queensland (FNQ) have consistently called for more connected, inclusive and culturally safe and responsive services. FNQ Connect responds to this shared vision by strengthening what works, addressing fragmentation, and ensuring people can access support that's close to home, responsive to local priorities, and shaped by community voices.

Aims: FNQ Connect seeks to transform how disability, rehabilitation and lifestyle services are delivered across FNQ. Through a collective impact approach, it aims to elevate community leadership, support a regionally grounded workforce, and create the enabling conditions for long-term, locally led reform.

Methodology: The initiative is being delivered by the FNQ Collective with a backbone team based at James Cook University. Governance arrangements centre lived experience and Aboriginal and Torres Strait Islander leadership, through a Cross-sector Leadership Table and three reference groups—Consumer, Aboriginal and Torres Strait Islander, and Service Provider. Roles have been shaped to suit individual strengths, and a flexible, relational approach guides engagement and workforce development.

Progress to Date:

In its first six months, FNQ Connect has:

- Recruited a diverse backbone team and begun co-design of roles with people with lived experience;
- Convened a representative Leadership Table and reference groups;
- Commenced planning with three pilot sites—Tablelands, Kowanyama and Cairns;
- Commenced planning for a shared data management and evaluation framework;
- Re-engaged with the FNQ Collective

Conclusion: FNQ Connect is laying the foundations for long-term, community-led reform. Early progress reinforces the importance of building trust, aligning effort, and centring lived experience as core processes—not just outcomes. This groundwork is enabling the conditions for more connected care, stronger local workforces, and inclusive systems shaped with, not for, communities.

The furthest corner. The finest care. – Delivering on a promise

Presented by Dr Geoff Clark

ROYAL FLYING DOCTOR SERVICE (QUEENSLAND)

List of authors

Dr Geoff Clark[1], Dr Michelle Hannan[1], Kathleen Loadsman[1], Jackie Chalhoub[1]

Author Institution/s

1. Royal Flying Doctor Service (Queensland)

Abstract:

Background: Australians living in remote and very remote Australia have poorer health outcomes, in part, due to structural barriers to accessing services outside of major cities. Among a large sample of patients seeking primary healthcare in remote and very remote areas (N=1,319), this study provides novel insights into who, why and how the Royal Flying Doctor Service (Queensland Section) reduces place-based healthcare inequities.

Aims: To characterise the demographic, clinical correlates and management outcomes of patients accessing the Royal Flying Doctors Service (RFDS) (Queensland Section)'s Primary Health Care (PHC) Services.

Methodology: Utilising the methodology from the Bettering the Evaluation and Care of Health (BEACH) survey, modified for the context of the RFDS (Queensland Section) Primary Health Care Services, two interrelated data collections – encounter data and patient data including demographics were collected on the first 25 patients encountered by clinicians after 1 February 2024 at all 26 RFDS (Queensland Section) PHC services. Clinician characteristics beyond clinician type were not collected. Descriptive analyses of patient demographics (i.e., sex, age at encounter, whether patients were Aboriginal and/or Torres Strait Islander, and the remoteness of the attended PHC clinic), clinical presentations (i.e., International Classification of Primary Care-defined reason for encounter; and the number, type and chronicity of problems managed at each encounter), and how problems were managed (e.g., clinical and procedural interventions, medications prescribed, referrals made and/or pathology ordered).

Results: A total of 1,319 patient records were sampled for inclusion. Clinicians managed 1,674 problems during these 1319 encounters. Most patients were female, aged between 45 and 64, and a third were Aboriginal and/or Torres Strait Islander peoples. Eight per cent of care was sought from remote clinics and 92% sought from very remote clinics. General and unspecified reasons, and skin, musculoskeletal, digestive, and endocrine, metabolic and nutritional conditions were the most common reasons for encounter, and problems managed. Chronic problems accounted for more than half of the reasons for encounter but accounted for 43.1% problems managed. Seventy-three percent (73%) of encounters did not need referral. Clinical and procedural interventions, and medication prescription were most used to manage patients' problems.

Conclusion: Females were slightly more likely to seek care and Aboriginal and Torres Strait Islander peoples accessed services at a rate relatively proportionate to the demography of the respective communities. Patients' reasons for seeking help were diverse but their rank order was comparable to other studies of remote primary healthcare services. Clinicians regularly managed chronic and multiple problems, and the majority of patient concerns were able to be managed without referral thereby supporting patients to receive care where and when it was needed without having to leave community.

Scientific Program, Session 2A

Experiences of staff and consumers with the Cape York Kidney Care team

Presented by Dr Alice Cairns

MURTUPUNI CENTRE FOR RURAL AND REMOTE HEALTH, JAMES COOK UNIVERSITY & OFFICE OF THE CHIEF ALLIED HEALTH OFFICER, SOUTH WEST HOSPITAL AND HEALTH SERVICE

List of authors

Alice Cairns[1,2], Jena Stephens[1], Andrea Miller[1, 3], Leanne Brown[1,3], Jaqui Hughes[4]

Author Institution/s

1. Murtupuni Centre for Rural and Remote Health, James Cook University, Australia
2. Office of the Chief Allied Health Officer, South West Hospital and Health Service
3. Torres and Cape Hospital and Health Service
4. Flinders University

Abstract:

Background: The Cape York Kidney Care (CYKC) team is a multidisciplinary team designed to support very remote Aboriginal communities with a high prevalence of kidney disease and prevent and delay progression to dialysis. This service is a 'secondary care' service, providing a conjoint between primary and tertiary care services.

Aims: To explore the experience of primary health care staff, patients and carers with the CYKC team.

Methodology: Qualitative semi-structured interviews were conducted with 31 patients, carers and primary health care staff in five Aboriginal communities in Cape York. Primary health care staff included Aboriginal and/or Torres Strait Islander health workers and practitioners, nurses and allied health. All transcripts were audio recorded and transcribed verbatim, data were thematically analysed.

Results: Three themes emerged: Culturally appropriate and safe service, Health promotion and community education, Integration of care. Across participant groups, CYKC was seen to provide an essential service that was highly valued with high levels of satisfaction reported. Consumers and their families reported improved knowledge of kidney disease prevention and management, every consumer requested community health promotion to be a key component of the service model. CYKC was seen to provide vital integration between primary and tertiary services, be responsive to community need (facilitated by the rural generalist scope of practice). Ongoing barriers to integration were reported as role clarity with primary health staff and lack of digital integration between multiple care providers.

Conclusion: Outreach services provide vital health services to remote communities. If the model of care and workforce skills mix are supportive, they can be well integrated and contribute to community priorities. The inclusion of community health promotion is seen by consumers as an essential component of the models of care and should be well resources with clear accountability.

Embedding Aboriginal and Torres Strait Islander Knowledges and protocols into our workplace

Presented by Sandra Levers[1] & Shaun Solomon[2]

CENTRAL QUEENSLAND CENTRE FOR RURAL AND REMOTE HEALTH, JAMES COOK UNIVERSITY; MURTUPUNI CENTRE FOR RURAL AND REMOTE HEALTH, JAMES COOK UNIVERSITY

List of authors

Sandra Levers[1], Shaun Solomon[1,2]

Author Institution/s

1. Central Queensland Centre for Rural and Remote Health, James Cook University
2. Murtupuni Centre for Rural and Remote Health, James Cook University

Abstract:

Background: Closing the Gap 2007 focuses on17 targets. Eleven have seen some improvement, however, five have no improvements. Three of the outcomes directly relate to health and all are still impacted by "good" health and wellbeing. Health professionals need to be informed of these and how they can contribute to better outcomes for Indigenous people. Additionally, provision of culturally safe care is required to ensure better engagement with health services leading to better outcomes in Indigenous people.

Aims: Demonstrate importance of embedding cultural knowledges and protocols in workplace to ensure cultural safety for both Indigenous clients and non-indigenous allied health, nurses and other service providers.

Methodology: As part of the orientation provided to students on placements, presentations to lay the foundations towards an understanding of Indigenous society and culture, and a walk on country are conducted. Two sessions - 4 and 2 hours each are provided and are vital to providing much information to staff and students on placement. Clinical yarning is also important to ensure that health care is provided in a proper and appropriate manner. Further, cultural training and delivery at the Murtupuni Centre, Mt Isa will be discussed in terms of alignment with IAHA's cultural responsiveness framework.

Results: Students have a better idea of what Closing the Gap is and are appreciative of the information received and the manner delivered. A culturally safe space has encouraged students to engage in meaningful discussion around issues of interest and concern. Students appear to be very positive, and it is hoped that the new information is carried out and evidenced in their daily work.

Conclusion: A workforce duly informed about the true history but also how to work with Aboriginal and Torres Strait Islander people. More importantly, staff and students feeling comfortable enough to raise issues and questions that would often be ignored or forgotten otherwise. There are no guarantees however, that what is being learnt will be used in other work situations.

Medications During Healthcare Transitions: Utilising Grounded Theory to Improve First Peoples Experience

Presented by Michelle Rothwell

JAMES COOK UNIVERSITY & CAIRNS AND HINTERLAND HOSPITAL AND HEALTH SERVICE

List of authors

Michelle Rothwell[1,2], A/Professor Karen Carlisle[1], Dr Alice Cairns[1,3], Valda Wallace[1]

Author Institution/s

1. James Cook University
2. Cairns and Hinterland Hospital and Health Service
3. Murtupuni Centre for Rural and Remote Health, James Cook University

Abstract:

Background: During transitions of care, First Peoples are at higher risk of medication misadventure due to inequitable quality use of medicines, potentially resulting in harm and hospital readmissions. Evidence states poor control of chronic disease states and subsequent higher hospital admissions, morbidity and mortality for First Peoples might be directly attributable to poor medicine management. Bainbridge et al articulate grounded theory as a methodology which enables awareness and comprehension into processes for raising the prosperity, health, and well-being of the First Peoples of Australia. This unique study provides an opportunity to describe a grounded theory methodology and increase appreciation and knowledge of its method and its application.

Aims: This project aims to work with First Peoples to improve health outcomes, through understanding lived experience during healthcare transitions.

Methodology: The study is guided by a culturally safe and respectful research framework and all First Peoples study interpretations have been centred through ongoing advice from the research team's cultural advisor. This study uses a variety of sampling methods: purposive, snowballing, and theoretical. Data is being generated through semi-structured interviews, ethnographic observations, fieldnotes and/or memos.

Sample size is thirty semi-structured interviews and 20 hours of observational data.

Results: Data collection is well underway with concurrent data analysis and comparative analysis occurring from the beginning; an essential element of GT distinguishing it from other qualitative methods. Analysis of semi-structured interviews and observations will be presented along with developing concepts and a preliminary substantive theory.

Conclusion: This GT study, the first of its kind to facilitate First Peoples voices in a hospital setting and across the transitions of care, will increase understanding of system interactions and processes relevant to pharmaceutical care, during healthcare transitions. Through understanding and enabling integration of lived experience into health service delivery, improvements in health outcomes can be achieved.

Evaluating training opportunities for improving community-led health workforce: Past, present, and future considerations from community

Presented by Roslyn Rowen

JAMES COOK UNIVERSITY

List of authors

Roz Rowen[1], Nalita Nungarrayi Turner[1], Catrina Felton-Busch[2], Sarah Larkins[1], Stephanie King[1,2], Veronica Matthews[3], Talah Laurie[1], Judy Taylor[1], Karen Carlisle[1]

Author Institution/s

1. James Cook University
2. Murtupuni Centre for Rural and Remote Health, James Cook University
3. University of Sydney

Abstract:

High primary health care (PHC) workforce turnover (both Aboriginal and Torres Strait Islander and non-Indigenous staff) in remote and rural areas is problematic for communities and their health services. Turnover undermines relational trust, cultural security, quality, and continuity of care. For rural and remote communities to be employed in health worker roles, means travel away from community for extended periods of time for vocational training. There has been limited emphasis placed on training and delivery models as a key strategy to improve workforce stability in communities. Feedback from four communities (Kowanyama, Mt. Isa, Kalkarindji and Lismore) has highlighted the need to improve health workforce training and training pathways to systematically incorporate Aboriginal and Torres Strait Islander perspectives into training delivery pathways and models. This paper provides a review of historical and current health workforce training pathways trialled with communities and brings in the community perspectives of training needs for future improved and more community-centric health workforce training models.

On Track: Co-designed strategies to strengthen Northern Queensland's First Nations Health Workforce

Presented by Lisa Gibson

JAMES COOK UNIVERSITY

List of authors

Lisa Gibson[1], Maryann Ansey[1], Rhiannon Dooley[1], Stephanie King[1,2], Kristin McBain-Rigg[1], Shaun Solomon[2], Sandy Campbell[1], Catrina Felton-Busch[2]

Author Institution/s

1. James Cook University
2. Murtupuni Centre for Rural and Remote Health, James Cook University

Abstract:

Background: A strong Aboriginal and Torres Strait Islander (hereafter First Nations) Northern Queensland health workforce is critical to address persistent health inequities experienced by First Nations peoples across the region. Health services delivered to geographically dispersed populations, create challenges for communities to access culturally appropriate services. Additionally, to recruit and retain a First Nations health workforce; issues include limited career and educational pathways to support staff. Working in partnership with hospital health sites to co-design strategies to strengthen First Nations health workforce is underway.

Aims: How can we strengthen the Aboriginal and Torres Strait Islander health workforce across Northern Queensland, to reach employment equity in Northern Queensland Hospital and Health Services and improve health outcomes for First Nations Australians?

Methodology: Placed based planning processes undertaken, allowed local priorities and strategies be identified; as scalable solutions to strengthen the First Nations health workforce. Over six months, a series of four two-hour co-design workshops were conducted with four hospital health sites across Northern Queensland. Partners from Queensland Health, Aboriginal Community Controlled Health Organisation health workforces, Primary Health Networks and key community members were invited to participate in four workshops.

Results: Each site had between nine-sixteen participants per workshop. Activities progressed from identifying what was working and not working well, to producing and ranking priorities for a feasible implementation within 12 months. Participants shared insights to how useful the workshops were; many found them to be safe and inclusive for generating 75 ideas (average) and two strategies for implementation per site.

Conclusion: Co-design workshops are useful for generating innovative ideas and prioritising strategies for implementation, to strengthen the First Nations health workforce across Northern Queensland. Co-design workshops can assist planning processes for partners across Queensland, to provide scalable solutions to strengthening First Nations health workforces.

Scientific Program, Session 2B

Remote versus rural placements...And the winner is....

Presented by Aaron Hollins

JAMES COOK UNIVERSITY

List of authors

Aaron Hollins[1], Leanne Hall[1], Jane Harte[1], Torres Woolley[1], Clare Heal[1]

Author Institution/s

1. James Cook University

Abstract:

Background: JCU College of Medicine and Dentistry have been undertaking rural and remote placements for 25 years. This presentation will collate the research and evaluation of medical student placements as well as bringing in some research from GP training looking at the differences between remote and rural placements from an educational perspective and student perspective.

Aims: How do students and GP registrars perceive their learning in rural and remote settings.

Methodology: This presentation will focus on a paper evaluating year 4 and year 6 rural and remote placements from post-placement surveys. Other JCU research will be woven in to this, including qualitative research using focus groups on perception of supervision and on perception of remote placement by medical students, as well as papers from GP training comparing learning of GP registrars in rural and remote locations.

Results: There is no significant difference between rural and remote placements from a student perspective. Remote placements edge ahead in a couple of areas including constructive feedback and inclusion in team, but this was not a significant change. GP registrars have equivalence of learning experiences across rural and remote areas, with remote registrars having to use more clinical reasoning. Remote placements for medical students require a 4th leg of the stool.

Conclusion: JCU will continue to place students in both rural and remote locations. This provides evidence for students to feel comfortable with their learning experiences in a remote setting.

Innovative Remote Allied Health Education and Training Hub

Presented by Steve Woodruffe

SOUTHERN QUEENSLAND RURAL HEALTH

List of authors

Steve Woodruffe[1], Clara Walker[1,2], Adam Hulme[1], Christie-Anne Hunter[1], Janette (Lee) Lingwoodock[1], Geoff Argus[1,2]

Author Institution/s

1. Southern Queensland Rural Health, University of Queensland
2. Centre for Health Research, University of Southern Queensland
3. Poche Centre for Indigenous Health, University of Queensland

Abstract:

Background: The Rural Health Multidisciplinary Training program aims to improve the recruitment and retention of health professionals in rural and remote Australia, primarily through offering health students the opportunity to train in rural and remote communities. Southern Queensland Rural Health in partnership with the local Aboriginal Community Controlled Health Organisation, aimed to establish an Allied Health Education and Training Hub (AHETH) in the remote town of St George to provide opportunities for students to undertake placements in a remote setting. A key component was the development of a student clinic to provide valuable learning opportunities for allied health students and high-quality healthcare services to the local community.

Aims: To describe implementation of the AHETH and present initial findings on student placement experience and community participant health improvement.

Methodology: Participant data was collected pre and post service delivery. Following completion of placement, students were surveyed to determine their satisfaction with the quality of the placement, learning opportunities and intention to practice rurally.

Results: The AHETH has facilitated 31 Allied Health student placements across multiple disciplines representing a combined total of 226 weeks in community. These placements have enabled innovative, interprofessional, student-resourced clinical service delivery to the St George community across a variety of chronic disease prevention and management programs. Since commencement, 231 community members have participated in the programs offered. Community participants who completed clinical programs achieved improvement in a range of health measures (e.g. exercise tolerance, quality of life). Student feedback was very positive with 100% of students surveyed recommending the placement. Students also reported an increased intention to practice rurally.

Conclusion: Implementation of the AHETH has demonstrated an innovative method of service delivery to increase rural health student placements and positively impact the health of the community.

The Keeping on Track, Leading with Strength: 10 Years of the IAHA Ultimate Student Leadership Challenge

Presented by Adjunct Associate Professor Kylie Stothers

INDIGENOUS ALLIED HEALTH AUSTRALIA

List of authors

Kylie Stothers[1], Jed Fraser[1], Tara Lewis[1], Ruth Barker[1]

Author Institution/s

1. Indigenous Allied Health Australia

Abstract:

Background: The IAHA Ultimate Student Leadership Challenge (USLC) is a cultural and clinical interprofessional development program. Since 2013, the USLC has supported Aboriginal and Torres Strait Islander students to step into leadership with cultural strength, purpose and connection. Created by Indigenous Allied Health Australia (IAHA), the USLC provides a culturally safe and responsive environment where students grow in confidence, capability, and cultural integrity. The USLC is a mechanism that supports students through their studies and then successful transition into the workforce.

Aims: The USLC was established to nurture emerging Aboriginal and Torres Strait Islander health workforce leaders who are proud in culture, strong in identity, and equipped to lead transformation in health, community, and policy settings. It strengthens the next generation of the health workforce by weaving together cultural knowledge, clinical thinking, and collaborative professional practice. Students are selected to participate in a three-day interprofessional challenge. In multidisciplinary teams, they work through a case scenario grounded in real-world community contexts, guided by Aboriginal and Torres Strait Islander mentors, facilitators and judges.

Methodology: Each year, Students learn through reflection, storytelling, teamwork and public speaking. Evaluation includes pre-post surveys, student reflections, and yarns with alumni and mentors.

Results: Over ten years, the USLC has supported over 280 students, representing 30+ health professions and 32 universities. Students have consistently rated the program highly, with more 90-100 % agreement on all areas of learning. Since 2022, pre-to-post evaluation data has demonstrated significant positive changes across 16 areas of learning. Alumni continue to return as mentors—demonstrating strong belonging, connection, and intergenerational leadership.

Conclusion: The USLC is a culturally grounded, strengths-based leadership experience that builds the future of the health workforce from the inside out. The program continues to grow a network of proud, capable, and culturally responsive leaders who are shaping stronger futures for their communities and the nation.

Confidence, heat, uncertainty; Student experiences in remote service-learning placements

Presented by Dr Alice Cairns

MURTUPUNI CENTRE FOR RURAL AND REMOTE HEALTH, JAMES COOK UNIVERSITY & OFFICE OF THE CHIEF ALLIED HEALTH OFFICER, SOUTH WEST HOSPITAL AND HEALTH SERVICE

List of authors

Alice Cairns[1,2], Narelle Campbell[3], Malama Gray[1], Debby Mauger (Worimi)[3], Chris Rissel[3], Murphy Dhayirra Yunupingu (Yolŋu)[3,4], Danielle Rodda[5], Chris Hince[3,4], Amy O'Hara[5], Kylie Stothers[3,6]

Author Institution/s

1. Murtupuni Centre for Rural and Remote Health, James Cook University, Australia
2. Office of the Chief Allied Health Officer, South West Hospital and Health Service
3. Flinders University, Rural and Remote Health NT, Australia
4. Yolŋu Elder, Gunyangara Community of East Arnhem,
5. Torres and Cape Hospital and Health Service, Australia
6. Indigenous Allied Health Australia

Abstract:

Background: Service-learning is a practice-based student placement model that has grown across northern Australia to address vital gaps in rural and remote allied health services and provide students an opportunity to work with First Nations communities to address local needs. University students, working with First Nations communities, need to build skills in culturally responsive practice.

Aims: This study explores the experience of allied health students completing service-learning placements in two remote First Nations communities.

Methodology: A qualitative post-placement study was undertaken. Semi-structured interviews were completed with allied health students (n=27) from Australian universities. Data was thematically analysed using inductive analysis to develop the themes, then deductively analysed where the experiences were coded against the capabilities in the Culturally Responsive in Action Framework (IAHA, 2019). The settings were community healthy ageing services in two remote northern Australian First Nations communities, one in Queensland and one in the Northern Territory. Students received interprofessional, discipline-specific, and cultural supervision and training.

Results: Three key themes and 13 subthemes emerged: Readiness for remote practice; cultural supervision and practice; and learning and skill development. Further, the experience of immersive service-learning placements in remote First Nations communities appear to support the transformation learning process required to build knowledge, confidence, and skills to engage in culturally responsive practice.

Conclusion: Students participating in these placements described experiences that are immersive, closely connected to the daily experiences of community members. This not only prepares the students for the realities of remote practice but appeared to be a key mechanism for the transformation learning required to develop the confidence to build culturally responsive practice skills. Results could inform university curriculum to better support students to prepare for rural placements and practice that is interprofessional, culturally responsive and community integrated, and identify resourcing requirements while students are participating in culturally immersive placements.

Scientific Program, Session 3A

Experiences and perceptions of rural and remote nurses caring for pregnant women

Presented by Michelle McElroy

JAMES COOK UNIVERSITY

List of authors

Michelle McElroy[1], Nikki Harvey [1], Kristin Wicking[1], Karen Yates[1]

Author Institution/s

1. James Cook University

Abstract:

Background: The closure of rural and remote maternity units in Australia has created a significant gap in care for pregnant women. The decline in the number of health professionals with dual nursing and midwifery registration has led to a shortage of midwives, resulting in registered nurses (RNs) being required to fill this gap. There is little documented about the impact this has on RNs.

Aims: The aim of the research was to gain a better understanding what it is like for RNs delivering maternity care in rural and remote contexts.

Methodology: Phenomenological research was conducted through eight semi-structured interviews with an average length of 30 minutes. Recordings were transcribed verbatim, and thematically analysed.

Results: From the data, three key themes emerged. First, "Being in the World of the Rural and Remote Nurse." Participants described their perception of rural and remote nursing as an entity with unchangeable aspects that cannot be understood in isolation. The second theme, "Scope of Practice – Unprepared or Underprepared," revealed that despite their extensive nursing skills, participants felt theoretically, practically, and mentally ill-equipped to provide care for pregnant women. The third theme, "Moral Distress," highlighted the participants' feelings of inadequacy, fear, and resignation. Due to the lack of maternity services in rural and remote areas, it is inevitable that RNs will have to care for pregnant women. Participants in this study unanimously articulated what it meant for them to be nurses providing maternity care in a rural and remote setting, both for themselves and for pregnant women.

Conclusion: This research provides a voice for RNs working in rural and remote environments who provide care to pregnant women. Advocating for improved maternity resources in these contexts will help improve maternity care for women and provide essential support to RNs.

Pilot: Enhancing care for Chronic Disease patients in Dajarra through inter-organisational collaboration

Presented by Casey McDermott

WESTERN QLD PRIMARY HEALTH NETWORK (WQPHN)

List of authors

Casey McDermott[1], Amber Scott[1], Clare Newton[2] , Dr Erica West[2], Dr Yvonne Doveren[3]

Author Institution/s

1. Western QLD Primary Health Network (WQPHN)
2. North West Hospital and Health Service (NWHHS)
3. Royal Flying Doctor Service (RFDS)

Abstract:

People living in North West Queensland experience high rates of chronic diseases but have incredibly limited access to primary health care services. In many remote communities, such as Dajarra, there is no General Practice and no hospital. Health services are delivered by a Primary Health Clinic (PHC): a nurse-led 24-hour acute and on-call emergency services, operated by North West Hospital and Health Service (NWHHS). Royal Flying Doctor Service (RFDS) visit on a regular basis.

Western Queensland Primary Health Network (WQPHN), NWHHS and RFDS have collaborated and codesigned a structured Model of Care that focuses on Chronic Disease Management for those living in Dajarra.

This clinic aims to:

- Increase access to vital health services;
- Increase health outcomes and continuity of care;
- Be sustainable & cost effective; and
- Increase engagement and motivation towards care

For chronic disease patients.

To achieve this, NWHHS and RFDS – using the existing care framework as a base – will collaborate to connect patients in Dajarra with chronic conditions with face-to-face and telehealth appointments where a care/wellbeing plan can be established. Continuity of care will be supported via HHS admin and nurse led support including mechanisms for regular follow-ups, reminders and recalls, as well as RFDS medical officer support – thus, enrolling patients into a continuous cycle of care.

This innovative, collaborative model aims to address a significant gap in care that is experienced in many rural and remote communities. If successful, this model of care could transform chronic disease management in other remote and very remote communities.

Advancing Remote Nursing Practice: Optimising Scope Through Protocol-Driven Education

Presented by Kylie Fischer

TORRES AND CAPE HOSPITAL AND HEALTH SERVICE

List of authors

Kylie Fischer [1]

Author Institution/s

1. Torres and Cape Hospital and Health Service

Abstract:

Aims and Background: The Remote Registered Nurse Practice Pathway was established to address critical nursing workforce challenges, including sustainability and skill shortages in remote areas of the Torres and Cape Health Service (TCHHS) region. This program enables Registered Nurses (RNs) to transition into the remote practice context, though learning outcomes aligned with optimisation of scope of practice using the Primary Clinical Care Manual. The Primary Clinical Care Manual (PCCM) serves as a guiding policy document, ensuring evidence-based, standardised practices that optimise scope and improve care delivery in underserved communities.

Intervention/Project Description: This comprehensive approach to workforce development integrates flexible education that reinforces the application of contemporary primary health care practices guided by Health Management Protocols outlined in the PCCM. Key components of the program include e-learning modules, hands-on training, and individualised learning plans tailored to develop skills in chronic disease management, emergency response, and culturally safe care. Structured mentorship and community engagement support nurses in delivering protocol-driven, culturally responsive care. By utilising the PCCM, nurses practice to their full scope, ensuring safety and consistency in clinical decision-making.

Discussion: Participants reported improved clinical competence and confidence in applying evidence-based care. The PCCM is instrumental in fostering critical thinking and standardising practices. While logistical challenges in placements were noted, feedback highlighted the value of protocol-driven education in meeting the unique demands of remote practice.

Conclusion: The Remote Registered Nurse Practice Pathway, underpinned by the PCCM, ensures standardised practices enhances patient safety, improves clinical outcomes, and supports decision-making. Nurses are empowered with greater autonomy and accountability, promoting staff satisfaction. Future initiatives will focus on expanding the integration of evidence-based protocols, refining educational strategies, and strengthening partnerships. This model highlights the vital role of protocols in advancing remote nursing practice and improving healthcare delivery for underserved communities.

Scientific Program, Session 3B

Clinical Supply Online Shopping Solution

Presented by Melony Heaver & Andrea Mann

TORRES AND CAPE HOSPITAL AND HEALTH SERVICE

List of authors

Melony Heaver[1], Andrea Mann[1]

Author Institution/s

1. Torres and Cape Hospital and Health Service

Abstract:

Background: Torres and Cape Hospital and Health Service (TCHHS) continued to experience a magnitude of errors and inefficiencies for clinical supply and consumable ordering. Clinical staff located in remote primary health care centres were spending a significant amount of time collating, product matching, stock counting and recording their weekly/fortnightly/monthly orders – often via hand written notes or emails. With the vision to reduce the burden on clinical staff, the time taken and create opportunities for non clinical staff to assist in the ordering process, the idea to establish an online shopping app that was visual for ordering clinical supplies for TCHHS Primary Health Care Centres (PHCCs) was created.

Aims: The aims of the project included:

- standardise clinical consumable imprest lists across all TCHHS PHCC'S.
- create an easy, effective and efficient process for clinical/healthcare worker teams to order their imprest supplies that was automated, visual, and reduced time taken to complete the regular task.
- Reduce waste from over ordering and incorrect ordering with set minimum and maximum levels.

Methodology: Created standardised clinical consumable imprest lists according to the size and staffing numbers of the primary health clinic, the population of the community where the services are delivered, outreach services provided and clinical needs.

The standardised imprest clinical consumable lists set with a maximum ordering quantity which allows sites to carry approximately 4-6 weeks' worth of stock reducing the frequency of the ordering process while simultaneously addressing logistical barriers the remote clinics often experience.

Results: TCHHS commenced the project with 3299 material numbers available for ordering at the PHCC locations. This was reduced to 329 initially with ongoing improvements continuing. The significant reduction will not only improve the financial picture, but significantly reduce the actual storage space required to house the consumables in our space limited PHCCs.

Feedback from nursing staff on the ground includes their workload completing the task has shifted from hours each week to 1 hour per fortnight; the visual online platform with set ordering levels proves less stress compared to their previous excel spreadsheet process.

Staff knowing that they can move to a different PHCC and the same stock is available.

Conclusion: Although the online solution is a new concept and only rolled out live across our TCHHS PHCC sites since FY23/24, the initiative has not only met its original intention and objectives, the solution has also captured the attention of our colleagues down south. We will continue to refine and update the electronic platform to ensure the online capabilities are exhausted to its full potential.

Developing implementation strategies for the implementation of a remote context guideline

Presented by Sally West

CENTRAL QUEENSLAND CENTRE FOR RURAL AND REMOTE HEALTH, JAMES COOK UNIVERSITY

List of authors

Sally West[1]

Author Institution/s

1. Central Queensland Centre for Rural and Remote Health, James Cook University

Abstract:

Introduction/Background: Aboriginal and Torres Strait Islander children experience a higher rate of acute respiratory disease in comparison to non-Indigenous Australian children. There was an opportunity to implement nasal high flow into these communities to increase the respiratory availability within remote home communities. Three remote hospital sites: Thursday Island, Weipa, Cooktown, have collaborated to implement a remote context guideline for the use of nasal high flow therapy. Implementation science methodology and ethnographic methods have been used to develop implementation strategies for the use of the nasal high flow guideline.

Aims:

1. To explore the barriers and enablers to implementing a nasal high flow (NHF) therapy paediatric guideline in three very remote hospitals in northern Australia.

2. To identify strategies that strengthen enablers or mitigate barriers to the implementation of NHF therapy in these settings.

Methodology: An implementation science study design includes the Theoretical Domains Framework and the COM-B wheel to develop implementation strategies. The ethnographic 'insider role' allows for the lead researcher to receive continual feedback during the implementation period and provide adjustments.

Results: The Theoretical Domains Framework identified thirty-four enablers and barriers. When mapped to the COM-B wheel, 4 were capability, 15 were opportunity, and 17 were motivation. 36 implementation strategies were developed that stratified into the following theme: logistics (4), consultation and engagement (13), resources (8), education and training (10), strategic decision-making (1).

Conclusion: Implementation science methodology paired with the observational ethnographic role was appropriate to identify the best implementation strategies in the remote context. The strategies were comprehensive and systematically developed that expanded on tradition training methods to a new intervention.

Interdisciplinary Student-Led Allied Health Group Therapy Clinic

Presented by Taegen Pascoe and Melanie Sisavanh

CENTRAL QUEENSLAND CENTRE FOR RURAL AND REMOTE HEALTH, JAMES COOK UNIVERSITY

List of authors

Taegen Pascoe[1], Asmita Mudholkar[1], Stephanie Burke[1], Kehinde Obimaro[1], Ines Zuchowski[1]

Author Institution/s

1. Central Queensland Centre for Rural and Remote Health, James Cook University

Abstract:

Background: In 2024, a multidisciplinary allied health student placement model co-locating within a rural general practice clinic to meet the health needs for people living in Central Queensland was established. Building on this, an interdisciplinary group therapy clinic was recently established to cater for the increasing demand for allied health services in the Central Queensland region.

Aims: The project aims to develop allied health student skills and knowledge to practice and provide group therapy within a rural primary health care setting, using an interdisciplinary practice model.

Methodology: A cross-sectional survey design with convenience sampling is being used. Data is being collected anonymously via REDCap assessing participating students' experience of the placement model using a semi-structured survey. The qualitative responses from the students' survey will be analysed using Nvivo. Client satisfaction survey will be analysed using SPSS version 29.0

Results: The interdisciplinary model of care provides a cohesive and efficient approach to client centred care, leading to increased satisfaction and better health outcomes. A number of group therapy programs have been offered since January 2025, including Chronic Pain, Connections, Balance and Mobility, Cognitive Rehabilitation and Wellbeing, through a combination of place-based and outreach programs. Future groups inclusive of paediatric clinic, respiratory and cardiac rehabilitation and lifestyle redesign are planned to commence delivery in May 2025. Many participants have provided positive feedback, and students have reported increased skill development through interdisciplinary collaboration and confidence and competence in group therapy facilitation.

Conclusion: The development of the interdisciplinary student-led allied health clinic has provided an increase in access to allied health client service delivery in Central Highlands and also fostered interdisciplinary learning opportunities for students.

Distribution and Severity of Road Crashes in Queensland

Presented by Kehinde Obamiro

CENTRAL QUEENSLAND CENTRE FOR RURAL AND REMOTE HEALTH, JAMES COOK UNIVERSITY

List of authors

Kehinde Obamiro[1], Stephanie Burke[1], Asmita Mudholkar[1], Bridget Fletcher[1], Oluwatobi Ajayi[1]

Author Institution/s

1. Central Queensland Centre for Rural and Remote Health, James Cook University

Abstract:

Background: Road crashes are a major public safety concern in Australia, with significant variation in frequency and severity across regions.

Aims: This study aimed to analyse road crash data across metropolitan, regional, rural and remote Queensland, identifying differences in crash severity across geographical areas and factors associated with road crashes in remote and very remote Queensland.

Methodology: The study was a cross-sectional study using road crash data for year 2023 available from the Department of Transport and Main roads. The study compared the frequency and severity of road crashes across major cities, inner regional, outer regional, remote and very remote Queensland, by the Australian Statistical Geography Standard remoteness classification. Factors such as road surface condition, weather conditions, traffic control, and crash zone speed limit were investigated as potential causes of road crashes.

Results: A total of 13278 road crashes occurred on Queensland public roads and reported to the police in 2023. Of these, 8560 crashes were observed in major cities, with 235 and 163 incidences in remote and very remote areas, respectively. Higher proportions of hospitalisations and fatalities were observed in remote and very remote areas compared to major cities. Altogether, 5.1% and 5.5% of crashes in remote and very remote locations resulted in fatalities compared to only 0.9% of crashes in major cities. Additionally, 73.6% and 69.3% of crashes in remote and very remote areas, resulted in hospitalisation compared to 43.3% of crashes in major cities. Factors identified to be associated with road crashes in remote and very remote Australia, included traveling in a speed zone area of 100-110km/h and on unsealed dry roads.

Conclusion: Understanding the spatial distribution and severity of road crashes in Queensland provides valuable insights for targeted safety improvements. Tailored strategies are required to reduce crash severity and improve overall road safety in different geographical contexts.

Skin Cancer Early Detection in Rural and Remote Queensland – A Dual Approach

Presented by Mary-Anne Quilter

CHECKUP AUSTRALIA

List of authors

Mary-Anne Quilter[1]

Author Institution/s

1. CheckUP Australia

Abstract:

Background: Rural and remote populations are at higher risk of developing skin cancer yet have limited/no access to skin cancer doctors. Outdoor workers in these areas are exposed to UV radiation 5-10 times more than indoor workers and geographical barriers mean patients have to travel significant distances for skin checks, treatment and monitoring. A shortage of GPS experienced in skin cancer medicine further compounds this inequity.

Aims: The aims of CheckUP's Skin Cancer Early Detection (SCED) program are to:

1. Remove access barriers to high-quality, affordable services focused on the prevention, early detection and treatment of skin cancers; and
2. Provide upskilling to local GPs to build capacity and expert knowledge in skin cancer medicine.

Methodology: Key actions included:

1. Recruiting qualified GPs to travel to rural/remote locations to conduct skin checks and treat suspected
2. skin cancers.
3. Upskilling rural/remote GPs through workshops delivered by skin cancer specialists.
4. Coordinating accessible, low-cost skin clinics in priority rural/remote locations.

Results: From 1 July 2023 – 31 December 2024, 1,957 patients attended SCED clinics across 18 locations. Of these, 29% received pre-cancer treatments, with 67% of these patients having histologically proven cancers detected.

Patients feedback (N=121) included:

- "A great service. Both my husband and I have had melanomas (we didn't know existed) taken off."
- "Travel would be too far for me (otherwise). I'm elderly and have no vehicle."
- "Have been postponing appointments in Townsville for six months due to timing and travel."

GP feedback (N=77) included:

- "An excellent program which has improved my confidence and skill as a rural GP."
- "Very valuable and will use the techniques daily in my Regional GP work."
- "It helped to increase my knowledge and changed my practice."

Conclusion: The SCED program addresses a critical gap in rural/remote health services. Without it, 25% of patients have told us they would not have skin checks. Upskilling workshop attendees reported increased knowledge, skills and confidence in providing skin cancer early detection services.

Data-driven approach to improve PI risk assessment and classification for all skin

Presented by Rachel Walker

JAMES COOK UNIVERSITY & TOWNSVILLE UNIVERSITY HOSPITAL AND HEALTH SERVICE

List of authors

Prof Rachel Walker[1,2]

Author Institution/s

1. James Cook University Institution
2. Townsville University Hospital and Health Service

Abstract:

Background: Pressure injuries (PI) represent significant and costly patient safety challenges within Australian health services. Outdated risk assessment tools, such as the Waterlow Score are subjective and lack robust validation leading to incorrect diagnosis and poor outcomes. In addition, current visual assessment methods often fail to accurately identify early-stage PIs, particularly in individuals with dark skin. While there are numerous ML studies related to PI, they are at high risk of bias due to reliance on outdated risk assessment tools.

Aims: This exploratory project aims to improve the accuracy of PI risk assessment and classification through a novel, data-driven approach developed by machine learning (ML).

Methodology: A prospective, three-phased quality assurance (QA) study will be conducted focusing on adult patients with PI.

- Phase 1: Capture of high-resolution, de-identified photographic images of PI using a specialised 3D imaging device. Risk assessment data, including Waterlow Scores and established risk factors, will be extracted from electronic medical records and published research.
- Quantitative analysis of images to enable precise PI classification based on parameters like area, depth, and volume. Textual risk assessment transformed into structured numerical categories.
- Phase 3: Development and prospective validation of ML prediction models using the high-resolution images and coded risk assessment data.

Results: This project is currently under review. If funded, this QA study has the potential to establish a standardised dataset of PI characteristics that will serve as an unbiased foundation for predictive analytics and ML applications for all risk factors and skin types.

Conclusion: As eHealth expands into rural and remote settings, this study has the potential to generate objective imaging data for accurate PI identification to establish a standardised dataset for predictive analytics in any health context.

Persistent Opioid Use After Cardiothoracic Surgery in Regional Queensland

Presented by Izza Zahid & Mahi Dhillon

JAMES COOK UNIVERSITY

List of authors

Izza Zahid[1], Dr. Stephen Perks[1], Dr. Sananta Dash[2], A/Prof. Nagaraja Haleagrahara[1], Maheep Dhillon[1]

Author Institution/s

1. James Cook University
2. Townsville University Hospital

Abstract:

Background: Opioid use following surgery is a standard component of postoperative care; however, their prolonged use raises significant clinical concerns. This issue is particularly pressing in rural, remote and regional (RRR) Australia, where access to alternative pain management is limited and opioid prescribing rates are higher. Despite the growing burden, there is limited data on postoperative opioid prescribing practices following major surgeries such as cardiothoracic procedures, and even less is known about the outcomes for Aboriginal and Torres Strait Islander patients.

Aims: This project aims to examine patterns of opioid prescribing and prolonged use among patients who underwent cardiothoracic surgery at Townsville University Hospital. It will explore the proportion of patients who develop persistent use and assess whether factors such as rurality or Indigenous status are associated with an increased risk.

Methodology: This retrospective cohort study includes adult patients who underwent cardiothoracic surgery between October 2021 and March 2023. Data sources include electronic medical records, intensive care unit records, and QScript, to capture postoperative opioid use at discharge, and at 3, 6, and 12 months. Demographic, surgical, and postoperative variables will be analysed using descriptive statistics and logistic regression to identify factors associated with persistent opioid use.

Results: Data collection is still underway, but the study expects to identify the proportion of patients developing persistent post-operative opioid use and observe clear trends in long-term opioid use. The study also aims to identify patient groups who may be at a greater risk of developing persistent use, such as those living in rural or remote areas and those prescribed extended-release opioids at discharge.

Conclusion: This project aims to guide safer opioid prescribing and improve patient outcomes by identifying long-term usage patterns and risks, leading to more equitable management strategies for patients in RRR areas.

Beyond the Pain: Investigating the Psychosocial Impacts of Adenomyosis

Presented by Sarah McDonnell

JAMES COOK UNIVERSITY

List of authors

Dr Tracey Ahern [1], Dr Madelyn Pardon[1], Sarah McDonnell[1]

Author Institution/s

1. Institution 1
2. Institution 2

Abstract:

Background: Adenomyosis is a prevalent yet often overlooked uterine condition associated with chronic pelvic pain, heavy menstrual bleeding, and significant psychosocial consequences. Affecting up to one-third of women of reproductive age, it is frequently misdiagnosed or confused with endometriosis. Despite its widespread nature, research into the broader psychosocial impacts of adenomyosis—particularly in rural and remote Australia—remains scarce, contributing to significant health disparities.

Aims: This cross-sectional study aims to explore the psychosocial impacts of adenomyosis on Australian women, with a focus on geographical disparities, access to healthcare, and the lived experiences of women in rural and remote areas. The research will address the following primary question: What are the psychosocial impacts of adenomyosis on Australian women aged 18 and over? Additional sub-questions will explore regional differences (rural, regional, metropolitan) in these impacts.

Methodology: A national, anonymous online survey will be distributed to Australian women aged 18 and older, all of whom have a clinical diagnosis of adenomyosis. Recruitment will take place through private gynaecology clinics, advocacy groups, universities, and social media platforms. The survey is based on the Endometriosis Impact Questionnaire (Jones et al., 2019) and includes 48 Likert-scale questions alongside open-ended items addressing psychosocial effects, diagnostic challenges, and healthcare access. Ethics approval is currently in final stages.

Results: Quantitative data will be analysed using descriptive and inferential statistics (Chi-square and ANOVA) to assess regional differences. Qualitative responses will be analysed to identify common themes.

Conclusion: This project aims to amplify the voices of women in underserved and rural communities. The findings will help inform culturally relevant, community-driven care models that promote equitable, compassionate, and accessible reproductive healthcare, especially in rural and remote areas.

Moving Minds: Exercise as Mental Health Care in Rural Communities

Presented by Kirsten Russell

MURTUPUNI CENTRE FOR RURAL AND REMOTE HEALTH, JAMES COOK UNIVERSITY

List of authors

Kirsten Russell [1]

Author Institution/s

1. Murtupuni Centre for Rural and Remote Health, James Cook University

Abstract:

Background: People in rural and remote areas face disproportionately high suicide rates, with 56% of those who die by suicide having a diagnosed mental illness. Mental illness is the leading global cause of disability, contributing to 18.7% of years lived with disability. While medication can offer short-term relief, long-term effects may be harmful. Exercise, on the other hand, is a promising alternative with proven mental and physical health benefits, particularly for those with mental illness.

Aims: This scoping review aimed to identify the characteristics of community-based exercise programs used as primary interventions for managing symptoms of diagnosed mental illnesses in adults living in rural and remote regions.

Methodology: A comprehensive scoping review was conducted across six databases—Medline, CINAHL, PsychInfo, Sports DISCUS, SCOPUS, and Web of Science—along with a grey literature search. Studies included adults in rural or remote areas with a primary mental illness diagnosis who engaged in exercise interventions to address their mental illness.

Results: From 8,892 studies, only five met the inclusion criteria. Three of these involved support from an Exercise Physiologist (EP). All studies reported improvements in psychological health, but only those involving EPs also showed gains in physical health.

Conclusion: Research into exercise-based mental health interventions in rural and remote areas is limited. However, current evidence highlights the clinical benefits of involving an EP. Integrating EPs into multidisciplinary community mental health teams may enhance both mental and physical health outcomes for rural populations living with mental illness.

Rural and remote stroke survivors driving their own recovery using technology

Presented by Sarah Jackson

MURTUPUNI CENTRE FOR RURAL AND REMOTE HEALTH & COLLEGE OF HEALTHCARE SCIENCES, JAMES COOK UNIVERSITY

List of authors

Sarah Jackson[1,2], Shaun Solomon[1], Ian Atkinson[3], Ruth Barker[4]

Author Institution/s

1. Murtupuni Centre for Rural and Remote Health, James Cook University
2. College of Healthcare Sciences, James Cook University
3. Chancellery, James Cook University
4. The Cairns Institute, James Cook University

Abstract:

Background: Rural and remote stroke survivors deserve equitable access to rehabilitation services where they live. Despite their resilience, geographic barriers often force difficult choices between accessing rehabilitation and maintaining community connections. Technology-based solutions like telerehabilitation offer potential, yet their effectiveness in rural and remote settings remains uncertain, particularly from stroke survivors' perspectives.

Aim: This research investigated how rural and remote stroke survivors could drive their recovery using technology, first exploring their perspectives on recovery and technology use, then developing a supportive technology-facilitated program.

Methods: A pragmatic approach incorporating elements of grounded theory, co-creation and action research guided this two-phase study. Phase 1 included interviews with stroke survivors and partners in remote northwest Queensland, followed by a systematic mixed studies review investigating rural and remote stroke survivors' perspectives from across Australia. Phase 2 involved co-designing a technology-facilitated program with a stroke survivor co-researcher and expert panel, then co-implementing and co-evaluating it with five rural and remote stroke survivors.

Results: Phase 1 established the Living My Life Framework, conceptualising recovery as "living my life, as it evolves by endeavouring to recover my way while navigating my recovery in my world." The systematic review confirmed these findings resonated with broader experiences. Phase 2 produced the Living My Life Program—five stages implemented through nine online sessions with an allied health coach over 12 weeks. Most participants successfully engaged using everyday technologies and progressed toward personal recovery goals without disrupting their lives.

Conclusion: By prioritising stroke survivors' perspectives, this research established a foundation for technology-facilitated recovery approaches honouring rural and remote stroke survivors' desire to recover their way, in their world. Future research should continue prioritising stroke survivors' perspectives, amplify diverse voices, and balance these perspectives with health and disability systems requirements.

Scientific Program, Session 4A

Role of Allied Health Professionals in Fertility Care: A Scoping Review

Presented by Amanda Mackay

PHARMACY, COLLEGE OF MEDICINE AND DENTISTRY, JAMES COOK UNIVERSITY, TOWNSVILLE

List of authors

Amanda Mackay [1], Selina Taylor[2], Emma Anderson[3], Beverley Glass[1]

Author Institution/s

1. Pharmacy, College of Medicine and Dentistry, James Cook University, Townsville
2. Murtupuni Centre for Rural and Remote Health, James Cook University, Mount Isa
3. College of Medicine and Dentistry, James Cook University, Townsville

Abstract:

Background: Infertility has a significant impact worldwide, with most people diagnosed pursuing medical treatment in attempt to attain pregnancy. Among the treatments available, Assisted Reproductive Technologies (ART) although prevalent, can be prohibitively expensive, especially for those in rural and remote areas.

Aims: This scoping review aims to explore the role of allied health professionals (AHPs) in the care and treatment of people experiencing fertility problems, and their place amongst fertility care teams.

Methodology: A search of six databases including CINAHL, Emcare, Medline, PsycINFO, Scopus, and Web of Science, resulted in the inclusion of 12 studies that explored the roles of AHPs in fertility care. Three studies included data on rural areas.

Results: Studies identified dietitians, nutritionists, counsellors, psychologists, social workers, and physiotherapists as AHPs in fertility care. Their roles fall into two main areas: providing education and monitoring lifestyle modifications and infertility risk factors and offering psychosocial support. Dietitians educate on nutrition and lifestyle changes that may enhance reproductive outcomes. Mental health professionals help manage the emotional stress of infertility through counselling and support. Physiotherapists use manual therapy to improve spontaneous conception or ART success. The integration of AHPs into fertility teams varies by location and clinic structure—some work within clinics, while others provide independent services. Living in rural areas was identified as a factor influencing fertility, highlighting the need for support mechanisms to address the challenges of rural service provision.

Conclusion: This scoping review highlights the importance of AHPs in the management of fertility. Their roles in providing education, lifestyle modification guidance, and psychosocial support are valuable in enhancing patient care and potentially improving both natural conception and ART outcomes. Accessible and ongoing AHP services need to available to address challenges in rural and remote areas.

Health, Partners, and Periods: What we miss in Australian Women's Health Survey

Presented by Dr Kris McBain-Rigg

COLLEGE OF MEDICINE AND DENTISTRY, JAMES COOK UNIVERSITY

List of authors

Dr Kris McBain-Rigg [1]

Author Institution/s

College of Medicine and Dentistry, James Cook University

Abstract:

Background: The Australian Longitudinal Study on Women's Health (ALSWH) is an Australian institution – it has been operating continuously since 1996 and has collected data and stories from a broad range of women across Australia. But one question on the survey has failed to capture the attention of researchers: the very last question – "Have we missed anything?". This pilot study attempts to explore how women – specifically those in rural and remote areas- responded to this question.

Aims: To explore the issues reported as 'missing' from the ALSWH surveys of Cohort 1973-1978 women, pre and post-COVID19 according to regionality.

Methodology: This study used a combination of content analysis (Leximancer) and thematic analysis to explore themes in women's responses, contained in over 1000 data points. Leximancer assisted analysis was then accompanied by qualitative thematic analysis – to provide depth to the Leximancer data, revealing differences within the cohort according to location (rurality) and pre/post-COVID19 lockdowns.

Results: Early analysis indicates that whilst there are some ubiquitous concerns that women held (and continue to raise) across the cohort, there were some factors unique to the experiences of rural and remote women that they felt were not being adequately captured in the survey.

Conclusion: Survey design often includes similar kinds of open-ended final questions– this study demonstrated that women used this final question as an opportunity to tell their stories in much more detail across a highly comprehensive survey – not just provide feedback on survey inadequacies. This study will continue to analyse the stories of women from other cohorts across time to show trends in what we have missed in such important health surveys.

Caring in Nursing: Insights from Collective Narratives

Presented by Tanya Park

JAMES COOK UNIVERSITY & CAIRNS AND HINTERLAND HOSPITAL AND HEALTH SERVICE

List of authors

Tanya Park[1,2]

Author Institution/s

1. James Cook University
2. Cairns and Hinterland Hospital and Health Service Institution

Abstract:

Background: A friend holding your hand, calming words when fear overwhelms, sitting with someone when they're afraid are all examples of how we might demonstrate caring. People with schizophrenia often do not have this experience. They have likely experienced discrimination, exclusion and have limited social supports. In this presentation, we will explore narratives of care and caring.

Methodology: Using a collective narrative approach—an affirmative, trauma-informed methodology grounded in storytelling—to explore stories of care from individuals with chronic mental illness and registered nurses. This presentation will share findings from the nurses' stories of care and caring.

Results: Nurses' Stories of Care: The narratives shared by registered nurses revealed a multifaceted experience of care, characterized by moments of connection, empathy, and advocacy. Nurses described care as more than just a task; it was a deliberate and relational act aimed at fostering healing and well-being. Several themes emerged from their stories:

- The Right Gift: Providing personalized care that meets individual needs.
- Hope for Change: Inspiring and supporting positive change in patients' lives.
- Navigating System Restrictions: Overcoming hurdles to deliver effective care.
- Being There, Just There: Offering presence and support during critical moments.

Conclusion: Through their stories of care and caring, registered nurses demonstrated a commitment to care. Their narratives underscored the relational and reciprocal nature of care, highlighting the importance of empathy, advocacy, and hope in fostering healing and well-being. Moving forward, it is essential to heed the insights gleaned from these narratives, striving towards a future where compassionate and understanding care is not only a possibility but a reality for all.

Facilitators and barriers to improving survivorship care for rural cancer survivors

Presented by Dr Lizzy Johnston

NOMINATED PRESENTER INSTITUTION

List of authors

Lizzy Johnston[1], Xanthia Bourdaniotis[1], Susannah Ayre[1], Hayley Fung[1], Nicole Craig[1], Fiona Crawford-Williams[2], Rebecca Bergin[3], Jon Emery[4], Raymond Chan[2], Belinda Goodwin[1]

Author Institution/s

1. Cancer Council Queensland
2. Flinders University
3. Deakin University
4. University of Melbourne

Abstract:

Background: People living in rural, regional, and remote areas report substantial gaps in survivorship care information received when transitioning from treatment in a city centre to primary care in their community.

Aims: This study engaged healthcare professionals involved in the care of rural cancer survivors to identify the facilitators and barriers to improving delivery of survivorship care information.

Methodology: Semi-structured interviews were conducted with 31 healthcare professionals (12 rural general practitioners, 12 rural or metropolitan-based nursing and allied health practitioners, 7 metropolitan-based treatment specialists). Participants' responses regarding current practices for delivering survivorship care information, perspectives on how this care should be delivered, and factors that may affect implementation of a new system, method, or guideline for delivering survivorship care information were extracted and categorized as either a facilitator or barrier to improving care. Barriers and facilitators were then mapped to the domains and constructs of the Consolidated Framework for Implementation Research to identify the settings and contexts in which they occur.

Results: Key facilitators included the evidence base and relative advantage of improving survivorship care information delivery to rural cancer patients, indicating that this initiative is perceived as important and valuable by healthcare professionals. Facilitators mission alignment and tension for change indicated that improving survivorship care information delivery to rural cancer survivors was within participants' organisations' goals, and that changes in survivorship care information delivery are needed as current practices are not sustainable. Key barriers included local conditions, policies and laws, and financing, such as the low availability of supportive care services and limited funding for post-treatment care in rural settings.

Conclusion: Findings highlight the need for streamlined referral systems and collaborative delivery of survivorship care information across specialist cancer treatment, primary care, allied health, and community services.

High Burden and Low Access: Sexual Health Care in Mount Isa

Presented Savannah Grudzinski

MOUNT ISA SEXUAL HEALTH, NORTH WEST HOSPITAL AND HEALTH SERVICE

List of authors

Savannah Grudzinski[1], Kylee Parsons[1], Shannon Anderson[1], Georgia Steele[1]

uthor Institution/s

1. Mount Isa Sexual Health NWHHS

Abstract:

Background: Remote Queensland faces significant challenges in sexual health care access due to geographic isolation, workforce shortages, and limited infrastructure. In Mount Isa, where Indigenous people comprise 21.5% of the population, the high burden of sexually transmitted infections (STIs) is further exacerbated by social determinants of health.

Aims: Analyse STI burden from 2010 to 2024 in North-West Hospital and Health Service (NWHHS) and service usage in Mount Isa Sexual Health Clinic (MISHC) to identify strengths and gaps.

Methodology: A retrospective audit of MISHC clinical encounters from 1 January to 31 December 2024 was conducted using data extracted from Communicare (Telstra), the clinic's primary consultation documentation system. A report filtering for sexual health locations and client demographics was exported to Microsoft Excel, excluding 'no client contact'.

Results: Of 5,644 clients, 38% were Indigenous. Ages ranged from <1 to 81, with largest group aged 21–30 (n= 2,269). Visits peaked in July (n=593) and lowest in January (n=358), averaging 470 clients monthly. Telephone consultations (n=2,937) were most common, followed by in-person (n=2,519) and home visits (n=155). Indigenous clients made up 83.8% of home visits, compared to 36.7% in-person.

According to North Queensland Public Surveillance Data (2024), Indigenous people account for 93% of syphilis and 87% of gonorrhoea notifications, yet only 38% visit MISHC. This disparity indicates issues with access, acceptability, and cultural safety. Despite being prioritised in the Queensland Syphilis Action Plan 2023–2028, attendance remains low due to inconsistent MISHC outreach and lack of dedicated staff.

Conclusion: There is a significant discrepancy between the high STI burden among Indigenous people in Mount Isa and their low engagement with MISHC services. Strengthening consistent outreach, staffing, and culturally appropriate care is essential to address these disparities.

Scientific Program, Session 4B

Avoidable cancer-related deaths due to spatial disparities in survival across Australia (2010-2019)

Presented by Dr Lizzy Johnston

CANCER COUNCIL QUEENSLAND

List of authors

Charlotte K. Bainomugisa[1,2], Jessica K. Cameron[1,2], Paramita Dasgupta[1,2], Peter D. Baade[1,2]

Author Institution/s

1. Cancer Council Queensland,
2. Queensland University of Technology

Abstract:

Background: There has been improvement in cancer treatment and outcomes over the years however, survival disparities by geographical location still exist in Australia and elsewhere. Disparities in cancer deaths have previously been estimated using relative measures and studies adjusted for stage at diagnosis which may lead to underestimations.

Aims: To quantify the number of cancer-related deaths within 5 years of diagnosis that could be avoided if spatial disparities in survival were reduced.

Methodology: Population-based data on cancer diagnosis and survival was obtained from all Australian cancer registries and population mortality data from Registries of Births, Deaths and Marriages. Residential location at time of cancer diagnosis was based on the 2016 Statistical Area 2. Bayesian spatial survival models were applied to estimate the number and percentage of avoidable deaths from 20 cancer types within 5 years of diagnosis in 2010−2019. The modelled number of cancer-related deaths was compared to the number of deaths expected if 5-year survival in each area met a benchmark, defined by the area with the top 20th centile survival.

Results: We found that 33,892 (11.7%) cancer-related deaths could have been avoided if the survival rate in all areas at least met the optimal benchmark. The percentage of cancer-related deaths that were avoidable increased with increasing remoteness and area disadvantage, with nearly a third (1,569 or 30.1%) of cancer deaths in remote areas related to spatial disparities. Numbers of avoidable cancer-related deaths were highest for lung, rare, pancreatic and head and neck cancers. The percentages of cancer-related deaths that could be avoided were higher in the northern and central regions of Australia.

Conclusion: These findings demonstrate the impact of spatial inequalities in cancer survival, highlighting the need for interventions aimed at reducing disparities through equitable access to health services, particularly in disadvantaged and remote areas.

Improving Access to Ultrasound in Remote Cape York Communities

Presented by Steve Wallin

TORRES & CAPE HOSPITAL AND HEALTH SERVICE

List of authors

Steve Wallin[1], Lee Williams[1], Kathryn Deed[1]

Author Institution/s

1. Torres & Cape Hospital and Health Service

Abstract:

Background: In late 2023, the Torres & Cape Hospital and Health Service launched a pioneering trial aimed at enhancing access to ultrasound services in five remote Cape York communities: Aurukun, Lockhart River, Pormpuraaw, Kowanyama, and Coen. These communities, comprising a total population of 3,710, are predominantly Aboriginal and Torres Strait Islander, with 92% of residents identifying as such.

Prior to this service development, patients from these communities would have to travel to larger centres for ultrasound imaging. Given the high prevalence of chronic diseases and adverse environmental factors, residents from Cape York communities frequently fall into higher risk categories. For antenatal patients, this often necessitates multiple scans throughout their pregnancies. The economic burden of uncovered travel costs, coupled with the social ramifications for the patients, their families, and their communities, cannot be understated. These barriers had a very real health impact. Prior to implementation, ultrasound utilisation rates in these areas were alarmingly low, standing at eight times below the Australian average.

Aims: The overarching goal of the service development is to bring care closer to home.

Methodology: The model of care was developed in a staged manner as the service proved its effectiveness.

Trial visits using portable ultrasound equipment resulted in more patients being examined in a single clinic than had travelled outside the community for similar services throughout the entire preceding year. The portable ultrasound machine however lacked imaging capacity. Consequently, women in these communities still faced the need to travel for essential obstetric scans.

In response to these limitations, a successful submission to Clinical Excellence Queensland resulted in the provision of high-end ultrasound machines enabling the development of a regular visiting service that offers all general, vascular, musculoskeletal and obstetric ultrasound.

Results: Since the implementation of this enhanced service model, more than 600 ultrasound examinations have been conducted within the Cape York communities. When compared with data from prior to the implementation, this represents a six fold increase in the access to imaging for these residents.

Conclusion: This initiative has enabled Queensland residents in remote areas to receive essential care without the disruption and costs of travel. This presentation will further explore the benefits this initiative has brought to the residents of Cape York communities and will highlight specific case studies that illustrate the profound impact of improved ultrasound access on their health journeys.

Bridging the Gap: Delivering Mobile Dental Care in Rural Queensland

Presented by Dr Stevie Dilley

ROYAL FLYING DOCTOR SERVICE (QUEENSLAND)

List of authors

Dr Stevie Dilley[1]

Author Institution/s

1. Royal Flying Doctor Service (Queensland)

Abstract:

Background: Access to dental care in rural and remote regions of Queensland presents unique challenges not faced in urban settings. Geographic isolation, financial constraints, and workforce shortages contribute to disparities in oral health outcomes. The Royal Flying Doctor Service (Queensland Section) (RFDS), is addressing these challenges by implementing mobile dental services to provide equitable, evidence-based care to underserved communities.

Aims: This project aims to evaluate the effectiveness of mobile dental services in improving oral health outcomes in rural and remote Queensland. Specifically, it explores strategies to enhance access, address logistical barriers, and foster collaboration with local healthcare providers.

Methodology: A multi-faceted approach is employed, including:

- collaboration with primary care nurses to implement fluoride varnish programs
- deployment of mobile dental unit to improve access to general dental care
- ongoing quality improvement research to refine service delivery
- integration of virtual dental health advice pathways to enhance patient engagement.

Results: The mobile dental service model utilised by RFDS contributes to increased access to care, improved patient outcomes, and strengthened community partnerships. Fluoride varnish programs and virtual consultation pathways support preventive care efforts, while mobile clinics reduce the burden of untreated dental conditions. Ongoing research aims to further quantify these impacts.

Conclusion: Providing mobile dental care in rural and remote Queensland is both challenging and rewarding. Collaboration, logistical innovation, and continuous evaluation are key to bridging the gap in oral health disparities between rural and urban populations. Future initiatives will focus on expanding service reach, strengthening preventive programs, and enhancing virtual care pathways to ensure sustainable, high-quality dental care for all.

Sustainability in Healthcare: Investigating oral nutrition supplement wastage in the hospital system

Presented by Gina-Maree Teixeira

NORTH WEST HOSPITAL AND HEALTH SERVICE

List of authors

Gina-Maree Teixeira[1]

Author Institution/s

1. North West Hospital and Health Service

Abstract:

Introduction/Aim: Oral nutrition supplement (ONS) wastage has been largely uninvestigated at Mount Isa Hospital. This project aimed to explore the amount of ONS being wasted and the cost to the health care system.

Methodology: Pre- and post-consumer data was collected to quantify ONS wastage both prior to and after reaching the patient. This included wastage due to expired or damaged stock, as well as unopened ONS that was discarded after being served to the patient. Additional data was collected to quantify the number of inpatients receiving ONS and the product most prescribed. Cost per bottle for each ONS was also collected.

Results: Medical ward had the most patients receiving ONS (an average of 28.9% of the ward), with Fresubin Energy Fibre being the most prescribed product. No ONS were found to be discarded due to damaged stock within a 4-week period. Within the same period, 108 expired ONS bottles were discarded, with the majority discarded from the hospital kitchen due to short-dated stock. An average of 30% of each ONS bottle was discarded after being served to patients over a 2-week period. The cost to the health service is currently being investigated.

Conclusion: A substantial amount of ONS are being wasted at Mount Isa Hospital, resulting in a considerable cost to the health service. Further efforts are currently being undertaken to identify the cause of wastage and waste reduction strategies, including the potential safety and feasibility of recycling processes. This will assist in improving health service environmental sustainability and budget.

Barriers to evidence-based paediatric burn care within rural, remote healthcare settings

Presented by Kylie Fischer

TORRES AND CAPE HOSPITAL AND HEALTH SERVICE

List of authors

Kylie Fischer[1], Professor Bronwyn Griffin[2], Dr Maleea Holbert[2]

Author Institution/s

1. Torres and Cape Hospital and Health Service
2. Griffith University

Abstract:

Background: Burn injuries are a leading cause of childhood trauma in Australia, with long-term physical, psychological, and social consequences. In Queensland, >4,500 children present annually to emergency departments with acute burn injuries. Children in rural and remote areas, particularly First Nations children, experience higher incidence rates, poorer outcomes, and longer hospital stays. Despite evidence supporting timely first aid, analgesia, and wound management, access to best practice burn care remains limited in these regions due to factors such as resource constraints, limited training, and challenges in pre-hospital and retrieval settings.

Aims: This research aims to map current models of care, identify barriers and enablers to delivering evidence-based paediatric burn care, and co-design strategies with healthcare professionals to address care delivery in rural and remote Queensland.

Methodology: This mixed-method study includes:

- **Phase 1:** Electronic questionnaires are distributed across five Hospital and Health Services (HHSs), Queensland Ambulance Service (QAS), and Retrieval Services Queensland (RSQ) to map current care models and identify perceived barriers and facilitators.
- **Phase 2:** Semi-structured interviews with healthcare professionals explore findings in depth and support the co-design of tailored strategies.

Results: Human Research Ethics Committee (HREC/2024/QCHQ/111138) approval has been obtained, and research governance processes are advanced across five HHSs, QAS, and RSQ.

This research will identify key barriers and enablers to the delivery of evidence-based paediatric burn care across rural and remote healthcare, prehospital, and retrieval services across Queensland. Co-designed strategies will respond to the identified challenges and support improved, context-specific care.

Conclusion: Findings will support the development of targeted strategies, such as improved training, access to resources, and telehealth support, to improve outcomes and reduce inequities for children with burn injuries in rural and remote Queensland.

Scientific Program, Session 5A

Home delivery ENT Diagnostics: Transforming Paediatric Sleep Apnoea Care in Regional Australia

Presented by Sue Hammoud

MONASH HEALTH, MONASH UNIVERSITY

List of authors

Paul Paddle[1], Chandrashan Perera[2], Yogesan Kanagasingam[3], Gillian Nixon[4], Sue Hammoud[5]

Author Institution/s

1. Monash Health, Monash University
2. WA Health
3. University of Notre Dame
4. Monash Children's Hospital
5. Nebula Health

Abstract:

Background: Paediatric obstructive sleep apnoea (OSA) significantly impacts child development and health. Timely diagnosis and management are particularly challenging for rural Australian communities, given extensive travel distances, waiting times, and costs associated with hospital-based diagnostics. These barriers were intensified during the COVID-19 pandemic, underscoring the need for accessible diagnostic alternatives.

Aims: To evaluate the diagnostic accuracy, feasibility, patient preference, and timeliness of remotely-delivered home oximetry (Heali-Ox) compared to traditional hospital-based oximetry, and to subsequently develop a comprehensive Paediatric OSA Screening Triple Test (POSTT), incorporating home oximetry, video-based tonsillar assessment, and digital sleep questionnaires.

Methodology: A prospective comparative study included regional Victorian paediatric patients aged 2–18 years, clinically diagnosed with OSA and awaiting adenotonsillectomy. Participants underwent both hospital-delivered oximetry (HDO), involving travel and overnight hospital stays, and remotely delivered oximetry (RDO) mailed to their homes. Diagnostic accuracy, delivery time, and patient preference were assessed. A subsequent cross-sectional cohort study (POSTT) comparing triple-test results to in-laboratory polysomnography (PSG) is ongoing, evaluating accuracy, feasibility, and patient satisfaction.

Results: Remotely delivered oximetry (RDO) results showed complete (100%) diagnostic agreement with traditional hospital-delivered methods. Patient preference strongly favoured remote diagnostics (89%), and mean test completion time significantly improved from 87.7 days (HDO) to 23.6 days (RDO). The POSTT study is ongoing, with preliminary diagnostic validation findings expected by late 2025.

Conclusion: Remotely-delivered ENT diagnostics for paediatric OSA are equally accurate, substantially preferred by patients, and notably faster than traditional hospital-based testing. The innovative POSTT model addresses critical healthcare barriers, improving diagnostic access, reducing referral delays, and promoting equitable paediatric ENT care in regional and rural settings. This approach provides a sustainable, scalable model for rural healthcare delivery and has enduring potential beyond the COVID-19 pandemic.

Technology-based teaching to support rural students' stroke clinical skills: A scoping review

Presented by Kylie Bower

MURTUPUNI CENTRE FOR RURAL AND REMOTE HEALTH, JAMES COOK UNIVERSITY

List of authors

Ms Kylie Bower[1], Dr Karen Carlisle[2], Dr Kate Scrivener[3], Professor Sarah Larkins[2], Assoc Prof Catrina Felton-Busch[1]

Author Institution/s

1. Murtupuni Centre for Rural and Remote Health, James Cook University
2. James Cook University
3. Macquarie University

Abstract:

Background: Rural stroke survivors face barriers to accessing specialist care, and the challenge is likely to grow as acute medical advances improve survival rates. Student-resourced services are used world-wide to support stroke rehabilitation, and there is growing interest in the use of technology-based teaching approaches to enable health student skill development. There is potential for technology-based student teaching techniques to support rural stroke service capacity, but this is currently unexplored.

Aims: This scoping review aimed to understand the breadth of use, and characteristics of, technology-based teaching techniques that support health students to develop clinical skills for stroke recovery.

Methodology: The PRISMA-ScR approach guided a comprehensive search of five databases and grey literature. Studies were included if the participants were health students who engaged in a short-duration, technology-based teaching activity that addressed clinical skills relevant to stroke rehabilitation. Studies from all geographical, clinical and educational contexts were considered, irrespective of study design. Ten data points were summarised descriptively, and content analysis was applied to describe facilitators of technology-based teaching, using an inductive approach.

Results: Forty-eight studies were included in the review. Studies were predominantly published in the last 5 years (54%), were of lower methodological quality (69%), and featured medical (43%), physiotherapy (27%) or nursing students (27%) in educational (71%) - not clinical - settings. Features of technology-based approaches were consistently identified as facilitators of teaching and learning eg online accessibility and engaging multimedia design. The intentional planning and integration of teaching techniques were important to meet learning objectives. Only one paper demonstrated the feasibility of using technology-based teaching approaches in a rural, student-resourced stroke service.

Conclusion: There is burgeoning interest in technology-based teaching of stroke clinical skills for students, but this is rarely applied in a rural clinical setting. A future qualitative inquiry will explore whether and how this approach could support growing stroke rehabilitation needs in rural regions.

Pharmacist recruitment and retention on the Darling Downs: Driving sustainable solutions

Presented by Lucy Parker or Louisa Handyside

SOUTHERN QUEENSLAND RURAL HEALTH (UNIVERSITY OF QUEENSLAND)

List of authors

Lucy Parker[1], Louisa Handyside[2], A/Prof Daniel Terry[3], A/Prof Chris Freeman[2]

Author Institution/s

1. Southern Queensland Rural Health (University of Queensland)
2. University of Queensland
3. University of Southern Queensland

Abstract:

Background: Rural and remote areas face a persistent shortage of pharmacists, contributing to disparities in access to healthcare, service quality, and population health outcomes. The recruitment and retention of pharmacists is a critical issue on the Darling Downs (DD),1 spanning metropolitan, rural, and remote areas. Pharmacist shortages and maldistribution impact all settings, including community pharmacy, hospital, aged care, and primary care. Personal, professional, structural, social, and economic factors impact pharmacist recruitment and retention;2 however, the specific drivers of workforce challenges in DD communities remain unclear.

Aims: This study aimed to identify recruitment and retention strategies to support pharmacy workforce sustainability in DD communities.

Methodology: Factors that inform pharmacy recruitment and retention were assessed in four communities (MM4 to MM5) encompassing seven services. A cross-sectional, mixed-method approach was employed, using the validated Pharmacist Community Apgar Questionnaire (PharmCAQ) tool.3,4 Participants (n=19) were hospital or community pharmacists working in one of the four rural communities. Interviews were audio-recorded and conducted face-to-face, taking approximately 40-50 minutes.

Results: Each community's recruitment and retention strengths and challenges were ascertained forming the basis of community-specific recommendations. Collectively, the three highest-rated factors essential to pharmacist recruitment and retention were the reputation of the pharmacy, loyalty of the community to the pharmacist, and respect and support between all health professionals in the community. The lowest-rated factors were the ability travel to and from the community, availability and accessibility of day care, and availability and affordability of housing.

Conclusion: This project identified the assets, capabilities, and challenges faced by Darling Downs communities and highlighted the critical factors that drive pharmacist workforce sustainability. These insights inform the development of strategic recruitment plans. Future work will focus on evaluating the effectiveness of the identified strategies in solving pharmacist workforce challenges.

Collaboratively Developed Domestic Violence Training Resources to Strengthen Rural Dental Workforce Capability

Presented by Alex Dancyger

COLLEGE OF MEDICINE AND DENTISTRY, JAMES COOK UNIVERSITY

List of authors

Felicity Croker[1], Ann Carrington[1], Alex Dancyger[1], Simone Dewar[2]

Author Institution/s

1. Dentistry, College of Medicine and Dentistry, James Cook University
2. Social Work and Human Services, College of Arts, Society and Education, James Cook University

Abstract:

Introduction/Background: Domestic violence (DV) is recognised as a pervasive, and preventable problem with significant health impacts and a disproportionate incidence reported in rural and remote communities. Dentists have an important frontline role identifying patients who have experienced DV and providing culturally appropriate, trauma informed care. A collaborative initiative between JCU Dentistry and Social Work developed online training resources aimed at supporting vulnerable populations in regional and rural areas and improving dental clinical skills related to domestic violence intervention.

Aims: This presentation addresses a critical knowledge gap by introducing evidence-based educational resources to build DV clinical skills and support best practices for vulnerable populations in regional and rural dental settings.

Methodology: A multidisciplinary team used Participatory Action Research to develop DV-responsive dental education resources, involving a range of participants including victim-survivors, students, practitioners, educators, and community stakeholders. A mixed-methods approach guided both design and evaluation phases. Six video scenarios with print materials were created, and feedback from students, experts, and reflections informed their refinement. An inductive thematic analysis was conducted, and a meta-analysis is ongoing. Two additional videos were added to cover previously unaddressed topics.

Results: Educational resources were created based on formative findings, resulting in changes in teaching practices, including comparisons of current dental and DV statistics, in-class discussions, an online portal with dentistry-specific videos, and partnerships with local services. Summative evaluation confirmed that these resources enhance person-centred dental care for patients affected by domestic violence.

Conclusion: Funded by a Keeping Women Safe from Violence grant, these resources, including eight videos and print materials, are the first of its kind in Australia and freely available on the JCU web portal at https://www.jcu.edu.au/college-of-medicine-and-dentistry/dv-training. These evidence-based resources empower dental students and professionals to recognise, respond to, and refer domestic violence cases with a trauma-informed approach, fostering positive change and better outcomes for patients and the dental community.

Scientific Program, Session 5B

An analysis of student placements in Weipa 2017-2024: setting the future vision

Presented by Danielle Newsome

TORRES AND CAPE HOSPITAL AND HEALTH SERVICE

List of authors

Danielle Newsome[1], Malama Gray[2], Penelope McArthur[2], Alice Cairns[2]

Author Institution/s

1. Torres and Cape Hospital and Health Service
2. Murtupuni Centre for Rural and Remote Health

Abstract:

Background: In 2017, a MCRRH site was established in Weipa (MM7). As part of a quality improvement activity, a review of placements since the inception of MCCRH in Weipa was undertaken and a proposed vision for future placements is being developed.

Aims: To describe the placement activity from 2017-2024 including conversion to a local health workforce. We will propose our future vision for student placements in this region.

Methodology: A review of routinely collected student placement data was analysed to describe the number, duration, placement model, host, profession, university of origin. and current rural practice. A brief survey of health professionals was conducted asking "What contribution to our community would you like to see students make?"

Results: Over the eight-year period Weipa has delivered 215 student placements; total numbers ranging from 8 in 2017 to a peak of 54 in 2021. Students that identified as Aboriginal and/or Torres Strait Islander is 4% (n=8) of the cohort. JCU consistently provides Weipa the largest number of health students, totalling 109 students with QUT being the next largest with 25. Reflective of the available supervisors, Occupational Therapy (n=68) was the most common profession with nursing (n=47) the second largest. Traditional placement models continue to dominate n=102 however 69 placements were categorised as 'mixed models' and 44 were service learning. Of the 128 AHPRA registered professionals who had placements in Weipa, n=47 (37%) are currently working in MM3-7 locations. Survey results informing the future vision will be presented.

Conclusion: Weipa has supported consistent and diverse placement opportunities that appear to be successfully contributing to a rural health workforce. Future research should track workforce location outcomes for all students at each year post graduation. The vision for student placements will strengthen innovative placement models supported by an integrated health, community and university workforce.

Service-learning placements in regional, rural and remote contexts: A realist review

Presented by Catherine Seaton

MURTUPUNI CENTRE FOR RURAL AND REMOTE HEALTH, JAMES COOK UNIVERSITY

List of authors

Catherine Seaton[1,2], Prof Beverley Glass[3], Kirsten Russell[1], Dr Alice Cairns[1,4]

Author Institution/s

1. Murtupuni Centre for Rural and Remote Health, James Cook University
2. College of Healthcare Sciences, James Cook University
3. Pharmacy, College of Medicine and Dentistry, James Cook University
4. South West Hospital and Health Service

Abstract:

Background: Over a quarter of Australians live in regional, rural and remote (RRR) locations, where populations experience poorer health outcomes, due to a maldistributed health workforce and lower accessibility and availability of health services. Over the last decade or so, University Departments of Rural Health (UDRHs) have delivered or coordinated service-learning placements. Service-learning is an educational model in which pre-registration students develop their discipline's skills and knowledge while providing services in response to community identified needs, resulting in mutual benefits for all stakeholders, and contributing to health equity and social justice. However, there is little understanding of the underlying factors and processes which influence the model's success.

Aims: This review aims to identify and explore the contexts, mechanisms and implementation outcomes associated with service-learning programs in RRR locations.

Methodology: This realist review included a systematic search of six health and education databases for peer-review papers published between 2014 and 2024. Data were extracted according to service-learning theory and implementation outcome taxonomy.

Results: A total of 1,838 papers were identified, and 19 met criteria for inclusion in the review. 17 of the papers were Australian-based, and included disciplines such as allied health, nursing, and dentistry. There were inconsistencies in how program mechanisms were labelled and described according to service-learning theory. Challenging and enabling factors for different stakeholder groups that influence RRR service-learning programs, and program implementation outcomes were also identified.

Conclusion: Findings indicate heterogeneity amongst RRR service-learning programs and how they are developed and implemented. Despite this, the reviewed programs were reported to have positive impacts on the communities they served. Other stakeholder populations including students, academics, community and health organisations, schools and universities also experienced positive outcomes. Consideration of the impact of the RRR context and role of UDRHs is important for implementing service-learning programs in RRR Australia.

Innovative student placement model in Far North Queensland: bringing allied health to Weipa

Presented by Erin Weekes

NORTH AND WEST REMOTE HEALTH

List of authors

Kate Nevin[1], Erin Weekes[1,2]

Author Institution/s

1. Murtupuni Centre for Rural and Remote Health, James Cook University
2. North and West Remote Health

Abstract:

Background: Service-learning occupational therapy (OT) student placements can address child development service gaps in remote communities and entice developing professionals to remote areas.

Aims: To describe the timeline, design, funding, and uptake of an innovative OT student placement model within a school in Weipa, Queensland, illustrating its role-emerging, collaborative elements across disciplines and agencies and its impact on school students and staff, the broader community and OT students. We will provide a template, as well as learnings for other locations interested in implementing a similar model.

Methodology: A service improvement review of the model involved brief interviews and questionnaires with stakeholders, reflections from previous OT students and a retrospective review of OT student placements at Western Cape College, Weipa (2020–2025).

Results: 23 OT students from eight universities have undertaken this service-learning placement since inception, with multiple students now employed in rural and remote settings. Qualitative data gathered from stakeholders indicate the model has delivered significant benefits through a tiered approach, addressing individual, small group, and whole-school needs in a culturally-safe manner. Diverse and targeted intervention programmes such as life skills, handwriting programs, and social skills groups have addressed developmental needs in children 4-17 years. The host school stakeholders have expressed an ongoing commitment to support and expand the program to increased student numbers across allied health disciplines. OT student reflections suggest for some a transformative professional and personal experience.

Conclusion: This placement model highlights the value of interagency and interdisciplinary collaboration to solve health equity driven by workforce issues in remote communities. By embedding OT services within remote schools, the model addresses developmental needs, particularly for Aboriginal and Torres Strait Islander children and OT students gain essential transferable skills, including cultural competence and adaptive problem-solving, which directly inform their practice.

Understanding staff preferences for retention interventions in remote primary health care services

Presented by Deborah Russell

MENZIES SCHOOL OF HEALTH RESEARCH

List of authors

Deborah Russell [1]

Author Institution/s

1. Menzies School of Health Research

Abstract:

Background: High staff turnover in remote Australian primary health care services undermines provision of appropriate care. Associated continual disruptions in staff-patient relationships leads to patients disengaging from their healthcare with potentially profound untoward consequences. Remote health services are currently making decisions about what to do to retain staff with limited understanding of staff preferences.

Aims: To quantify the relative importance of different aspects of retention interventions implemented by remote Australian primary health services.

Methodology: This research is underpinned by a rapid realist review which drew on the authors' and project advisory group's topic knowledge and expertise, searches of relevant literature, primary qualitative data collected through individual interviews and focus group discussions with remote health workforce academic and industry experts. Retention intervention attributes were identified and refined through semi-structured interviews with remote health service staff. Remote primary health care staff preferences for retention attributes will next be tested using either an online or in-person administered Best-Worst Scaling survey. Results will be analysed by staff groups using multinomial regression models.

Results: This research is currently underway. The rapid realist review identified an initial 38 retention intervention attributes. Testing with remote health service staff during qualitative interviews led to a reduced and refined near-final list of 19 attributes.

We have determined that a Best-Worst Scaling survey is the most appropriate stated preference study design. We have also determined that because employment of Aboriginal community members is so critical in remote Aboriginal communities, a combination of online and in-person survey administration with interpreter support will be used to optimise participation.

Conclusion: This research will improve understanding of the preferences of different groups of staff for various aspects of retention interventions which will inform how retention interventions are designed and implemented in remote primary healthcare services, thereby improving staff members' workplace experiences and improving retention.

Primary care workforce gaps in remote QLD: perceptions of practitioners/ managers

Presented by Melissa Brimelow & David Stanyer

HEALTH WORKFORCE QUEENSLAND

List of authors

Melissa Brimelow[1], Manelle Sellars[1], David Wellman[1]

Author Institution/s

1. Health Workforce Queensland

Abstract:

Background: Workforce planning for primary care in remote areas takes into consideration factors such as small community sizes, travel distances, difficulties in attracting/retaining staff, and the high cost of delivering services. Traditionally, planning efforts are informed by community health needs data. Another approach may be to consider the perceptions of practitioners/managers regarding workforce gaps in their communities which may differ according to remoteness.

Aims: To investigate remote and very remote practitioner/manager perceptions of workforce gaps in their communities.

Methodology: Health Workforce Queensland undertakes an annual Health Workforce Needs Assessment by distributing an online survey to practitioners/managers located in MM2-7 QLD locations. Survey participants were asked to rate whether there was a serious gap across 20 primary care workforce types with a 101-point agreement rating scale (0 = Strongly disagree; 100 = Strongly agree), with space for comments. The survey was active from Sept 2024 to Feb 2025.

Results: There were 1,013 participants, with 91 from remote (MM6) and 65 from very remote (MM7) QLD. Participants overall ranked the two most serious workforce gaps as dental practitioners and psychologists. Remote participants reported psychologists as the most serious workforce gap, whereas very remote participants indicated dental practitioners. Remote participants ranked general practitioners second while very remote participants ranked it twelfth. Very remote participants ranked exercise physiologists as fifth, whereas remote participants ranked it fifteenth. Participant comments will also be discussed.

Conclusion: Practitioner/manager perceptions of workforce gaps were found to differ between remote and very remote practitioners reflected by ranking variations. This implies that remote and very remote communities have different workforce needs and that consideration of perceptions of the existing workforce may assist in developing workforce models that are tailored to specific communities. Innovative models that incorporate both community health needs and practitioner/manager perceptions may warrant investigation.

Developing a framework to support the delivery of high quality Australian rural clinical placements

Presented by Catherine Seaton

MURTUPUNI CENTRE FOR RURAL AND REMOTE HEALTH, JAMES COOK UNIVERSITY

List of authors

Elyce Green[1], Claire Quilliam[2], Jane Ferns[3], Melba Ridd[4], Catherine Seaton[5], Rohan Rasiah[6], Lyndal Sheepway[7], Leigh Moore[4], Jodie Bailie[8,9], James Debenham[10], Carolyn Taylor[7], Kathryn Fitzgerald[6]

Author Institution/s

1. Charles Sturt University, Wagga Wagga
2. Department of Rural Health, The University of Melbourne
3. Department of Rural Health, The University of Newcastle
4. Flinders University Rural and Remote Health, Flinders University
5. Murtupuni Centre for Rural and Remote Health, James Cook University
6. Western Australian Centre for Rural Health, The University of Western Australia
7. La Trobe Rural Health School, La Trobe University
8. University Centre for Rural Health, The University of Sydney
9. School of Public Health, The University of Sydney
10. Majarlin Kimberley Centre for Remote Health, The University of Notre Dame

Abstract:

Background: For over 25 years, the Australian Government has funded University Departments of Rural Health (UDRHs) under the Rural Health Multidisciplinary Training (RHMT) program to deliver clinical placements in regional, rural and remote regions of Australia. Rural clinical placements contribute to student learning, enhancing rural health service capacity and attracting future rural health workforce, however understanding what constitutes a high-quality rural placement is important for enhancing these outcomes.

Aims: This study aimed to develop a framework which can be applied by UDRHs to guide the design, implementation, and evaluation of rural clinical placements.

Methodology: This project integrated the findings from three studies to develop a framework to support the delivery of high quality rural clinical placements. The three studies included a scoping review, an explanatory sequential mixed-methods study involving university staff experienced with health student placement delivery, and a multiple-case Employing COnceptUal schema for policy and Translation Engagement in Research (ECOUTER) study which captured determinants that contribute to the development of high-quality health student placements from the perspective of UDRH staff. Through a rural lens and with consideration of experiential education theory, the findings of these studies were combined using content analysis to develop the framework.

Results: The framework includes components related to learning in a rural place, rural community and collaborations, pedagogy, student allocation and advocacy, and placement infrastructure, student support and safety. The framework will enable UDRHs to design, facilitate and coordinate high quality rural clinical placements across regional, rural and remote Australia.

Conclusion: This study resulted in the development of an evidence-informed framework for high quality rural clinical placements. The framework can be used by the Australian Government and other placement stakeholders, including UDRHs, to guide and evaluate practice. Further research exploring the experiences and perceptions of other stakeholder groups is planned.

Getting them to train rural – initiatives and policy levers that have impact

Presented by Dr Michael Clements and Dr Cindi Jackson

ROYAL AUSTRALIAN COLLEGE OF GENERAL PRACTITIONERS

List of authors

Dr Michael Clements[1], Dr Cindi Jackson[1], Rebecca Towns[1], Kristie Forrest[1]

Author Institution/s

1. Royal Australian College of General Practitioners

Abstract:

Background: Health workforce is an ongoing challenge in rural and remote communities. High quality primary care is crucial to healthy communities and there is a maldistribution of the general practice workforce that impacts rural and remote communities the most. With the transition to college-led training in 2023, the RACGP has had increased control on initiatives and policy levers designed to improve registrar distribution. Distribution of registrars between general and rural pathways and across MM2-7 communities is a key performance indicator for the government funded Australian General Practice Program.

Aims: This session will cover an overview and evaluation of the effectiveness of RACGP's workforce planning strategies, particularly the combined use of financial incentives and compulsory distribution measures. It also explores the role of external factors such as the single employer model (SEM) and rural initiatives.

Methodology: The RACGP has deployed a number of strategies across Queensland, including financial incentives between $5,000 and $45,000 per six-month community general practice based placement for registrars in identified high priorities of workforce need. In June 2024, North West Queensland joined South East Queensland in an open market placement model, using practice caps and region groupings to ensure broader distribution. The shift to practice caps has enabled a more equitable distribution of registrars across training practices within a regional group.

Other focal areas include one-on-one case management via Training Coordinators (TCs) and Medical Educators (MEs), targeted rural placement webinars, registrar rural excursions, increased promotion of the benefits of rural training to all registrars, and engagement with community leaders to support long-term workforce sustainability. The role of SEM, as seen in Kingaroy, is also examined in supporting rural and regional attraction.

Results: Early data shows improved registrar distribution across Queensland. In the 2024.2 term, only 18 registrars were placed in incentivised locations (high priority areas of workforce need) across 24 training sites. However, in the 2025.1 term, this number increased significantly to 57 registrars in 39 training sites. This demonstrates that the increased focus on workforce distribution through a complementary mix of initiatives, incentives, collaboration and policy levers is having a growing impact resulting in increased numbers of registrars training in rural locations that have struggled to attract them previously. There has been mixed feedback on the introduction of caps – there are winners and losers. Practices that have been set up for training large numbers of registrars in regional centres have been disadvantaged by caps and there has been some confusion around the process in north west Queensland which had previously been used to a registrar matching process. It is also important to consider these strategies with a future focus – we need to ensure sustainability in the model to support training the increased numbers of registrars.

Conclusion: Whilst these strategies have improved registrar distribution, we need to continuously adapt and work with communities to ensure long-term attraction and to identify opportunities to impact on rural retention post fellowship. The presentation at AYRI aims to share the learnings and then open the floor for a impactful discussion with stakeholders recognising that securing a registrar in a rural placement is just the first step—keeping them there is the real challenge.

Scientific Program, Session 6B

Culturally safe workplaces: supporting social-emotional wellbeing of First Nations health staff

Presented by Rhiannon Dooley

JAMES COOK UNIVERSITY

List of authors

Rhiannon Dooley[1], Maryann Ansey[1], Sandy Campbell[1], Catrina Felton-Busch[2], Lisa Gibson[1], Stephanie King[1,2], Kristin McBain-Rigg[1], Shaun Solomon[2]

Author Institution/s

1. James Cook University
2. Murtupuni Centre for Rural and Remote Health, James Cook University

Abstract:

Background: The First Nations health workforce is critical in improving First Nations health outcomes, particularly in rural and regional communities. However, First Nations staff within Hospital and Health Services (HHSs) often experience racism, isolation, high cultural load, and lateral violence, which can negatively impact their mental health. Cultural safety in the workplace is a key enabler of emotional and psychological wellbeing, mitigating the risk of cultural burnout, and enhancing staff retention. In the context of workforce shortages and commitments towards achieving employment equity, there is a pressing need for organisational strategies that embed culturally safe supports for First Nations staff.

Aims: To improve access to culturally safe social-emotional wellbeing (mental health) supports for First Nations HHS staff.

Methodology: Using a participatory action research approach, co-designed strategies are being implemented through an HHS-JCU partnership. These include:

- Procuring a First Nations Employee Assistance Program (EAP) service
- Establishing a Cultural Mentoring program for First Nations staff
- Creating a peer support network for new First Nations staff

The project is grounded in First Nation's research principles including self-determination and reciprocity. A mixed-methods process and outcome evaluation will be conducted, drawing on workforce data, surveys, interviews, and document analysis.

Results: Anticipated results:

- Establishment of a First Nations EAP service
- Implementation of cultural mentoring and peer support programs
- Enhanced capacity of First Nations staff to manage complex workplace challenges
- Reduced cultural load and risk of cultural burnout
- Decreased feelings of isolation amongst staff
- Improved staff retention

Conclusion: If successful, this initiative will enhance the social-emotional wellbeing of First Nations staff and provide culturally safe workforce practices that HHSs across Queensland, and Australia, can replicate. Embedding these organisational strategies can contribute to staff retention, health equity, and improved health outcomes for First Nations peoples.

Case Study: Place-based health planning in a remote NQ community

Presented by Dr Karen Johnston

JAMES COOK UNIVERSITY

List of authors

Dr Kaz Johnston, Dr Deb Smith[1], Mrs Catherine Wilkes[1], Ms Mim Crase[1], Christopher Rouen[1], Stephanie Topp[1], Maxine Whittaker[1], Alex Edelman[1], Sarah Larkins[1]

Author Institution/s

1. James Cook University

Abstract:

Background: The four-year Integrating Health Care Planning in North Queensland project aimed to improve responsiveness of health services to local community health needs and complement regional health service led planning. In Phase 2, place-based health planning was carried out in three communities: Clermont, Hughenden and Kowanyama. This approach utilised local knowledge and data, while also considering a community's environmental, cultural, social, and demographic characteristics. This presentation will focus on a case study in the remote community of Clermont.

Aims: The project explored how to best develop and implement integrated place-based planning for health services in the unique contexts of North Queensland.

Methodology: The co-design process involved local and regional stakeholders, and self-nominated community members. It was carried out over four steps through workshops and individual meetings. These discussions resulted in a prioritised action plan, with implementation of agreed upon actions led by the local Project Support Officer. Actions were evaluated where possible, with success defined by participants' own experiences and significant changes.

Results: The co-design process resulted in a comprehensive place-based health plan for Clermont. Prioritised actions included strengthening connections between stakeholders; improved access to information and services; and growth of peer support networks. Project outcomes included publication of a local service directory, (re)establishment of an interagency health-focused meeting, and community-led advocacy for a community healthcare navigator. Perceived significant changes included increased child health and maternity services, increased community awareness and accessibility of various services, and better coordination, collaboration and connection among service providers.

Conclusion: Place-based health planning was well received and effective in the Clermont community. Participants valued the opportunity to engage over time with open and productive conversations in a respectful, comfortable environment. Actions resulted in some sustainable changes in the community. The place-based health plan provides evidence for local community organisations and residents to advocate for further change.

Short-term fixes, long-term gaps: rural health workforce policy in Queensland and Australia

Presented by Thu Nguyen

COLLEGE OF MEDICINE AND DENTISTRY, JAMES COOK UNIVERSITY

List of authors

Stephanie M. Topp[1], Thu Nguyen[1]

Author Institution/s

1. College of Medicine and Dentistry, James Cook University

Abstract:

Background: The federal government's 2018 Stronger Rural Health Strategy (SRHS) aimed to strengthen the rural and remote health workforce (HWF) under the broad themes of 'teach', 'train', 'recruit' and 'retain'. Despite this national commitment, long-standing challenges in HWF availability, recruitment and retention remain across Australia's rural and remote regions.

Aims: This study examined the status and characteristics of rural and remote HWF policy at both federal and state (Queensland) level, comparing relative emphasis on the strategic domains of HWF supply, distribution and performance.

Methodology: Rural HWF policy documents were identified and extracted from websites of the federal Department of Health and Aged Care, Queensland Health and other relevant bodies. Documents were coded for demographic data, policy type, health profession and service focus, and overarching strategic focus.

Results: At total of 108 documents (71 federal; 37 state) were identified. Federal policy is dominated by short-term (3-5 year) mixed instruments—grants, programs, and sub-programs—including initiatives under the SRHS. A large proportion focuses on supply of medical doctors and nursing professionals. Queensland policy places greater emphasis on HWF retention, via incentives contained in employment policies such as financial allowances, leave, development opportunities and workload management. Neither federal or state policy substantively address well-documented drivers of retention linked to broader social, cultural and work environment factors. HWF policy in both state and federal jurisdictions tended to frame performance narrowly, privileging individual or professional, over system-level outcomes.

Conclusion: Despite the presence of SHRS, findings highlight the complexity and underlying fragmentation of Australia's rural HWF policy. The co-existence of multiple federally driven programs and grants alongside state-level employment policy makes it difficult to track the full scope and impact of HWF policy in rural and remote regions. Greater cross-jurisdictional coordination with clearer alignment of individual policies to system-wide (versus health professional) performance goals is needed

Join us in our vision for *Healthier Western Queensland Communities*

Western Queensland Primary Health Network is an independent, not-for-profit organisation funded by the Australian Government to streamline health services, particularly for those at risk of poor health outcomes, and to ensure people receive the right care, in the right place, at the right time.

Our Core Services

We're driving healthcare reform aligned to the quintuple aim for better health, care experience, cost-efficiency, provider wellbeing, and equity, by:

- **Coordinating** and integrating local health services with Hospital and Health Services to improve care quality, experience, and efficiency.
- **Commissioning** services in primary care and mental health to meet local needs and improve access and equity.
- **Capacity-building** primary care providers through practice support and workforce development.

Our Impact

Together with our partners, we have supported communities and healthcare providers through key initiatives that bring us closer to our vision, including:

- **Healthy Outback Communities** – locally led, place-based health and wellbeing services for very remote populations.
- **WQ Nursing Futures Program** and **GP Workforce Planning & Prioritisation Program** – strengthening a local, skilled workforce and supporting pathways to grow our own.
- **Primary Sense** clinical decision support tool, and **HealthPathways** - informing quality outcomes for patients and families.

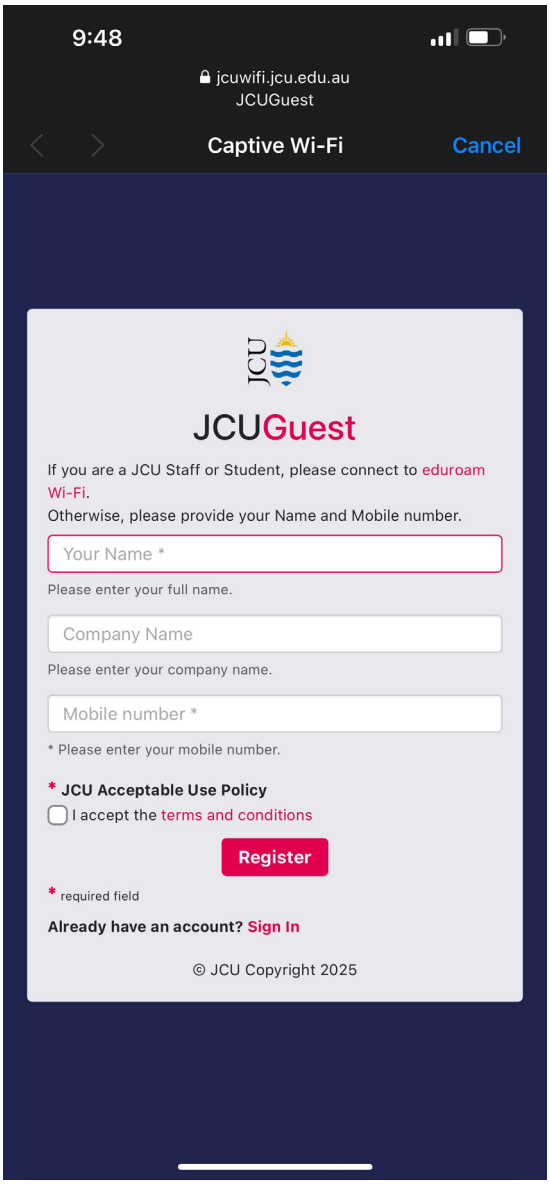
For more information about our role in supporting health and wellbeing services across Western Queensland, visit:

WQPHN.COM.AU

phn WESTERN QUEENSLAND

An Australian Government Initiative

EDUROAM WIRELESS SETUP GUIDE



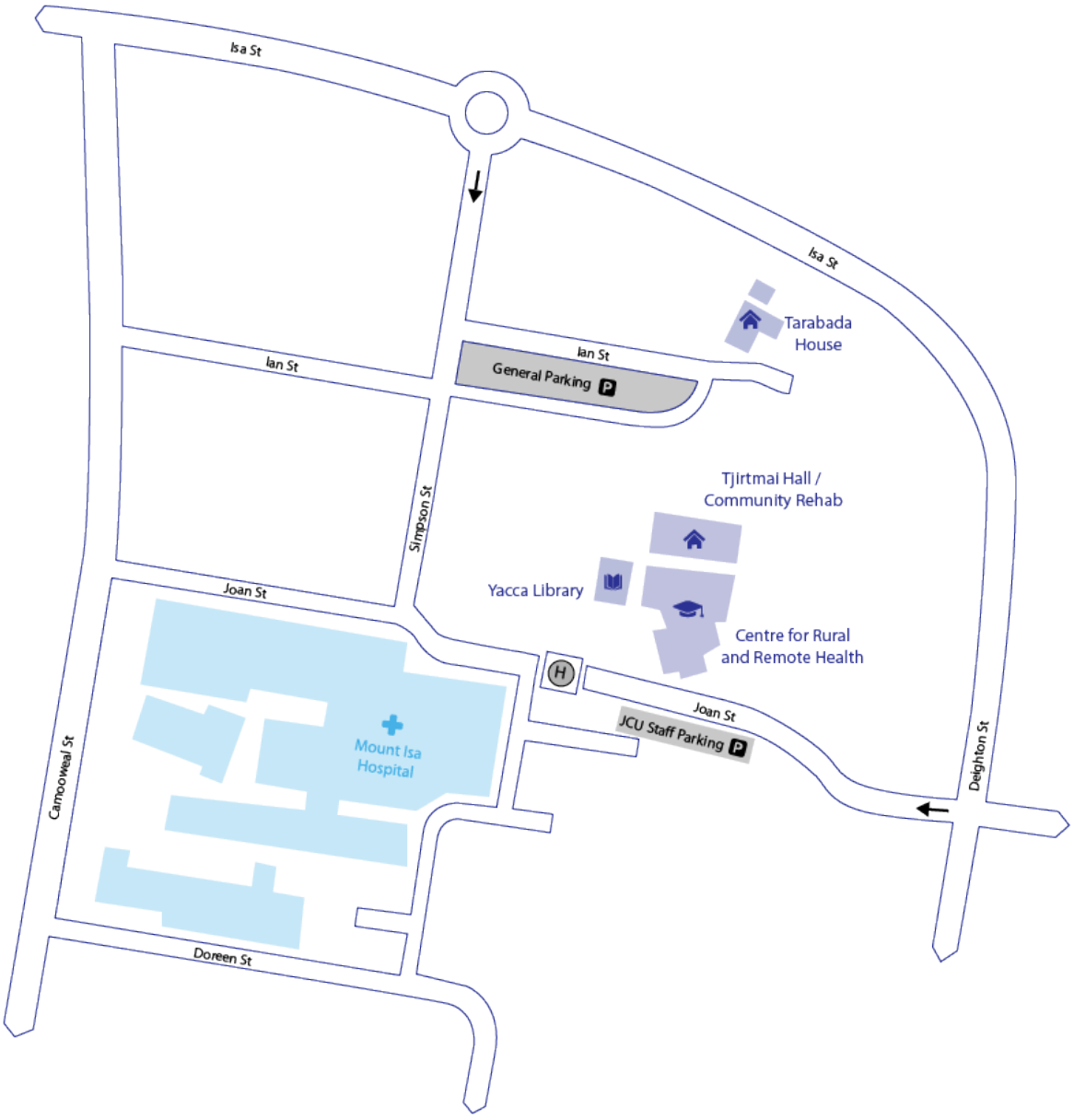
GETTING CONNECTED TO WIRELESS

James Cook University provides wireless connectivity to its Students, Staff and visiting academics from other supported institutions through eduroam. It has never been easier to stay connected across all areas of our campuses and remote sites with your laptop or other portable device.

For instructions on how to configure your computer for the Eduroam Wireless Network use the QR code.

Murtupuni Centre for Rural & Remote Health

Mount Isa Hospital, 100 Joan Street, Mount Isa QLD 4825




REGISTRATION
Day 1
TJIRTAMAI
COMMUNITY HALL
REGISTRATION
Day 2
Zonta
Coffee Cart
YACCA
LIBRARY
STUDENT
BREAKOUT
ROOM
MAIN BUILDING
CESU LABS
&
DEBRIEF
ROOM
BUILDING
ENTRY
TEA
ROOM
AMENITIES
Undercover
seating area
PRESENTERS
ROOM
WEST
BOARD
ROOM
LECTURE
ROOM 1
BBQ
AREA
AYRI Information Centre
Toilets
Food/Coffee Stations
Breakout Rooms
NOT TO SCALE

"Are You Remotely Interested...?"

THANK YOU

crrh.jcu.edu.au

FOLLOW US ONLINE!

Facebook: CRRHJCU

Instagram: crrh_jcu

JAMES COOK UNIVERSITY AUSTRALIA

MURTUPUNI CENTRE FOR RURAL & REMOTE HEALTH