WESTERN NSW HEALTH RESEARCH NETWORK

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RESEARCH SYMPOSIUM

Innovating for Health Equity

BRIDGING GAPS IN RURAL HEALTHCARE

ABSTRACT BOOKLET



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Morning Concurrent Session

Building the Rural Health Workforce: Leadership, Education and Innovation

Advancing nursing leadership for health equity: exploring the lived experience of advanced practice nurses in rural New South Wales

Presenter: Luke Marks

Authors and affiliations

1. Mr Luke Marks, Western NSW LHD | Charles Sturt University
2. A/Prof Jessica Biles, Charles Sturt University
3. Professor Samantha Jakimowicz, Charles Sturt University
4. Professor Linda Deravin, University of Southern Queensland | Charles Sturt University

Abstract

Background and Aims: Nursing leadership is often framed in terms of competencies, frameworks, and organisational roles; however, there is limited understanding of how leadership is experienced in practice, particularly in rural and regional healthcare contexts. This gap is significant in settings where workforce limitations, access constraints, and service demands directly impact care delivery and health equity.A recent scoping review identified that leadership is shaped by organisational context rather than theory alone, and that rural perspectives are largely absent from the existing literature. Building on this, the aim of this study is to explore the lived experience of leadership among Advanced Practice Nurses (APNs) across Western NSW and Far West Local Health Districts, with a focus on how leadership is enacted in everyday practice and how it contributes to addressing challenges in rural healthcare delivery.

Methods: This study is informed by hermeneutic phenomenology and explores leadership as it is experienced in practice. Participants include Advanced Practice Nurses working across WNSW and FW LHDs. Data are being collected through in-depth, semi-structured interviews conducted via online platforms and analysed through iterative, interpretive processes. The research is shaped by the researcher's position as a Wiradjuri nurse leader with senior oversight of APN roles across the district. This positioning informs a relational and contextually grounded approach to understanding leadership as embedded within practice, community, and responsibility.

Results: Data collection is currently underway. Findings are expected to provide insight into how leadership is experienced in practice, including how APNs navigate competing clinical, organisational, and system-level demands within resource-constrained environments. The study is also expected to generate context-specific insights into leadership within rural and remote settings, including how leadership is enacted to maintain service delivery, support teams, and respond to community needs.

Implications: This study addresses a gap in the literature by examining leadership as lived experience within rural healthcare systems. By focusing on Advanced Practice Nurses across WNSW and FW LHDs, it aims to generate insights that are directly relevant to local service contexts. Understanding leadership as relational, context-dependent, and embedded in practice provides a foundation for developing more responsive leadership approaches that support workforce sustainability and contribute to improving health equity in rural and remote communities. This positions leadership not only as a workforce function, but as a critical mechanism for addressing inequities in access, coordination, and quality of care across rural health systems.

What are the experiences and outcomes for health students undertaking long term placements in rural or regional areas?

Presenter: Elise Ryan

Authors and affiliations

1. Ms Elise Ryan, Charles Sturt University
2. Dr Sharon Laver, Charles Sturt University
3. Ms Taylor Barton, Charles Sturt University
4. MS Keden Montgomery, Charles Sturt University

Abstract

Background and Aims: To explore experiences of health discipline undergraduate students undertaking long-term rural or regional placements and identify associated educational, personal, and socioeconomic outcomes.

Methods: A scoping review was undertaken, following the JBI scoping review methodology, to identify and map existing evidence about experiences and outcomes of health discipline students undertaking long-term rural or regional placements. Relevant studies will be identified through systematic database searches.

Results or expected outcomes: Identifying factors that influence student satisfaction, learning outcomes, and future workforce intentions. Results may identify placement characteristics that contribute to positive rural workforce outcomes.

Implications: This review identify key influences on long-term rural and regional placements for undergraduate health science students. The findings support recommendations to offer a variety of rural and regional placement models to support student success and, potentially build a capable and sustainable rural health workforce.

Towards a Homegrown Workforce: Evaluation of the implementation of a Dermatology training pathway in Western NSW

Presenter: Pip Southwell

Authors and affiliations

1. Dr Pip Southwell, Western NSW Regional Training Hub

Abstract

Background and Aims: Rural and regional communities continue to experience inequitable access to specialist care, driven in part by metro-centric training pathways that limit workforce distribution. In Western NSW, a dermatology training model was established to enable trainees to complete the majority of their specialty training locally. This initiative aimed to address workforce maldistribution by embedding training in-region and strengthening long-term retention. This project included an evaluation the implementation of this rural-centric training model, with a focus on understanding how the use of a Consortium model of stakeholder engagement could support equitable access to specialist care.

Methods: A concurrent evaluation framework was applied over the first two years of implementation, combining service-level data with qualitative inquiry. Project development was mapped against national rural workforce priorities and funding requirements. Semi-structured interviews were conducted with project stakeholders from 2024 - 2026. Data were analysed using iterative thematic and framework approaches to identify key implementation processes, enablers, and system-level barriers across the consortium model. . The initiative is funded by the Australian Government Department of Health, Disability and Ageing through the Flexible Approaches to

Training in Expanded Settings program, administered through the Australasian College of Dermatologists (ACD).

Results: Two years of a four-year training pathway has been successfully implemented with trainees now embedded in Western NSW. The pathway has rolled out across diverse training settings, including public hospitals, Aboriginal Medical Services, private practices, and outreach services. Key implementation outcomes included increased Specialist Training Program-funded positions, expanded site accreditation, strengthened supervision capacity, and supported trainee relocation into the region. Critical enablers included strong local professional networks, and place-based leadership underpinned by strong buy-in and leadership from ACD. Structural complexities, including variable stakeholder authority, competing service priorities, and accreditation and governance processes have required coordination across a highly fragmented system. Workforce constraints, supervisory capacity, and reliance on local professional relationships posed ongoing risks to scalability.

Implications: This evaluation demonstrates that rural-centric specialist training models are feasible and can be effectively implemented through a coordinated, consortium-based approach. Embedding training within rural systems can strengthen workforce pipelines and contribute to improved health equity. Importantly, successful implementation depends on sustained partnership models and a recognition of the relational and structural complexities inherent in rural health systems. These findings provide practical insights for scaling similar models nationally including a publicly available model and resource for the development of rural-centric training pathways based on the learnings from this project.

Generative AI in Regional Clinical Practice: Building the Evidence Base for Collaborative Governance in Rural Health

Presenter: Madeleine Tropman

Authors and affiliations

1. Dr Madeleine Tropman, Wagga Wagga Base Hospital
2. A/Prof Joseph Suttie, Wagga Wagga Base Hospital

Abstract

Background and Aims: Generative artificial intelligence (generative AI) is entering clinical workflows globally, yet governance frameworks have failed to keep pace. Regional and rural health services face a particular challenge: elevated administrative burdens and limited specialist access make these tools appealing, while constrained governance infrastructure leaves clinicians navigating complex medico-legal terrain without institutional support. Despite this, the experiences of rural clinicians remain largely uncharacterised in the literature. This study aimed to describe the patterns of generative AI use, attitudes, and barriers among hospital medical clinicians at Wagga Wagga Base Hospital, Murrumbidgee Local Health District.

Methods: A cross-sectional survey was conducted over one month, inviting all medical clinicians across specialties and seniority levels (n=40). Quantitative items included multiple-choice and five-point Likert scales; free-text responses were analysed thematically. Domains covered professional generative AI use, tool type, device, confidentiality practices, output verification, perceived benefits and risks, barriers, policy awareness, and predicted future use.

Results: Most participants had previously used a generative AI tool (92.5%), with 57.5% reporting professional use. ChatGPT dominated (85%), accessed almost exclusively via personal devices; no participant used a work device alone. Perceived usefulness was moderate (mean 3.37/5) and views on patient care benefit were mixed (mean 3.30/5), with 22.5% rating generative AI as potentially harmful to care quality. Confidence in AI output accuracy was low (mean 2.73/5), contrasting with

higher confidence in self-verification (mean 3.53/5), a divergence with patient safety implications. The principal barriers were data privacy (65%), medico-legal concerns (62.5%), and absence of institutional policy (52.5%). Strikingly, 95% of participants were unaware of any applicable governance guidance, despite the NSW Health AI Framework being published concurrently with the survey period.

Implications: Clinicians at a regional hospital are already using generative AI professionally, largely outside institutional oversight and without awareness of applicable governance. The barriers identified are structural rather than individual and cannot be resolved by any single health service. A networked response is required: collaborative, multi-site surveillance of AI adoption across rural services; jointly developed governance and training frameworks; and coordinated advocacy for data-secure, institutionally endorsed tools. This study contributes one piece of a regional evidence base that the Western Health Research Network is well-placed to build and expand.

Innovating Within Rural Medical Education to Advance Health Equity

Presenter: David Schmidt

Authors and affiliations

1. Dr David Schmidt, University of Sydney, School of Rural Health
2. Dr Christopher Hayward, University of Sydney, School of Rural Health
3. A/Prof Paul Lunney, University of Sydney, School of Rural Health

Abstract

Background and Aims: Health inequities between rural and metropolitan communities are well recognised and are closely linked to workforce distribution, access to care and continuity of services. Rural medical education sits at the intersection of these challenges, reflecting the realities of limited subspecialisation, geographical isolation and constrained resources that characterise rural healthcare delivery. The challenge of relative isolation and resource limitation both allows and requires innovation to provide positive educational experiences, grounded in the distinctive educational strengths offered by rural contexts.Rural medical educators are predominantly part time, working across clinical and educational roles. This dual identity is central to sustaining rural training pathways and promoting workforce retention. However, the roles, responsibilities and pedagogical approaches of rural medical educators have not been well described. This study aimed to explore how rural medical educators describe their roles and responsibilities. In this presentation we look to explore how rural medical educators innovate within context to support equitable education.

Methods: This presentation reports findings from a mixed methods study exploring rural medical education. We surveyed 79 rural medical educators and conducted semi structured interviews with 20 rural medical educators and key informants across Australia. Surveys were online using Qualtrics, while interviews were undertaken via Microsoft Teams and analysed using a cut and paste coding technique. Iterative thematic analysis was conducted collaboratively using Microsoft Whiteboard, enabling reflexive discussion and refinement of themes.

Results: Ensuring an equitable educational experience for rural medical students, doctors-in-training and the medical educator themselves was identified as a responsibility of rural medical educators and their employing institution. Equity was seen as more than attempting to replicate urban models with online content, with educators open to maximise the unique opportunities to engage with rural communities and create positive learning cultures. Rural medical educators apply a diverse range of educational approaches including problem-based learning, gamification and mentoring to foster curiosity and encourage a respect for rural practice. This not only enhances rural medical education, but also creates potential for rural careers which benefit both the medical profession and the communities they serve.

Implications: Rural medical educators play a critical role in advancing health equity by preparing a workforce equipped for the realities of rural practice. By leveraging contextual knowledge, generalist expertise and flexible pedagogies, rural clinician educators innovate to bridge gaps in rural healthcare delivery. Recognising and supporting this workforce is essential to sustaining equitable, high quality rural health systems.

Digital Rural Health: Connecting Communities, Clinicians and Expertise

Implementation of a novel telehealth intervention supporting expert wound care delivery into rural residential aged care

Presenter: Heather Russell

Authors and affiliations

1. Dr Heather Russell, School of Rural Health, The University of Sydney
2. Dr Annie Banbury, Coviu Global Pty Ltd
3. Prof Michelle Barakat-Johnson, Susan Wakil School of Nursing, the University of Sydney
4. Prof Meredith Makeham, Faculty of Medicine and Health, the University of Sydney
5. A/Prof Georgina Luscombe, School of Rural Health, the University of Sydney

Abstract

Background and Aim: Chronic wounds affect nearly half a million Australians and cost the healthcare system more than AU$6 billion annually. These wounds, which do not heal as expected, disproportionately affect people living in residential aged care homes (RACHs). Specialist wound care can improve outcomes, but access is challenging for rural and aged care residents. Virtual wound care has the potential to overcome access gaps, but current interventions lack seamless video telehealth integration. This study assesses the benefits, costs and factors associated with successful implementation of WoundView, an innovative computer vision-based artificial intelligence (AI) wound analysis tool embedded in a video telehealth platform, bridging the gap between aged care residents and specialist wound care.

Methods: An observational cluster stepped-wedge implementation study using mixed methods is being undertaken at four Western NSW RACHs. RACHs commenced the intervention sequentially after receiving WoundView training. Residents with chronic wounds present for three or more weeks are eligible to participate. Manual and AI wound measurements and health-related quality of life (HRQoL) surveys are collected at baseline and end of study. During the study, wound measures and patterns of WoundView usage are collected. Semi-structured interviews and surveys with residents, RACH staff and wound specialists are being used to gauge user satisfaction.

Results: Study outcomes are based on the RE-AIM (reach, effectiveness, adoption, implementation, maintenance) framework. WoundView's reach will be measured by the proportion of target population and RACHs who participate. Technical effectiveness will be assessed using accuracy and reliability data from AI wound measurements, and HRQoL measures and wound outcomes will inform clinical effectiveness. Acceptability, adoption, and costs of WoundView are also being evaluated along with maintenance of the intervention by intention for ongoing use after study completion. RACH recruitment has been affected by the introduction of the Strengthened Aged Care Standards and ongoing workforce shortages and turnover. Partnerships with local RACHs, WNSW Primary Health Network and wound specialists have been critical to enhance recruitment in the region.

Conclusion: WoundView's implementation is expected to lead to better access to specialist care, earlier wound intervention, and improved wound outcomes for rural and aged care residents. The

outcomes of this study will inform our understanding of virtual care acceptability, assess real-world uptake and demonstrate the value of virtual care research in rural RACHs, an understudied setting.

Recommendations for how to improve access to comprehensive primary health care in remote communities using digital technologies

Presenter: Tim Shaw

Authors and affiliations

1. Prof Tim Shaw, University Of Sydney
2. A/Prof Deborah Russell, Menzies School of Health Research
3. Dr Vishnu Khanal, Menzies School of Health Research
4. Dr Emily Saurman, University of Sydney
5. Dr Josielli Comachio, University of Sydney
6. Dr Amy Von Huben, University of Sydney
7. Ms Karina Coombes, Menzies School of Health Research
8. Prof Sarah Norris, University of Sydney

Abstract

Background and Aims: Access to comprehensive primary health care improves health outcomes for remote Aboriginal and Torres Strait Islander communities. While the use of technology in communities is widespread, there is a lack of clear recommendations regarding how consistent, cross-jurisdictional strategies can be applied to support the sustainable application of digitally supported models of care in remote locations. This abstract reports on findings from a multi-partner, four-year program of research in the Northern Territory.

Methods: A participatory-based research methodology was employed across this program of research to define a core set of recommendations to increase access to comprehensive primary healthcare using digital health in remote communities. Project partners include NT Health, The Department of Health Disability and Ageing, Healthdirect, the Australian Digital Health Agency, NT PHN, Aboriginal Medical Services Alliance NT (AMSANT), The University of Sydney and Menzies School of Health Research. The program worked in close partnership with four remote communities in the NT and included community-based researchers. Thought leader interviews were conducted across Australia. Extensive community and provider consultations were held regarding preferences for the use of digital technologies to improve access to care and a range of new or existing hybrid models of care were evaluated.

Results: Through a consensus process across partners, a series of recommendations, priority areas and targeted action items have been defined across workforce, practice, community engagement, technology and funding. These recommendations have been mapped against existing policies and responsibility for enacting each action item has been defined.

Conclusion: The recommendations derived from this project provide a clear roadmap for the systematic application of digitally supported models of care to increase access to comprehensive primary healthcare and have been endorsed by the partners responsible for their realisation.

Rural–Urban Differences in Virtual Oncology Care Use and Associated Patient, Clinical and Service-Related Factors Across Three Australian States

Presenter: Ramya Walsan

Authors and affiliations

1. Dr Ramya Walsan, Australian Institute of Health Innovation
2. Prof Rebecca Mitchell, Australian Institute of Health Innovation
3. Dr Huah Shin Ng, Flinders University
4. Dr Tim Badgery Parker, Australian Institute of Health Innovation
5. Prof Reema Harrison, Australian Institute of Health Innovation

Abstract

Background and Aims: Geographic inequities in cancer outcomes remain a major concern in Australia, where rural patients often face substantial travel, cost and service access barriers. Virtual oncology care may help reduce these barriers, but its use across rural and urban populations remains poorly understood. This population-based retrospective cohort study examined geographic differences in virtual oncology consultations among adults with cancer receiving public outpatient oncology care in New South Wales, Victoria and Queensland between 2018 and 2022. Secondary analyses explored variation by consultation modality, including telephone and video consultations.

Methods: A population-based retrospective cohort study of adults aged ≥18 years with a confirmed cancer diagnosis who received public outpatient oncology care in New South Wales, Victoria or Queensland between 1 January 2018 and 31 December 2022 was conducted. Linked outpatient, cancer registry, hospital admission and mortality data were used. Virtual care was defined as oncology consultations delivered by telephone or video during 24 months of follow-up. Rurality was classified using the Australian Statistical Geography Standard. Negative binomial regression estimated adjusted associations between rurality of residence and virtual consultation use, accounting for demographic, clinical, socioeconomic and jurisdictional factors.

Results: The cohort included 334,505 patients. Rural patients had fewer outpatient encounters overall than urban patients but received more virtual consultations. After adjustment, rural residence was strongly associated with higher virtual oncology care use, with rural patients having more than three times the rate of virtual consultations compared with urban patients (IRR 3.67, 95% CI 3.44–3.92). The adjusted mean number of virtual oncology consultations over 24 months was 6.39 for rural patients and 3.62 for urban patients. Rural patients had higher rates of both telephone consultations (IRR 3.49, 95% CI 3.26–3.73) and video consultations (IRR 6.10, 95% CI 5.23–7.11). Virtual care use also varied by age, country of birth, comorbidity, socioeconomic status, cancer type and state.

Conclusion: Rural patients with cancer used virtual oncology care substantially more than urban patients, suggesting that virtual care is an important access mechanism for geographically dispersed populations. However, variation by age, socioeconomic status, cancer type and jurisdiction highlights the need to address digital inequities and support equitable integration of virtual care into routine oncology service delivery.

Enhancing Health Access: Preparing the Health workforce for digital health and Virtual Care

Presenter: Rachel Rossiter

Authors and affiliations

1. Prof Sharon Brownie, Charles Sturt School of Rural Medicine
2. Associate Prof Andrew Dimech, Peter MacCallum Cancer Centre
3. Dr Patrick Broman, Curtin University
4. Dr Lauren Parkinson-Zarb, University of Melbourne

Program and submission difference: The scheduled presenter differs from the submission contact.

Abstract

Background and Aims: Virtual healthcare, originating from telephone-based service delivery, has rapidly evolved into a widely adopted model of care and is increasingly used to improve equity of access to health services. Despite the rapid expansion of virtual healthcare delivery, the literature highlights limited integration of virtual care practice into health professional education, contributing to a substantial gap between education and clinical practice. Aims were to identify: 1) clinical guidelines supporting health professionals undertaking routine virtual health assessments, triage, and follow-up care; and 2) educational curricula designed to prepare health professionals for virtual care delivery. Informed by the literature, the study will also collect qualitative data and undertake co-design activities within a major cancer treatment service to define core competencies and develop curriculum content for nurses participating in telehealth clinics.

Methods: This phased, multi-method study includes reviews of existing literature followed by qualitative in-depth interviews. The project aims to inform the development and implementation of telehealth guidelines and an accompanying educational syllabus.

Results: Literature reviews indicate a limited availability of evidence-based guidance for virtual health assessment and highlight the urgent need for telehealth competency frameworks and curricula for health professionals in both training and clinical practice. Qualitative interviews will provide contextual insights to support the development of practice guidelines and educational resources (data collection and analysis will be completed by the time of conference presentation).

Conclusions: Collaboration with health providers, consumers, and academics in the development of standards and educational resources will help ensure the future nursing workforce is equipped to meet the growing demand for virtual care. Completion of this project will address a current gap in both practice guidance and professional education for health professionals delivering virtual care.

Sleeve, Snap, Send: validating image-based assessment of breast cancer-related lymphoedema as a rural tele-health detection tool.

Presenter: Prithi Ashok Murthy

Authors and affiliations

1. Miss Prithi Ashok Murthy, University of Sydney
2. Dr Brenda Svensson, NSW Health
3. Dr Nicola Fern, University of Sydney
4. A/Prof Emma Webster, University of Sydney

Abstract

Background and Aims: Breast cancer-related lymphoedema (BCRL) is one of the most feared long-term complications of breast cancer treatment, causing reduced function and psychological distress.

Early detection is critical in preventing progression to a permanent, debilitating condition, yet current detection tools rely on specialist clinics that are scarce outside major cities, creating health equity gap that falls hardest on those in rural and remote Australia. The Whole Arm Pitting Oedema Test (WArP~iT), a low-cost ribbed compression sleeve worn for ten minutes, leaves visible skin corrugations in arms affected by BCRL; in a preliminary in-person study it detected all known cases and agreed closely with established measures. This project determines whether image-based WArP~iT assessment is concordant with in-person assessment, and whether lymphoedema-specific clinician training affects that concordance, to evaluate its potential as a remote telehealth detection tool.

Methods: In this inter-rater reliability and agreement study, lymphoedema-trained clinicians (via the Australian Lymphoedema Professionals Group) and non-specialist clinicians (via Dubbo Base Hospital) independently assessed standardised WArP~iT photographs of both arms from 25 women in the in-person study (50 arms), classifying each arm in REDCap as positive, negative, or unable to determine. Agreement with the in-person reference standard used percentage agreement, Fleiss' and pairwise Cohen's kappa, and diagnostic accuracy (sensitivity, specificity, predictive values); a mixed-effects logistic regression tested whether training predicted agreement.

Results: Data collection is ongoing; this interim analysis includes 39 raters (22 trained, 17 non-specialist) who assessed all 50 arms. Image-based assessment showed substantial agreement with in-person assessment (Fleiss' kappa = 0.67, 95% CI 0.66–0.68), near-identical in trained (0.67) and non-specialist (0.66) raters, with no significant effect of training (mixed-effects logistic regression, p = 0.45). Treating "unable to determine" as a positive assessment (a conservative screening default), sensitivity was 84%, specificity 92%, negative predictive value 93% and accuracy 90%; restricting to confident calls raised specificity to 95% and accuracy to 92%. The high negative predictive value indicates a negative result is unlikely to miss true BCRL. implications: In this ongoing study, image-based WArP~iT assessment has shown substantial agreement with in-person assessment, regardless of whether raters had specialist lymphoedema training. Developed into a low-cost, accessible telehealth pathway, this could allow women in rural and remote Australia to be assessed for early BCRL close to home, turning early detection from a metropolitan privilege into an equitable standard of care, and catching disease before it becomes a lifelong burden.

Healthy Beginnings: Improving Care for Rural Mothers, Babies and Children

Community-based continuity of care model: bridging gaps in rural perinatal healthcare

Presenter: Kate Freire

Authors and affiliations

1. A/Prof Melissa Nott, Charles Sturt University
2. Dr Kate Freire, Charles Sturt University

Abstract

Background and aims: Many rural and regional communities experience gaps in perinatal care particularly for women who require support for high-risk pregnancies. Community based midwifery programs offer continuity of care (ante-natal and post-natal); typically limited to low-risk populations. Women with high-risk pregnancies (due to complex medical and social backgrounds) are typically excluded from publicly funded midwife care models, requiring costly private obstetric care. This research evaluated a regional not-for-profit community health care service providing a mid-wife led ante-natal and post-natal service to antenates at high risk of poor health outcomes due

to complex medical and social backgrounds, including humanitarian migrants and antenates of low socio-economic status. The research aimed to evaluate the service from four key perspectives, to investigate whether the service was safe and appropriate for all pregnant women, including those with high-risk pregnancies.

Methods: The four perspectives were: a retrospective file audit (1 July 2024-30 June 2025) evaluating key clinical outcomes at birth and up to six weeks post-partum; referring agencies perspectives via a telephone survey; experiences of mothers who had participated in the program via interviews and focus groups; and a health economic perspective via a return on investment analysis. Data was analysed using descriptive, content and thematic analyses.

Results: A overview of findings from all four perspectives will be presented. Birth outcomes were better than those reported in the National Perinatal Data Collection including: higher rate of normal vaginal births and fewer caesarean sections; fewer premature births; and fewer newborns with low birth weight. The referrer telephone survey found that the service filled an important gap in the community, particularly in provision of care for medium-to-high-risk women from low socio-economic backgrounds who had no other options due to limited number of antenates the local hospital was able to accommodate. Fifteen participants took part in seven individual interviews and three focus groups. Eight themes were identified: seeing the same care provider builds therapeutic relationship; creating safe spaces through acceptance and reassurance; being informed and up-to-date during pregnancy; connecting with services and supports; preparing clients to advocate for themselves; bringing along fathers (and others) too; preparing clients for post partum care; and access and equity. Findings from the economic analysis are to be finalised.

Conclusion: The study highlights the positive impacts that small, regional, community healthcare centres provide for their communities and how they can reduce maternal and newborn health inequalities.

Addressing paediatric health needs in Western NSW: An initial evaluation of the Flying Start program

Presenter: Kylie Irvin

Authors and affiliations

1. A/Prof Matt Thomas, Marathon Health
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3. Mrs Kylie Irvin, Marathon Health

Program and submission difference: The scheduled presenter differs from the submission contact.

Abstract

Background and aims: Children in rural and remote Western New South Wales experience significant inequities in access to paediatric and allied health services, particularly for diagnostic assessment of developmental conditions. These access barriers limit entry to supports through the National Disability Insurance Scheme (NDIS) and the education system. The Variety Flying Start program was co-designed to address these gaps through a multidisciplinary, place-based model of care integrating an outreach paediatrician with allied health and local service providers. This study aimed to evaluate the need for, feasibility, acceptability, and early outcomes of the Flying Start program.

Methods: A mixed-methods evaluation was undertaken using clinic activity data, deidentified client records, and publicly available NDIS data, alongside semi-structured interviews with 16 stakeholders across health, education, and community sectors. Quantitative data were collected over a 12-month pilot period (April 2024–March 2025), with qualitative interviews conducted in August 2025. The evaluation focused on indicators of need, feasibility, acceptability, and early impact.

Results: Seven paediatric clinics were delivered alongside 225 allied health sessions. A total of 43 children were assessed, with a 98% appointment attendance rate, indicating high engagement. Substantial unmet need was identified, with 72% of children receiving diagnoses that would otherwise have been inaccessible. Over half (51%) were deemed eligible for NDIS supports, and 81% were recommended for therapy. The model demonstrated strong feasibility, supported by multidisciplinary collaboration and integration with local systems, including schools and primary care (local GPs). High acceptability was evidenced by strong stakeholder endorsement and culturally responsive engagement through trusted local roles. Early outcomes included increased access to NDIS supports, improved educational adjustments, and reduced stress for families and educators.

Conclusion: The Flying Start program demonstrates that a co-designed, place-based model of care, supported by modest targeted investment, can substantially improve access to diagnostic assessment and coordinated care in underserviced rural communities. The findings of this initial evaluation support scaling of similar models, with emphasis on flexible funding, strengthened cross-sector partnerships, and sustained local coordination to optimise long-term impact.

Beyond the Birth: Embedding Woman-Led Fourth Trimester Planning into Routine Maternity Care Through Consumer Co-Design

Presenter: Julie Inman

Authors and affiliations

1. Ms Emily Mitchell, Consumer

Program and submission difference: The scheduled presenter differs from the submission contact.

Abstract

Current hospital postnatal care reveals a critical gap in supporting women during the fourth trimester, the first twelve weeks after birth. This is a time of profound transformation where women navigate complex physical recovery, emotional adjustments, and identity change with limited guidance, also known as matrescence. Addressing this gap required an innovative, woman-led approach that reframed postpartum care as a continuation of the maternity continuum rather than its conclusion. Introducing the Beyond the Birth booklet—an original, co-designed resource developed through a consumer-led partnership in Western NSW Local Health District. Grounded in lived experience and shaped through collaborative co-design workshops with regional women, clinicians, and support networks, the booklet represents a novel approach to postpartum preparation. Rather than prescribing care, it empowers women to actively design their own fourth trimester experience through guided reflection, education, and facilitated conversations. This woman-led tool can be used in its entirety or tailored to individual priorities, supporting personalised care. It actively includes partners and support people, equipping them with practical tools to communicate effectively and provide support. This personalised approach strengthens postnatal care, addressing disparities in access and outcomes, contributing meaningfully to improved health equity for women and families in rural and regional communities. The resource was piloted over six months in the Orange Midwife Group Practice Program with surveys collected from women, clinicians, and support people to evaluate effectiveness. Evaluation findings were highly positive: over 90% of participating women reported increased awareness and preparedness, and all respondents indicated they would recommend the resource. All midwives found it effective in prompting conversations and 100% of support people reported improved understanding of postpartum needs. The Beyond the Birth initiative has driven sustainable, system-level change by embedding fourth trimester planning into existing antenatal care pathways rather than creating additional workload. Introduced through routine third trimester interactions with the Midwife Group Practice, the booklet is clinician-facilitated but woman-led, ensuring it enhances rather than burdens service delivery. Ongoing support and leadership from the Agency for Clinical Innovation

(ACI), NSW Health Kindlab, and the NSW Health Maternity Stream ensured sustained collaboration throughout design and implementation. Beyond the Birth is an evidence-informed initiative that enhances antenatal care by strengthening early engagement with postpartum planning. It shows that a simple, woman-centred tool can enhance communication, confidence, and preparedness, contributing to improved postpartum experiences and highlights the importance of recognising matrescence in maternity care.

Evaluating the impact of the 'hard-stop policy' in reducing neonatal jaundice admissions in regional health services. A retrospective audit

Presenter: Velisha-Mae Bramble

Authors and affiliations

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4. Dr M Mamun Huda, Charles Sturt University, Rural School of Medicine

Abstract

Background and aims: Neonatal jaundice is a leading cause of newborn hospital admissions, with early elective birth a well-recognised risk factor. The 'hard-stop policy' is a strict protocol implemented at Orange Health Service since 2024 to reduce elective induction of labour before 39+0 weeks of gestation, particularly when not medically necessary. While this policy was introduced with anticipated clinical benefits, its impact on neonatal jaundice admission rates has not been evaluated. The framework is an evidence-based response to Orange Health Service having the highest non-medically indicated induction rates in the state. This study aims to examine the proportion of elective inductions at Orange Health Service before and after the policy's implementation and to determine the policy's effect on neonatal jaundice admission rates.

Methods: This retrospective, hospital-based cohort study includes more than 3,000 maternal and neonatal patient records from the Orange Health Service. The primary outcome is neonatal jaundice admission rates within 28 days of birth, alongside rates of elective induction of labour. Secondary outcomes include maternal and neonatal complications such as postpartum haemorrhage, hypoglycaemia, respiratory distress, and birthweight. Logistic regression, adjusted for potential confounders such as maternal demographics and health factors, is the planned approach for estimating policy effects. Ethics approval has been granted by GWHREC. Data access is ongoing, and complete results are anticipated for presentation at the conference.

Expected outcomes: It is expected that on conclusion of the study, implementation of the policy will have improved neonatal outcomes at Orange Health Service, demonstrated by a decrease in readmission rates to the special care nursery for jaundice. This would align with previous research indicating that the risk of jaundice is inversely proportional to gestational age. It can also provide evidence on whether the hard-stop policy improves newborn outcomes and reduces readmissions for neonatal jaundice. By understanding what is working well and where the policy is not being followed, the results are anticipated to help refine the protocol and support staff in delivering more consistent, safer care.

Conclusion: This project supports the priorities of the Greater Western NSW Local Health District, with a focus on strengthening preventive health early intervention, under the First 2000 Days of Life Framework. This study provides a basis for research to improve neonatal care pathways and ensure safer, higher-quality care for babies and families in regional communities.

Evaluating Hospital-Related Outcomes and Carer Experiences Associated with the Paediatric Acute Review Clinic at Coffs Harbour Health Campus

Presenter: Michael McCarron

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Program and submission difference: The scheduled presenter differs from the submission contact.

Abstract

Background and aim: Increasing demand for paediatric emergency and inpatient services continues to challenge regional Australian healthcare systems, where access to specialist paediatric care is limited. The Paediatric Acute Review Clinic (PARC), established October 2024 within the Mid North Coast Local Health District, provides consultant-led ambulatory follow-up for children under 16 years requiring specialist reassessment without ongoing inpatient admission. Despite its recent establishment, the clinical impact and carer experience of PARC in this regional setting has not yet been formally evaluated. This study aimed to evaluate the impact of PARC on hospital utilisation, service delivery and caregiver experience.

Methods: A retrospective service evaluation was conducted using routinely collected clinical data from children managed through PARC. Demographic characteristics, referral pathways, presenting complaints and clinical outcomes were extracted from electronic medical records and PARC documentation. Descriptive analyses characterised patient presentations, service utilisation type and reason for visit. Caregiver experience was evaluated using a voluntary satisfaction survey assessing communication, care coordination and overall satisfaction. Data collection is currently underway, with preliminary analysis based on PARC booking sheets (N=732) and seven completed carer surveys. Complete data and full analysis are anticipated for presentation at the conference.

Results: A total of 732 appointments were recorded over the 15-month study period (October 2024–December 2025), averaging 49 appointments per month (range 34–77). Most consultations were conducted in person (81%). Investigation review was the most frequent reason for attendance (n = 143, 19.5%), followed by dermatological conditions (10.8%), developmental and anatomical concerns (10.4%), and respiratory presentations (10.0%). Post-emergency department and post-hospital reviews accounted for a further 8.1% of consultations, while ENT, gastrointestinal, neurological (including seizures), and musculoskeletal/orthopaedic presentations each comprised 3–8% of the caseload. Caregiver survey responses (n = 7) indicated high satisfaction with the service: six respondents strongly agreed that staff listened to their concerns, all agreed or strongly agreed that information was communicated clearly, four strongly agreed that PARC was well integrated with other hospital services, and five strongly agreed they were satisfied with the care provided.

Conclusion: Preliminary findings indicate that PARC is delivering accessible, high-quality paediatric care across a clinically diverse caseload, with strong family engagement reflected in the dominance of in-person attendance and consistently high caregiver satisfaction. As data collection and analysis are ongoing, firm conclusions await the complete dataset. Ongoing evaluation will further strengthen the evidence base and support the broader implementation of sustainable paediatric ambulatory care models across regional Australia.

Rural Mental Health and Wellbeing: Community, Connection and Support

Rural and Remote Young People in New South Wales: Their Use of Social Media to Communicate Suicidality

Presenter: Ann-Maree Fardell Hartley

Authors and affiliations

1. Dr Annie Fardell Hartley, Charles Sturt University
2. Dr Judith Crockett, Charles Sturt University
3. Dr Shaoyu Wang, Charles Sturt University

Abstract

Background and Aims: This study examined the use of social networking sites (SNSs) among rural Australian youth with lived experience of suicidality. The research aimed to understand how young people in rural communities use SNSs during suicidal distress and how these interactions are perceived and responded to by peers, family, and professionals.

Methods: Participants included young adults (18–24 years), family members and friends, and rural health or school professionals from rural New South Wales. A further 65 rural residents completed online questionnaires rating risk in vignettes depicting SNS posts from suicidal young people. Recruitment occurred via SNSs, print advertising, and word of mouth. Interviews were transcribed and analysed using inductive thematic analysis, while demographic and vignette data were examined using descriptive statistics and thematic analysis.

Results: Young rural people used SNSs during suicidal crises for three main purposes: self-regulation during distress, co-regulation through connection in moments of crisis, and farewell communication before suicidal action. Suicidal ideation was often expressed via graphic tools such as memes and GIFs; written messages were typically veiled and directed to a small, curated group of peers. Decedents used SNSs to send final goodbye messages to close friends. While rural community members reported confidence in recognising and responding to suicidal posts, many also expressed stigmatising beliefs—viewing disclosures as attention-seeking, a developmental phase, or hormonally driven. These perceptions contributed to young people feeling burdensome and socially excluded, reinforcing reliance on SNSs for support and, in some cases, intensifying online expressions of suicidality.

Conclusion: This study proposes a model illustrating the interplay between offline and online needs of suicidal youth and recommends adapting theoretical frameworks to incorporate SNS dynamics into mental health interventions. Findings have implications for: clinical assessment, incorporating SNS use into suicide risk evaluation, educational policy, promoting digital literacy and stigma reduction, and cyber safety protocols, recognising SNSs' role in crisis communication. Understanding how rural youth use SNSs during crises can inform more integrated, responsive, and culturally relevant suicide prevention strategies across both digital and real-world contexts.

Exploring the potential of SMART Recovery Mutual-Support Groups for Supporting the Mental Health and Wellbeing of Rural Men: A Mixed-Methods Evaluation

Presenter: Alison Beck

Authors and affiliations

1. Dr Alison K. Beck, School of Psychology, Faculty of Science, Medicine and Health, University of Wollongong,
2. Dr Chloe J. Haynes, School of Psychology, Faculty of Science, Medicine and Health, University of Wollongong
3. Dr Rebecca M. Gray, School of Psychology, Faculty of Science, Medicine and Health, University of Wollongong
4. A/Prof Katinka van de Ven, 360Edge
5. A/Prof Briony Larance, School of Psychology, Faculty of Science, Medicine and Health, University of Wollongong
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7. Mr Ian Waddell, Western NSW LHD Community Mental Health/ Drug and Alcohol Service, Bathurst Health Service
8. Ms Tracy Allen, Western NSW LHD Community Mental Health/ Drug and Alcohol Service, Bathurst Health Service
9. Dr Elle Coleman, School of Psychology, Faculty of Science, Medicine and Health, University of Wollongong
10. Dr Isabella Ingram, School of Psychology, Faculty of Science, Medicine and Health, University of Wollongong

Abstract

Background and aims: Rural men face disproportionate burden from alcohol and other drug (AOD) use and mental health concerns. They are also less likely to access professional support due to stigma, self-reliance, and limited service availability. Action-oriented, self-management approaches may be more acceptable to men. SMART Recovery is a facilitator led mutual-support group that applies cognitive behavioural and motivational approaches to support people to make self-directed changes across AOD use and other behavioural concerns. SMART Recovery has been shown to reduce AOD use and improve mental health. However, the potential for supporting the mental health and wellbeing of rural men has not been examined.

Methods: A mixed-methods design examined the characteristics, outcomes and experiences of men attending SMART Recovery groups in Western NSW LHD. This included a prospective longitudinal cohort study (n=29; assessed at baseline, 3-months and 6-months), and a subsample (n=18) of semi-structured qualitative interviews. Interviews were audio-recorded, transcribed and analysed using iterative categorisation. This presentation describes baseline characteristics and qualitative interview findings.

Results: The average age of participants was 47.65 (SD=10.86). At baseline, 23/29 (79%) screened at severe or extremely severe levels on the Male Depression Risk Scale; and 12/29 (41%) reported high psychological distress on the Kessler-6. Over half had lifetime trauma exposure (17/29; 58.6%), with 10 screening positive for probable PTSD on the Primary Care PTSD screener. Four interconnected themes were identified from participant interviews. First, help-seeking was typically reactive and delayed, often triggered by external consequences of AOD use (relationship breakdown, justice involvement, housing instability) and referral from trusted health, social care, or peer supports. Second, SMART Recovery's harm-minimisation approach, emphasis on self-management, and flexible participation created a safe and acceptable environment for reflection and disclosure. Third, hearing other men's experiences fostered self-awareness by encouraging reflection on values, identity, relationships, and future aspirations. Finally, benefits extended beyond AOD use to include greater social connection, improved wellbeing, enhanced coping skills, and renewed engagement in meaningful roles.

Conclusion: SMART Recovery can support the mental health and wellbeing of men in rural regions. Earlier engagement could be promoted by increasing community awareness of SMART

Recovery, framing messaging around the active, goal-focused, self-driven, abstinence-optional approach and equipping frontline contacts (e.g. GPs, employers, housing, justice and peer workers) to facilitate linkage. Improving accessibility (after hours availability, discreet venues for face-to-face groups, hybrid access, transport support) may reduce reliance on crisis intervention.

Mind the Body: Implementing metabolic screening and management for rural patients prescribed antipsychotic medications

Presenter: Sophia Nelson

Authors and affiliations

1. Ms Sophia Nelson, School of Clinical Medicine, University of New South Wales Medicine and Health, Rural Clinical Campus
2. Dr Shannon Pike, School of Clinical Medicine, University of New South Wales Medicine and Health, Rural Clinical Campus, Wagga Wagga; Wagga Wagga Ambulatory Rehabilitation Service, Murrumbidgee Local Health District
3. Dr Sean Hogan, Murrumbidgee Local Health District; School of Clinical Medicine, University of New South Wales Medicine and Health, Rural Clinical Campus, Wagga Wagga

Abstract

Background and Aims: Antipsychotic medications are essential in treating severe psychiatric illness, yet their use is strongly associated with increased cardiometabolic morbidity and premature mortality. Despite evidence-based clinical guidelines recommending targeted metabolic monitoring and management, clinical uptake remains low. This persistent evidence-practice gap is further exacerbated in rural medical settings, with limited resources to implement structured metabolic care for this complex patient group. This study aims to evaluate the impact of a targeted, low-cost education package on metabolic screening and intervention rates for patients prescribed antipsychotic medications in the acute mental health inpatient unit (AMHIU) at Wagga Wagga Base Hospital (WWBH).

Methods: This study is the second phase of a larger before-and-after interventional audit. This study designed and implemented a targeted education package, informed by Phase 1 baseline findings, on the AMHIU over a 3-month period. A repeat audit of electronic medical records for 100 consecutive patients prescribed antipsychotic medications was performed to assess the rates of guideline-recommended metabolic monitoring and intervention. Data collection commenced 1-month post-education, to allow clinician implementation into practice. Primary analysis used descriptive data to present frequencies and percentages of screening and intervention completed. Data will be examined for statistically significant changes from pre- to post-implementation of the education package using chi-square tests for categorical data and T-tests for continuous data. The RE-AIM framework will be applied retrospectively to assess the reach and adoption of the education.

Results: The impact of the low-cost education package on the clinical management of metabolic health for patients taking antipsychotics will be presented. Study outcomes will provide valuable insight into feasibility and uptake of clinical interventions for a vulnerable and complex patient population, specifically within a rural context. These findings may support rural clinicians in developing and implementing context-specific, scalable interventions in their own practice settings.

Conclusion: Conducting this study has highlighted challenges in embedding metabolic management practices in rural clinical settings. High staff turnover and locum psychiatrists provide ongoing barriers to embedding consistent management practices. Competing priorities in the AMHIU also interfere with clinician's capacity to adopt new processes. Improving metabolic screening and intervention rates for patients prescribed antipsychotics may serve to reduce preventable cardiometabolic harm and narrow the disparities in mental and physical healthcare in rural settings. Embedded routine practice provides impact beyond individual care; with potential opportunity for

earlier intervention, reduced downstream healthcare burden, and improved equity for rural populations living with severe psychiatric illness.

A Grazier Ecological Model: Multi-Level Determinants of Mental Health in Rural Australia

Presenter: Giti Haddadan

Authors and affiliations

1. Dr Giti Haddadan, BHUDRH
2. Ms Eliza Emmlin, Royal Flying Doctors South Eastern Section
3. Ms Vanessa Latham, Royal Flying Doctors South Eastern Section
4. Ms Mary Tilyou, University of Wollongong
5. A/Prof Robert Brooks, BHUDRH

Abstract

Background and Aims: Graziers managing livestock on remote properties in rural Australia experience unique and intersecting stressors that affect their mental health and wellbeing. These include environmental pressures such as drought, occupational risks, geographical isolation, financial stability and limited access to health care. The We've Got your Back program (WGYB), is a peer-led model, that draws on the lived experiences of trained community champions, who provide informal support within their communities. Aim was to explore the multi-level determinants of grazier life across the individual, family, community, and broader systemic levels and their influence on mental health outcomes.

Methods: Purposive sampling was used to recruit participants. WGYB Champions (n=4) and users (n=7) participated in 45–60-minute interviews. Data was analysed using an iterative, interpretive approach, informed by the ecological framework to map multi-level determinants of wellbeing. Participation was voluntary.

Results: Identity emerged as a central theme, with a strong connection to land and expectation to 'tough it out'. While family ties were closely connected, grazier related stressors can strain relationships, with succession planning identified as a major source of conflict. Environmental challenges had cascading financial impacts, affecting both individuals and families. Repeated and anticipated events such as drought, loss of life stock and other stressful events reduced communication, increased alcohol and drug use negatively affected mental health and wellbeing. Although community connection is an important aspect of grazier life, geographical distance, privacy concerns, and mental health challenges limited engagement. Cultural norms of resilience discouraged help-seeking and delayed engagement with formal services.

Conclusion: The Grazier Ecological Model highlights the complex, multi-level determinants of mental health in rural Australia. These findings underscore the importance of targeted context specific supports, such as WGYB to improve wellbeing across grazier communities.

The Accredited Mental Health Social Worker Blueprint Program: An innovative approach to supporting the rural mental health workforce

Presenter: Leigh Davison

Authors and affiliations

1. Mr Leigh Davison, Marathon Health
2. Ms Kathryn Castelletto, Three Rivers Department of Rural Health

3. Ms Rebecca Barry, Three Rivers Department of Rural Health
4. Dr Matt Thomas, Marathon Health

Abstract

Background and aims: The Accredited Mental Health Social Worker (AMHSW) Blueprint Program was developed to address the need for a skilled rural mental health workforce. The program was designed with the objective of supporting the newly qualified mental health workforce to deliver safe and effective interventions using focused psychological strategies (FPS). This provided a structured development pathway to achieve the Australian Association of Social Workers (AASW) AMHSW credential. A comparison and appraisal of various models of supervision was considered with the aim of ensuring balance between the three functions of supervision – education, support and accountability.

Methods: The AMHSW Blueprint Program commenced with a series of 8 foundational workshops. Following the workshops, NQSWs engaged in ongoing supervision-based program components. These included on-call consultation, monthly external clinical supervision, monthly internal clinical supervision, monthly multidisciplinary FPS group supervision, and access to monthly social work group supervision. These components were formed with the objective of providing balanced supervision functions to support NQSWs as they transitioned from qualifying degree study to the mental health service system. The presentation will outline the Blueprint Program and provide an appraisal of supervision models undertaken to achieve a balance between the three core functions of supervision; accountability, education and support. These functions are critical in rural contexts, where mental health clinicians often work in isolation and experience high service demand. The Proctor Model was selected and used as a framework to underpin the program design.

Results: This AMHSW Blueprint Program has assisted an increase in rural mental health recruitment and provided structured specialist mental health training for NQSWs. Additionally, it has supported professional development towards the AMHSW credential. The pilot of the AMHSW Blueprint Program has identified three key contributions; (1) the promotion of recruitment, retention and workforce wellbeing (2) the provision of structured specialist mental health training for NQSWs (3) an innovative professional development opportunity towards AMHSW credentialing. An evaluation of outcome, experiences and return of investment is in progress.

Conclusion: Social workers are well placed to bridge the rural mental health gap. However, limited opportunities exist for NQSWs to develop the professional experience necessary for effective FPS interventions and pathway to the AMHSW credential. The AMHSW Blueprint Program is one innovative workforce development solution that addresses these gaps and strengthens rural ment

Afternoon Concurrent Session

Rural Mental Health and Wellbeing: Community, Connection and Support

Rural and Remote Young People in New South Wales: Their Use of Social Media to Communicate Suicidality

Presenter: Ann-Maree Fardell Hartley

Authors and affiliations

1. Dr Annie Fardell Hartley, Charles Sturt University
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Abstract

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A Grazier Ecological Model: Multi-Level Determinants of Mental Health in Rural Australia

Presenter: Giti Haddadan

Authors and affiliations

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The Accredited Mental Health Social Worker Blueprint Program: An innovative approach to supporting the rural mental health workforce

Presenter: Leigh Davison

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Conclusion: Social workers are well placed to bridge the rural mental health gap. However, limited opportunities exist for NQSWs to develop the professional experience necessary for effective FPS interventions and pathway to the AMHSW credential. The AMHSW Blueprint Program is one innovative workforce development solution that addresses these gaps and strengthens rural mental health system capacity.

Chronic and Complex Care in Rural Health

Innovating for Health Equity: Smarter Radiotherapy Scheduling in Rural Settings

Presenter: Sophie Hardie

Authors and affiliations

1. Ms Sophie Hardie, Central West Cancer Care Centre

Abstract

Background & Aim: To compare treatment quality and delivery times between two radiation therapy machines- the Halcyon and TrueBeam linear accelerators (LINACs) across six tumour sites, and to identify which patient groups benefit most from preferential scheduling on the Halcyon to optimise departmental efficiency.

Methods: This two-phase study examined six tumour sites: Head & Neck, Chest/Abdomen, Prostate (±nodal irradiation), Brain/Head, Free Breathing Breast, and Palliative. Phase 1 was a retrospective paired dosimetric comparison of 60 patients (n=10/site) treated between January 2023-July 2025. Each patient had dual treatment plans generated, one for Halcyon (6 MV FFF) and one for TrueBeam (6 MV or 10 MV), using Eclipse v16.1 with VMAT or IMRT techniques. Plans were evaluated for planning target volume (PTV) coverage and organ-at-risk (OAR) mean and maximum doses. Phase 2 prospectively recorded treatment time (imaging commencement to final field delivery) in 120 patients (n=20/site) on both LINACs. The Wilcoxon Signed Rank Test (two-tailed) was used for statistical comparisons, with significance set at $p<0.05$.

Results: Across all sites, Halcyon achieved superior PTV coverage (97.88% vs 97.63%; p=0.037), lower OAR Dmean ($p<0.001$), and lower Dmax (p=0.001) compared to TrueBeam. The largest improvement was seen in Free Breathing Breast cases, where average and maximum dose to key OARs were greatly reduced. Reductions to average OAR doses were also demonstrated in Head & Neck and Prostate ± Nodes patients, while the Brain/Head cohort showed a reduced maximum dose. No significant differences were found for the Chest/Abdomen and Palliative sites. In Phase 2, Halcyon demonstrated shorter treatment times across all sites; statistically significant reductions were observed for Free Breathing Breast (p=0.005), Head & Neck (p=0.005), and Brain/Head (p=0.037). Treatment time differences for Chest/Abdomen, Prostate ±Nodes, and Palliative were statistically insignificant.

Challenges: The study excluded treatments using breath-hold, stereotactic radiosurgery, and stereotactic ablative body radiotherapy, reflecting the current capabilities of the Halcyon LINAC at CWCCC. Additionally, inconsistent photon beam energies in TrueBeam plans introduced variability in time comparisons. Future research with larger cohorts, standardized energies, and inclusion of advanced techniques would strengthen these findings.

Conclusion: Halcyon demonstrated combined dosimetric and treatment time advantages for Free Breathing Breast, Head & Neck, and Brain/Head treatments. Prioritising these cases for Halcyon delivery, excluding patients requiring stereotactic, SABR, or breath-hold techniques, may improve treatment efficiency and support optimal utilisation of departmental radiotherapy resources. A booking decision tree has been developed to guide LINAC allocation based on these findings.

Adapting HEARTS for rural Australia: integrating primary care context mapping and policy discourse analysis to strengthen hypertension care in Western NSW

Presenter: Katrina Wilkinson

Authors and affiliations

1. Ms Katrina Wilkinson, The University of Sydney
2. Dr Anna Thompson, The University of Sydney
3. Ms Alison Ainsworth, The University of Sydney
4. Mr Gautam Satheesh, The University of Sydney
5. Ms Catherine Sanford, Broken Hill University Department of Rural Health
6. Mr Tim Creagh, The University of Sydney
7. Dr Niamh Chapman, The University of Sydney

Abstract

Background: Hypertension affects 7.2 million Australian adults, yet fewer than 40% have controlled blood pressure. The challenge is amplified in rural communities, where hypertension is more common, general practitioner access is limited, and care relies on responsive primary care services across diverse settings and workforce arrangements. The WHO HEARTS technical package provides an evidence-based framework for improving hypertension detection, treatment and control through standardised protocols, team-based care and monitoring systems. However, implementation in rural Australia depends on local practice readiness and policy settings that shape funding, roles, referral pathways and data sharing.

Aim: The aim of Phase 1 of the AUS HEARTS project is to inform local adaptation of WHO HEARTS by mapping current hypertension care in Western NSW primary care and identifying the policy and practice conditions required for sustainable, team-based implementation.

Methods: Phase 1 uses a convergent mixed-methods design combining primary care context mapping with policy discourse analysis. Primary care services caring for patients with hypertension will complete a self-assessment checklist covering staffing, patient management and practice systems. Interviews and focus groups with primary health professionals, alongside Clinical Advisory Group and Consumer Advisory Group input, will explore workflows, training needs and implementation supports. In parallel, local, state and national policy documents relevant to primary care, hypertension management, team-based care, digital health and funding will be analysed to examine how policy frames the roles, authority, incentives and systems required for HEARTS implementation.

Findings: will identify variation in hypertension detection, treatment, follow-up and monitoring across Western NSW primary care services, alongside policy-level enablers and constraints for HEARTS implementation. The policy discourse analysis will distinguish barriers addressed through local adaptation from those requiring broader reform. Early findings show that Australian policy strongly endorses prevention, person-centred care, equity, digital reform and multidisciplinary care, yet often reinforces General Practitioner (GP)-centred delivery through funding arrangements, referral rules and fragmented data systems. These settings can limit task-sharing, routine monitoring and scalable team-based care.

Implications: AUS HEARTS will generate evidence on adapting a proven global model for rural Australian primary care. Outputs will inform a hypertension quality improvement framework, clinical indicators, training resources, monitoring systems and supports for the Phase 2 cluster randomised controlled trial. Sustainable impact will require more than practice-level flexibility: it will require

funding mechanisms, role clarification, shared protocols, referral pathways and interoperable data systems that enable GP-led but not GP-dependent team-based hypertension care.

Survivorship Care for Radiation Therapy Patients in Rural, Regional and Remote Populations: A Mixed-Methods Study

Presenter: Bridgitte Evans

Authors and affiliations

1. Mrs Bridgitte Evans, Central West Cancer Care Centre, Orange Hospital; The Radiation Oncology Collaborative Network, The University of Newcastle, Newcastle, Australia
2. Dr Laura Feighan, The Radiation Oncology Collaborative Network, The University of Newcastle, Newcastle, Australia; College of Health, Medicine and Wellbeing, The University of Newcastle, Newcastle, Australia
3. Dr Toni Kelly, Illawarra Cancer Care Centre, Wollongong, Australia
4. Prof Tracy Burrows, College of Health, Medicine and Wellbeing, The University of Newcastle, Newcastle, Australia; Hunter Medical Research Institute (HMRI), Newcastle, Australia
5. Prof Yolanda Surjan, The Radiation Oncology Collaborative Network, The University of Newcastle, Newcastle, Australia; College of Health, Medicine and Wellbeing, The University of Newcastle, Newcastle, Australia

Abstract

Background and aims: Cancer is the leading cause of disease burden in Australia. (1) Survivorship rates continue to rise due to population growth, and advances in early detection and treatment. (2-5) Cancer survivorship encompasses the health and well-being of an individual from diagnosis through the remainder of their life. (6-7) Radiation therapy (RT) plays a crucial role in cancer treatment, with half of all cancer patients potentially benefiting from RT as part of their treatment. (8) Despite technological advancements, many patients who receive RT will experience radiation-associated side effects. (9) Survivors have broad, often unmet needs across psychological and physical domains as they transition to life after treatment. (10) In rural, regional and remote (RRR) areas such as Western NSW (WNSW), these challenges are compounded by geographic isolation, a limited specialist workforce, and reduced access to follow-up services. (11)This research examines survivorship care after RT in RRR populations, focusing on WNSW, to identify gaps and opportunities for more equitable service delivery.

Methods: This research employs a mixed-methods design informed by implementation science frameworks across four phases. Phase one includes a scoping review examining survivorship care programs, delivery approaches, and demographic considerations following RT. Phase two involves two surveys currently underway: a practitioner survey targeting healthcare providers in radiation oncology nationally, and a survey for cancer survivors in WNSW exploring lived experience in accessing survivorship care post-RT. Subsequent phases will use these findings to inform the development of a survivorship care intervention for WNSW patients.

Results: Findings from the scoping review highlighted a limited integration of survivorship care into routine RT practice, and a lack of evidence specific to RRR contexts. Survivorship care was frequently described as fragmented, with unclear responsibility across disciplines and limited structured approaches. Survey data collection is underway, with findings expected to further highlight variability in care provision and key barriers across locality settings.

Challenges: Recruiting RRR patient participants introduces challenges around generalisability. Additional considerations include self-reported survey bias, logistical complexity across a phased study design, and the need to balance methodological rigour with practical constraints.

Implications: This research has direct implications for how survivorship care is embedded in RRR settings. By integrating clinician and consumer perspectives, it aims to inform a relevant, scalable survivorship care intervention embedded within RT services in WNSW, ensuring that where a patient lives, does not determine the quality of survivorship care they receive.

Trends in the prevalence of diabetes in Western NSW: a population-level data linkage study

Presenter: Emma Cox

Authors and affiliations

1. Ms Emma Cox, Leeder Centre for Health Policy, Economics and Data, University of Sydney
2. Dr Joanne Gale, Leeder Centre for Health Policy, Economics and Data, University of Sydney
3. A/Prof Michael Falster, Medicines Intelligence Research Program, University of New South Wales.a
4. Prof Natasha Nassar, Leeder Centre for Health Policy, Economics and Data, University of Sydney
5. Dr Alice Gibson, Leeder Centre for Health Policy, Economics and Data, University of Sydney

Abstract

Background and Aims: Diabetes prevalence in Western NSW is currently estimated at 6.7% based on National Diabetes Services Scheme (NDSS) registrations, yet our previous work has shown NDSS data may underestimate the prevalence of diabetes by up to 35%. Linked administrative health data offer a more accurate picture of diabetes prevalence to inform service planning. This study aimed to examine trends in the prevalence of diabetes in Western NSW Primary Health Network (PHN) from 2013 to 2021 using whole-of-population linked health data.

Methods: This study used a population-level linked data asset containing records for all Medicare-eligible adults residing in NSW, Australia, from 2005–2020 (n=7.4 million). Individuals with diabetes (excluding gestational diabetes mellitus) were identified using a validated algorithm based on a combination of dispensed insulin and/or glucose-lowering medicines, diabetes-related medical service claims, and diabetes-related hospital admissions. Diabetes cases in Western NSW were identified using the individual's postcode recorded in the Medicare Enrolment File as of 1 January of each year. The number of adults living with diabetes, and prevalence (%) estimates were calculated annually. Small-area (statistical-area level 2) geospatial analysis to identify diabetes hotspots and coldspots within Western NSW are currently underway, with results expected by October.

Results: The number of adults living with diabetes in Western NSW increased by 33.2% (an average of ~965 people per year) between 2013 and 2021. The prevalence of diabetes increased from 10.2% in 2013 to 12.6% in 2021 and was consistently higher among men compared with women. While prevalence remained low among those aged 18–39 years (1.7% to 2.7%), this group experienced the largest proportional increase in prevalence (57%) of any age group.

Implications: Our findings show a substantially higher diabetes prevalence within Western NSW PHN than suggested by NDSS registrant data. Routine monitoring of the prevalence of diabetes using linked administrative health data could be used to support local health district and PHN needs assessments, guide investment in diabetes prevention and management, and highlight successful local-level initiatives. Targeted efforts may also be needed to address the rise in younger-onset diabetes within the region.

Opening the Black Box of Atrial Fibrillation Through Rural Clinician–Librarian Collaboration: Building Research Networks to Translate Complex Knowledge into Rural Health Action

Presenter: KAM Wong

Authors and affiliations

1. Dr Kam Cheong Wong, Westmead Applied Research Centre
2. Ms Frances Guinness, Western Sydney University

Abstract

Background & Aims: This project aimed to demonstrate how collaboration between a rural clinician-researcher and a rural health librarian can strengthen interdisciplinary research networks and improve the translation of complex knowledge into practical rural healthcare action by co-writing the book Unboxing Atrial Fibrillation Through Black Box Thinking and a Critical Realist Lens: A Patient-Centred Approach for Clinicians, Researchers and Librarians. Atrial fibrillation (AFib) affects an estimated 59.7 million people globally and contributes substantially to stroke, heart failure, and healthcare burden, including within rural populations.

Methods: The project applied the concepts of black box thinking and critical realism to investigate AFib, using observable clinical findings to elucidate deeper biological and system-level mechanisms. Ten historical and contemporary cases spanning 100 years were synthesised with evidence from electrophysiology, digital health, screening research, and patient-centred care. The collaboration also incorporated visual analytical tools, including mind maps and Ishikawa diagrams, to organise complex relationships among risk factors, pathophysiological pathways, healthcare systems, and patient experiences. The librarian's role extended beyond literature retrieval to evidence synthesis, critical appraisal, and navigation of rapidly expanding biomedical knowledge.

Results: The project produced a book that connects clinical observations, biomedical mechanisms, healthcare systems, and information management into a unified approach for understanding AFib. The book will be published by an international publisher (Taylor & Francis). The collaboration demonstrates how rural clinician–librarian partnerships can support knowledge translation, strengthen research capacity, and bridge gaps between research evidence and clinical practice. The project also highlighted the evolving role of rural health librarians as active contributors to evidence synthesis, interpretation, and implementation within healthcare and research ecosystems.

Implications or Take-Home Message: Complex rural health challenges require collaborative, interdisciplinary research networks that extend beyond traditional boundaries. This project demonstrates that partnerships between rural clinicians and librarians can enhance the interpretation, organisation, and translation of knowledge into practical healthcare action. Utilising the varied skills of clinicians, researchers and librarians adds value to the project, and optimises the output of each participant, who can then focus on the tasks they do best. The collaboration that results subsequently benefits others, as skills and knowledge become transferable across networks, breaking down ‘silos’ of health information in the process. The approach developed through this collaboration may be transferable to other chronic diseases where fragmented evidence, workforce limitations, and inequities in rural healthcare access continue to affect patient outcomes.

Safer Rural Healthcare: Quality, Safety and Patient Outcomes

Environmental Noise in Rural Intensive Care Units: Insights from a Multisite Rural Australian Study

Presenter: Renae Bryant

Authors and affiliations

1. Ms Renae Bryant, WNSWLHD
2. Dr Alice Munro, WNSWLHD
3. Dr Levi Osuagwu, Western Sydney University

Abstract

Background & Aim: Excessive environmental noise in intensive care units (ICUs) is associated with adverse effects on patient recovery, staff wellbeing and clinical performance. While environmental noise in ICUs has been widely studied internationally, most evidence is derived from metropolitan tertiary hospitals. Limited evidence exists describing the acoustic environment of rural Australian ICUs, despite differences in infrastructure, unit configuration, staffing and clinical workload that may influence both noise levels and their contributors. This study aimed to quantify environmental noise levels across three rural Australian ICUs and identify clinical and environmental factors associated with increased noise exposure.

Methods: A multisite observational study was conducted across three rural ICUs in New South Wales, Australia. Continuous 24-hour environmental noise monitoring was undertaken over a four-week period at each site using wall-mounted SoundEar® devices. Mean equivalent continuous sound levels were recorded at one-minute intervals and analysed alongside contextual unit-level data, including patient occupancy, admissions, discharges, staffing activity, rapid response calls and visitor presence. Non-parametric statistical analyses were used to examine associations between noise levels and clinical activity.

Results: Noise levels consistently exceeded World Health Organization recommended limits across all study sites. Average sound levels ranged from 45–65 decibels, with peak levels frequently exceeding 80 decibels. Significant variation in environmental noise was observed between sites.Noise levels were positively associated with patient occupancy, admissions, discharges, staffing activity and rapid response calls, highlighting the contribution of routine clinical processes to the acoustic environment. Distinct diurnal patterns were observed across all sites, with noise levels increasing during periods of peak clinical activity and remaining above recommended limits throughout the 24-hour period.No significant association was identified between environmental noise levels and visitor presence. This finding challenges common assumptions regarding sources of ICU noise and suggests that environmental noise within rural ICUs is predominantly associated with clinical and operational activity rather than social factors. Environmental noise was a persistent feature of rural ICU care and varied according to workload, patient acuity and unit configuration.

Implications or take-home message: This study provides rare baseline evidence describing the acoustic environment of rural Australian ICUs and highlights environmental noise as a system-level issue embedded within routine care delivery. Understanding the relationship between workload, operational activity and environmental noise is an important step towards developing locally relevant improvement strategies that support patient recovery and staff wellbeing in rural healthcare settings.

Perioperative Nurses' Experiences of Recognising and Managing Post-Anaesthetic Paediatric Emergence Delirium: A Narrative Review Motivated by a Challenging Experience

Presenter: Patience Moyo

Authors and affiliations

1. Ms Patience Moyo, Charles Sturt University
2. Prof Karen Francis, Charles Sturt University
3. Mrs Maryanne Podham, Charles Sturt University
4. A/Prof Racchel Rossiter, Charles Sturt University

Abstract

Background: Post-anaesthetic paediatric emergence delirium is a distressing condition characterised by acute confusion, agitation, and hallucinations during recovery from anaesthesia. It can negatively impact recovery, increase clinical risk and may have adverse impacts for several months post-surgery. In rural healthcare settings perioperative nurses often work in generalist roles and manage diverse clinical presentations. In these settings, limited awareness may reduce both recognition and implementation of timely interventions. For one author, a personal experience served as the impetus to undertake this review.

Aim: To explore perioperative nurses' experiences in recognising and managing post anaesthetic paediatric emergence delirium and to enhance awareness of effective assessment and intervention strategies.

Methods: A focused literature search was conducted in October 2024 and updated in May 2025. Literature exploring perioperative nurses' experiences of post anaesthetic paediatric emergence delirium was identified through PubMed, CINAHL, and Scopus. Hand-searching and reference list screening were also undertaken to ensure comprehensive coverage.

Results: The review revealed five key areas of knowledge and skill development to enable perioperative nurses to safely and effectively care for children undergoing surgery; ability to recognise possible post anaesthetic paediatric emergence delirium; to identify children at risk; awareness of diagnostic challenges; employ validated screening tools to support early identification and timely intervention; and utilise evidence-based nursing interventions. All perioperative nurses play a pivotal role in postoperative care by monitoring recovery, recognising early indicators of post-anaesthetic paediatric emergence delirium, and initiating interventions that reduce its effects and improve health outcomes.

Implications /Conclusion: Post anaesthetic paediatric emergence delirium remains under-recognised but has significant implications for paediatric recovery. In rural settings where access to specialist support is limited, strengthening perioperative nurses' knowledge, skills and confidence is essential. Enhancing recognition and management can improve patient safety and outcomes.

Pregnancy Outcomes in Women with Class I-III Obesity in Regional and Rural Australia: A 5-year Hospital-Based Retrospective Study

Presenter: M Mamun Huda

Authors and affiliations

1. Ms Raisa Rowshan, School of Rural Medicine, Charles Sturt University
2. Dr Nita Dhupar, Wagga Wagga Health Services
3. Dr Catherine Keniry, School of Rural Medicine, Charles Sturt University.a
4. Dr M Mamun Huda, School of Rural Medicine, Charles Sturt University

Abstract

Background & Aim(s): Obesity during pregnancy is an emerging global and national health concern and is associated with an increased risk of adverse maternal and neonatal complications. Despite well-known research into pregnancy outcomes associated with obesity there remains a lack of robust local evidence examining these outcomes across different obesity classes (Class I-III) in rural populations. This study aims to address this gap in local data by examining the prevalence and trends in maternal obesity and its associated pregnancy outcomes in a regional Australian cohort.

Methods: Using a retrospective cohort audit study design, we obtained data from the eMaternity electronic medical record system for women who gave birth at Wagga Wagga Base Hospital between January 2021 to December 2025. A total of 6,614 birth records were analysed. Maternal Body Mass Index (BMI) at antenatal booking was utilised as the primary exposure and was further classified into obesity Class I (30-34.9kg/m2), Class II (35-39.9kg/m2) and Class III (340kg/m2). Pregnancy outcomes of interest included gestational diabetes, gestational hypertension, labour-related complications, preterm birth, birthweight, and stillbirth. Prevalence was estimated and trends examined using average annual rate of change. The association between maternal obesity and pregnancy outcomes was assessed using logistic regression, adjusted for maternal sociodemographic, health, and healthcare-related factors.

Results: The overall prevalence of maternal obesity was 31.9% (95% CI: 30.7–33.0). By class, Class I obesity was most common (15.3%), followed by Class II (8.7%) and Class III (7.9%). Obesity prevalence was notably higher among women in outer regional or remote areas (41.2%) compared to inner regional areas (29.6%). The highest prevalence observed in the most disadvantaged quintiles (Q1: 37.8%; Q2: 39.2%) compared to Q3–5 (27.6%). Obesity prevalence increased over the study period, from 29.1% in 2021 to 34.4% in 2025, representing an average annual increase of 3.2% points. The steepest rise was observed in Class II obesity (5.4 %). All obesity classes were significantly associated with increased odds of gestational diabetes and gestational hypertension, with risk escalating with obesity severity (GDM OR range: 2.30–3.79; gestational hypertension OR range: 1.44–1.96). Class I obesity was associated with reduced odds of labour complications (OR 0.77), while Class III was the only class significantly associated with high birthweight

Conclusion: Maternal obesity is prevalent and rising in regional Australia, with severity strongly associated with gestational diabetes, hypertension, and high birthweight. These findings underscore the urgent need for targeted antenatal interventions for women with obesity in regional and rural settings.

Proportion of patients admitted to rural and remote hospitals that experience a 30-day medication-related readmission: a retrospective cohort study

Presenter: Kingston Yeung

Authors and affiliations

1. Mr Kingston Yeung, Faculty of Medicine and Health, The University of Sydney
2. Mr Gi Kon Nam, Faculty of Medicine and Health, The University of Sydney
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7. Dr Hana Amer, Faculty of Medicine and Health, The University of Sydney
8. A/Prof Jonathan Penm, Faculty of Medicine and Health, The University of Sydney
9. NA Rest of the TIC TOC Team, Faculty of Medicine and Health, The University of Sydney

Abstract

Introduction and Aims: Medication errors are a significant and preventable cause of patient harm. Patients living in rural and remote areas may face inequitable access to healthcare and fragmented continuity of care, increasing their vulnerability to medication-related harm. Despite this, the burden and drivers of medication-related harm in these settings remain poorly understood. Determining the current burden and identifying factors associated with medication-related readmissions is essential to inform targeted strategies to improve medication safety. This study aims to determine the proportion of adult patients with a medication-related readmission within 30 days of discharge from rural and remote hospitals, and to identify factors associated with these readmissions.

Method: A retrospective cohort study was conducted using medical records of adults admitted to rural and remote hospitals in New South Wales, Australia, between June 1, 2022 and August 31, 2023. Readmissions within 30 days were assessed for medication-related causes using AT-HARM10, a validated 10-item tool based on data from admission notes, medication lists, inpatient pathology results, and discharge summaries. Patient demographics, comorbidities and admission details were extracted. Comorbidity burden was calculated using the Charlson Comorbidity Index (CCI). Medication lists were based on medications charted 12 hours before discharge. Univariable logistic regression was performed to identify factors associated with 30-day medication-related readmissions.

Results: Of the 2220 patients admitted during the study period, 6% (n=133) experienced a 30-day readmission, of which 22.5% (n=30) were medication-related. Overall, 1.4% of all admitted patients experienced a 30-day medication-related readmission. Older age (OR 1.04; 95% CI 1.01-1.07), higher CCI (OR 1.22; 95% CI 1.04-1.44), a greater number of regular medications (OR 1.07 per additional medication; 95% CI 1.01-1.14), and insulin use (OR 2.80; 95% CI 1.06-7.42) were associated with medication-related readmission. Implication: In rural and remote hospitals, a small but clinically important proportion of patients experienced a medication-related readmission within 30 days. Older age, multimorbidity, polypharmacy and insulin use were associated with increased risk. These findings highlight opportunities for targeted interventions to improve medication safety. Larger studies are needed to validate these findings and evaluate strategies to reduce medication-related harm in rural and remote populations.

Hospital Hypos, Unfortunate Typos, Problems They Might Pose: A retrospective audit of hypoglycaemic episodes in two hospitals in the WNSWLHD

Presenter: Connor Drum

Authors and affiliations

1. Mr Connor Drum, University of Sydney School of Rural Health (Orange)
2. Dr Christopher Hayward, University of Sydney School of Rural Health (Orange)
3. Dr Manik Mayadunne, Charles Sturt University

Abstract

Background and Aims: Hospital-Acquired Hypoglycaemia (HAH) is a treatable and readily identified complication of hospital care as offered for a wide spectrum of primary pathologies. It poses an immediate mortality risk to in-patients and is a significant prognostic factor regarding chronic disease progression in the community. Nevertheless, rates and causal contexts of HAH are comparatively understudied in Australian settings.In this context, this study aims to explore the prevalence and impact of relevant disease and treatment variables applying to non-ICU patients who developed HAH at Orange Health Service and Dubbo Base Hospital across a 12-month period. It also aims to review and assess the content of discharge communications regarding HAH episodes.

Methods: Medical records of all adult patients who developed HAH (confirmed by capillary glucose testing) while admitted to non-ICU wards at Orange Health Service and Dubbo Base Hospital over a 12-month period were audited retrospectively. Descriptive multivariate analyses of hypoglycaemic episodes, pre-existing chronic health conditions and patterns of care provision were performed.

Results: Final data analyses are pending. Nevertheless, preliminary results are available. These show that pre-existing CVD, organic neurological disease and frailty diagnoses were highly prevalent across both Orange and Dubbo patient groups, irrespective of age; that HAH frequency, length of stay, rurality, and increasing number of comorbidities of interest tend to associate positively; and that detailed description of HAH in discharge communications to GPs is uncommon.

Implications: Patients who develop HAH in regional healthcare settings frequently live with comorbidities that can develop mutually-exacerbating relationships with hypoglycaemia, irrespective of diabetes status. This exposes hypoglycaemic patients to long-term, multivalent health and wellbeing vulnerabilities that may also exacerbate existing socioeconomic and resource-access disadvantage. The resources available for management of these vulnerabilities in the community could potentially be better targeted, if community care teams (especially GPs) are given more comprehensive information regarding HAH events during admission, including relevant precipitating factors. Bridging such gaps in continuity of care could help patients and their care teams to sustain improved quality of life over time. Specific approaches to these matters, and broadening the base of our knowledge regarding the incidence and course of HAH in rural and regional settings, would be attractive targets for further research.

Strengthening Rural Health Systems: Access, Capability and Continuity

Organisational Capability for Multidisciplinary Team-based Care in Rural and Remote Areas

Presenter: John Mackenzie

Authors and affiliations

1. Dr John Mackenzie, University of Newcastle
2. Dr Matt Thomas, Marathon Health

Abstract

Background and aims: Rural and remote healthcare faces well-documented pressures from chronic disease, population ageing, workforce shortages, fragmented services and persistent health inequities. Internationally, multidisciplinary team-based primary care has emerged as a key strategy for achieving effective and equitable models of care under constraints. In Australia, the Federal Government's Strengthening Medicare reforms have reinforced this direction. While evidence increasingly demonstrates that team-based care can improve patient outcomes, workforce satisfaction and service integration, comparatively little attention has been given to the organisational capabilities required to implement and sustain these models, especially in rural and remote contexts. This review aims to synthesise the international evidence and Australian policy context, identifying organisational development enablers to support integrated team-based care. This presentation documents the preliminary findings of an empirical evaluation of team-based primary care innovations in chronic disease management and neurological development in regional NSW.

Methods: A critical narrative review was undertaken of international and Australian scientific and policy literature relating to team-based primary care, interprofessional collaborative practice and integrated care. The review examined policy documents, evidence syntheses and empirical studies, including from the World Health Organization, OECD, Australian Government and leading health services research. Particular attention was given to rural, regional, remote and Indigenous health contexts and the organisational factors influencing successful implementation.

Expected outcomes: The review demonstrates strong evidence for improved patient outcomes, workforce experience and system performance associated with team-based care. However, it also identifies gaps in our understanding of the organisational capabilities required to implement and sustain this model of primary care, in terms of leadership, governance, workforce, service integration and continuous improvement.

Challenges: The current evidence base is more focused on clinical outcomes and team effectiveness, with comparatively limited research examining organisational capability, implementation processes and long-term sustainability. There is also relatively little evidence addressing place-based models of integrated care in rural, regional and remote Australia or the lessons offered by Aboriginal Community Controlled Health Organisations.

Implications: Rural health equity requires moving beyond questions of whether team-based care works towards understanding how organisations and practitioners can better implement, sustain and adapt integrated, collaborative models of primary care. The findings from this review draw on two decades of global learning to outline the barriers, enablers and success factors of organisational capability for team-based care, providing a foundation for future research and practical, direct guidance for rural and remote health services.

How an infrastructure grant has lead to increased capacity and capability across Western NSW clinical trials landscape

Presenter: Michelle Tusler

Authors and affiliations

1. Mrs Michelle Tusler, Western NSW Local Health District
2. Dr Kerrie Noonan, Western NSW Local Health District

Abstract

Medical Research Futures Fund provided grant opportunity for clinical trials closer to home as part of an infrastructure grant. The Western Cluster established a centralised Clinical Trial Support Unit (CTSU) to support clinical trials in Western NSW LHD, Far West LHD and Nepean Blue Mountains LHD (Lithgow region). Working collaboratively across the different districts there is a vast increase in clinical trial activity, trials knowledge and commercial sponsorship engagements across the Western Cluster. With data collected from before July 2023 we can demonstrate the differences in clinical trial activity (patient enrollments, therapeutic areas, number of trainings and investigators involved in clinical trials). The data sets show increases well above the estimated amounts at the start of the grant funding period. There are opportunities for investigator initiated trials as well as commercial trials to be supported by the CTSU as well as education possibilities and support for Good Clinical Practice (GCP) and study start up and governance process education. CTSU has been instrumental in developing the Decentralised Clinical Trial Framework with pilot projects and innovative trial design delivery opportunities (such as Rapid Activation Decentralised Trial Model - RADTM). There have also been opportunities to collaborate with university groups and ethics committees to further explore innovative trials delivery suitable for the rural and remote context and how we can actually deliver clinical trials closer to home for our underserviced participants. We have developed patient centric models of care, along with communities of practice to promote and support workforce

capabilities and capacity building. The district supports nursing staff being principal investigators to promote trials in areas of need that cannot always be supported by clinical medical staff.

From Dubbo to medical practise: Impacts of an end-to-end rural medical program on medical student professional identities

Presenter: Simon Mahoney

Authors and affiliations

1. Mr Simon Mahoney, University of Sydney
2. Dr Brie Turner, University of Sydney
3. Prof Lynn Monrouxe, University of Sydney

Abstract

Background and Aims: There is a well recognised shortage of health professionals in rural and remote areas of Australia. In response, there has been a growth in rural-based medical education programs aimed at strengthening the rural health workforce. These initiatives are grounded in evidence suggesting that rural medical education is associated with an increased likelihood of rural practice among medical graduates. However, while the effects of comparatively short rural placements are well understood, the effect of end-to-end rural medical programs requires further investigation. The recently established University of Sydney end-to-end rural medical program in Dubbo, provides an opportunity to explore how sustained, place-based medical education influences medical student professional identity.

Methods: We conducted a longitudinal qualitative study of medical students who were part of the inaugural cohort in the Sydney Medical program in Dubbo. Individual interviews, audio diaries and group interviews were collected over the course of students' degree, alongside individual interviews in their first year of medical practise. Transcripts were analysed using both deductive and inductive thematic methodological approaches: deductive analysis was performed by using prior themes identified on an initial subset of the same data, and extended inductively to include the full dataset.

Results: Our findings from previous and current analysis yielded four master narratives that occurred in different time periods over the program. Rural Identification reflected a progressive and increasing identification with being 'rural' over the course of the program. Implicit Obligation described a sense of responsibility to serve rurally, shaped in part by the investment made in student's medical education. Homegrown Doctors captured an earnest desire among students from rural backgrounds to practise medicine in rural areas. Explicit Obligation was found to be an explicit pressure applied by the local medical community for students to remain in the same location as their education.

Implications: The results suggested that the longer students engaged with rural medical education, the more ingrained their rural identities became. Orientation towards rural practice appeared to be shaped less by obligation and more by an internalised commitment to rural communities, indicating that the key aims of the program are being realised. However, all study participants narrated degrees of perceived pressure to remain in the same location as their training. We suggest that end-to-end rural programs might benefit from incorporating experiences across multiple rural locations, supporting both place-based connection and wider engagement with rural healthcare contexts.

Investigating the Impact of Patient Travel Distance on Bowel Preparation Quality for Screening Colonoscopy: A Mixed-Methods Study in Regional New South Wales.

Presenter: Joseph Pearce

Authors and affiliations

1. Dr Angus Brown, ACRRM
2. Dr Catherine Keniry, CSU
3. Dr Mamun Huda, CSU
4. Mr Joseph Pearce, CSU

Abstract

Background: International research has shown that increasing travel distance to hospital negatively correlates with the quality of bowel preparation for screening colonoscopy. Failed bowel preparation results in an inadequate detection rate of colorectal carcinoma and requires the patient to be scheduled for a repeat procedure. Thus, inadequate bowel preparation increases the burden on the healthcare system whilst decreasing patient access to adequate healthcare. Australians living in rural regions often travel great distances to hospital, however there is no data available on the impact of travel distance on colonoscopy preparedness. The study aims to review patient travel distance and bowel preparation success, identify barriers to successful bowel preparation, understand the patient experience and explore potential interventions to improve outcomes for patients in rural areas.

Methods: This study employs a mixed-methods approach, integrating quantitative data analysis through a retrospective audit of electronic medical record (eMR) data and qualitative investigations involving patient interviews of individuals who have undergone a failed colonoscopy procedure in Parkes Hospital between Jan 2021 to Dec 2025 (MMM-4). Analysis of electronic eMR data will enable the relationship between patient driving distance from home to hospital and colonoscopy bowel preparation quality, as measured by the Boston Bowel Preparation Score (BBPS), to be assessed. Interviews with patients who presented for colonoscopy and had inadequate bowel preparation will be done to understand the patient experience of preparation for colonoscopy in a rural setting, and identify barriers to successful bowel preparation, and potential enablers to improve bowel preparation in this rural population.

Expected outcomes: This study is expected to show that driving distance from home to hospital is inversely associated with bowel preparation quality, with patients travelling longer distances more likely to receive an inadequate BBPS score. Interviews will likely surface a consistent set of barriers and enablers that inform a locally tailored bowel preparation protocol for rural patients.

Implications: The findings have important translational implications for rural healthcare. They may inform policy changes to improve access and outcomes, including better resource allocation and targeted interventions such as pre-admission support to enhance preparation quality and success rates. Strengthening patient education and support may also improve adherence to follow-up procedures. Given the challenges associated with travel in rural areas, policies aimed at reducing transportation barriers are needed. These may include enhanced transport assistance and accommodation programs and expanded use of telehealth for pre-procedural consultations, ultimately promoting more effective healthcare delivery for rural populations.

Bridging Healthcare Transition Gaps for Young People with Intellectual Disability: A Scoping Review on the Role of Primary Care

Presenter: Sofia Rundback

Authors and affiliations

1. Ms Sofia Rundback, School of Rural Health, Faculty of Medicine and Health, The University of Sydney
2. Dr Jodie Bailie, University Centre for Rural Health, The University of Sydney, Lismore, Australia. Centre for Disability Research and Policy, The University of Sydney, Camperdown, Australia

Abstract

Title: Bridging Healthcare Transition Gaps for Young People with Intellectual Disability: A Scoping Review on the Role of Primary Care

Background & Aims: Young people with intellectual disability often experience poorly coordinated transitions from paediatric to adult healthcare, which can result in delayed access to services and poorer outcomes. Although clinical and policy guidelines recommend greater primary care involvement during healthcare transition, the role of primary care in supporting young people with intellectual disability remains unclear. To date, no review has synthesised the evidence regarding the role of primary care in this transition.

Aims: To explore the nature and extent of published literature on the role of primary care in supporting the transition from paediatric to adult healthcare for young people with intellectual disability.

Methods: This scoping review is conducted in accordance with JBI methodology. The following academic databases were searched for relevant peer-reviewed publications up until 27 March 2026: Embase, Scopus, MEDLINE, and CINAHL. Covidence software was used to support screening and data extraction. Titles and abstracts were screened by one reviewer with 10% screened by a second reviewer. Full-text screening was conducted by two independent reviewers. Data extraction was completed by one reviewer and checked by another.

Findings: were synthesised using qualitative content analysis. Reporting followed the Preferred Reporting Items for Systematic Reviews and Meta-Analyses-Extension for Scoping Reviews (PRIMSA-ScR).

Results: Of the 17,700 publications identified, 14 met our inclusion criteria, with majority from the United States (n=8). Most reported the perspectives of carers (n=6), health care providers (n=3) or both. Most publications did not specify the rurality of the study setting (n=10), but four studies included regional or rural perspectives. Commonly reported roles of primary care providers in healthcare transition included care coordination, continuity of care, service referrals, advocacy and support and transition planning.

Conclusion: Our review highlights that the role of primary care providers in healthcare transition for young people with intellectual disability remains poorly defined. Key evidence gaps include the limited involvement of people with intellectual disability in research and a lack of evidence on how rurality influences primary care involvement. Future research addressing these gaps during transition for young people with intellectual disability should be co-designed with primary care providers. Primary care providers have key roles which when appropriately defined, can be harnessed to improve transition experiences and reduce health inequities in this priority population.

Community, Culture and Place: Locally Led Rural Health

Patient-Reported Factors Influencing Participation in Home-Based Subcutaneous Immunoglobulin (SCIg) Therapy in Rural and Remote NSW: A Qualitative Study

Presenter: Karen Beattie

Authors and affiliations

1. Mrs Karen Beattie, Western NSW Local Health District

Abstract

Background and aims: Immunoglobulin replacement therapy is the standard treatment for patients with primary and secondary immunodeficiencies and may be administered intravenously in hospital settings or subcutaneously in the home. Home-based, self-administered subcutaneous immunoglobulin (SCIg) therapy is clinically effective, associated with fewer systemic adverse events, improves patient autonomy and quality of life and offers significant healthcare cost savings. As healthcare systems increasingly prioritise home-based models of care, understanding the factors that support or hinder successful participation in SCIg programs is essential. Although SCIg has the potential to reduce the burden of treatment for rural and remote patients, factors including access to specialist support, service coordination and logistical demands may influence whether home-based therapy is practical and sustainable. This study aims to explore patient-reported barriers and enablers to participation in a home-based SCIg program within a rural and remote setting.

Methods: A qualitative descriptive study will use semi-structured interviews with adults currently or previously enrolled in the Western NSW Local Health District (WNSWLHD) SCIg Home Injection Program. Following informed consent, interviews will be conducted during home visits to explore participants experiences of home-based SCIg therapy within their treatment environment. Interview data will be analysed thematically to identify factors influencing treatment engagement, self-management, service delivery and patient experience.

Expected outcomes: The study is expected to identify factors that facilitate successful participation in home-based SCIg therapy, including treatment flexibility, greater independence, reduced travel burden, increased confidence in self-management and effective support from healthcare providers. Anticipated barriers include limited access to specialist services, supply and consumable availability, cold-chain storage requirements, sharps and equipment disposal, digital connectivity and reduced access to ongoing clinical support, particularly for geographically isolated patients.

Challenges: Recruiting participants across a geographically dispersed health district and capturing a broad range of rural and remote experiences may present logistical challenges. Ensuring representation from participants with varying treatment durations and levels of confidence with self-administration will be important to maximise the transferability of findings.

Conclusion: This study will address an important evidence gap regarding the experiences of rural and remote patients receiving home-based SCIg therapy.

Findings: will inform service improvements within WNSWLHD and contribute to the development of equitable, patient-centred and sustainable models of care. By identifying barriers and enablers to successful home treatment, the study will support strategies to improve access, optimise patient experience and strengthen long-term delivery of SCIg therapy for geographically isolated populations.

Welcome Baby to Bourke Ceremony. A Cultural Ceremony ensuring our Babies are connected to Country.

Presenter: Pat Canty

Authors and affiliations

1. Patricia Canty, Western NSW LHD

Abstract

Welcome Baby to Country Ceremony, commenced in Bourke five years ago. The Welcome Baby to Country was a concept discussed during the lengthy discussions with the Bourke community in regards to Bourke Health Service no longer providing birthing services to the community. It was important for our community to still ensure that our babies are connected to our community and country. The Ceremony holds deep significance for local Aboriginal families especially, as the women have to leave Bourke to give birth. This cultural ceremony focusses on alleviating the cultural disconnection experienced by Aboriginal women from not birthing on country, and establishing a cultural connection for their babies and children. The Ceremony brings together, families, community and our Elders Introducing our babies to community is a traditional practice that has been taken place across Australia through generations and this practice dates back to thousands of years. It is important we have this ceremony for our babies, especially for our Aboriginal babies. Being born off Country, can have an impact on their cultural ties to the land in years to come. Aboriginal people belong to and are connected to the land and water, its our identity. The Ceremony is a collaborative approach with agencies across the community. Collaborating in this cultural ceremony empowers our community to ensure that it is community-owned and led event with a cultural platform. With this community initiative and the Committee works hard so it does not leave any little newborns out. Its imperative that we ensure everyone is offered this cultural experience not only for their babies but their families as well. The Dad's play a major role in the Ceremony as well. The introduction of the First 2000 Days Health and Wellbeing program in Bourke, supporting children from birth to five years and their families to improve health and social outcomes, therefore this Ceremony is also a key initiative for the program.The Welcome Baby to Bourke Ceremony assisted by our by Aboriginal Elders includes a traditional welcome, a formal welcome and a presentation of the children to the community. The whole family are involved and supported by other community members and importantly acknowledged by our Aboriginal Elders which provides the carriage for strengthening family capacity.The Welcome Baby to Bourke ceremony continues to thrive and is now being offered in other communities across the Local Health District. We need to keep our Culture strong.

Yarning about Marang Dhali: How an Aboriginal healthy eating and cooking program is bridging gaps in Western NSW.

Presenter: Reza Godwin

Authors and affiliations

1. Mr Reza Godwin, University of Sydney
2. Mrs Gabriella Barrett, Western NSW LHD

Abstract

Background & aims: Marang Dhali Eating Well is an Aboriginal cooking and healthy eating program delivered in Western NSW, formed as a successful partnership between Health Promotion and the Aboriginal health workforce, who facilitate the program. Our research aims to answer two questions: 'What are the experiences of participants and Facilitators of the Marang Dhali Eating Well program?' and 'Does Marang Dhali meet the needs and expectations of communities in Western NSW?' Through our research, we aim to improve the viability and effectiveness of Marang Dhali, while continuing to prioritise the needs of the Aboriginal community.

Methods: for our study were devised to follow both an Indigenist framework, as described in Ways of Knowing, Being and Doing, and Braun & Clarke's thematic analysis. Done with the intention to decolonise our research process, whilst acknowledging the value in both Indigenous and Western knowledge traditions. Our methods included collecting qualitative data through two yarning groups, including facilitators and participants of the program. The yarning groups were recorded and turned into a transcript, and codes and themes were generated from the transcript. The research team and Aboriginal Research Governance Group discussed these themes.

Results: Our preliminary results show a desire to continue to engage in and innovate the program from both the Facilitators and participants. Demonstrating a positive benefit for Aboriginal communities in Western NSW from the program. Themes from our yarning also show the realities of how a colonial legacy has affected the eating habits of a community. However, the resilience of Aboriginal communities to respond to and address this challenge is also being demonstrated. Currently, challenges of the research include time constraints of the student research block and the difficulties of novice researchers undertaking the ethics submissions for the first time.

Implications: This research provides the opportunity for self-determination in privileging Aboriginal and Torres Strait Islander ways of knowing, being and doing. In sharing this research, we contribute to reporting on culturally informed program evaluations. It is important to acknowledge the difficulties in doing research the right way, and we believe that it starts with partnering with Aboriginal staff and communities to recentre Aboriginal people in their own health care. While this option may not be as appealing from a government level, due to funding and time constraints, we believe this approach is what grants us the opportunity to improve and innovate more effective community programs for all.

Assessing Senior Farmers Work Capacity on Farms in NSW Central West Region

Presenter: Ruby Staunton

Authors and affiliations

1. Ms Ruby Staunton, School of Allied Health, Exercise and Sports Sciences, Charles Sturt University, Orange NSW
2. Dr Shaoyu Wang, School of Dentistry and Medical Sciences, Charles Sturt University, Orange NSW
3. Dr Judith Crockett, School of Nursing, Paramedicine and Healthcare Sciences, Charles Sturt University, Bathurst NSW
4. Ms Haimei Zhang, Community Aged Care/Hospital in the Home, Bathurst Health Service, Bathurst NSW

Abstract

Background: The sustainability of rural agriculture is threatened by an ageing and shrinking workforce alongside a shortage of younger workers willing to inherit farm work. This study aimed to investigate the work capacity of senior agricultural workers in the Central West region of NSW. It evaluated senior farmers' self-assessed health, medical conditions, and explored their intentions of continued farm involvement beyond the age of 65.

Methods: A mixed methods questionnaire was provided to a targeted cohort of agricultural workers aged 45+ within the Central West. Eligible participants had to be actively engaged in farming activities for at least 50% of their time. Data collection tracked demographic attributes, farm types, operational roles, self-perceived health, physical diagnoses, and long-term work intentions.

Results: A sample of eligible 18 participants with a median age 66-70 (range 51-75+) filled in the questionnaire. The data analysis revealed that cattle (78%), sheep (67%), and cropping (61%) represented the primary farm models across standalone and specified mixed farms. Farm owners

comprised 78% of the cohort, with 56% operating simultaneously as farm managers. The three major health conditions identified included lower back pain (56%), hearing difficulties (44%) and eye trouble (33%). Despite physical conditions, 100% of the respondents characterised their overall health as "Good" or better, with 56% labelling it as "Very Good". 67% expressed a strong intent to continue agricultural labour beyond the age of 65. Operational decisions were influenced by perceived personal capability, environment (weather patterns) and financial insecurity. Spouses, partners, and children (50%) represented the primary influencing parties regarding farm work continuation. Peers and accountants had a combined influence on continuation of farm work with of 14%.

Implications: Senior workers exhibit high health optimism and strong behavioural commitments to farm work due to generational norms and succession requirements. The three major health conditions resist effective working capacity even through a 'good' level of self-reported health. This can result in unsafe operation on farmland due to the discrepancies in their perceived and actual health levels.The limitation of this study is self-selection bias as the enrolment relied on voluntary responses. The data may overrepresent healthier, highly motivated individuals. This pilot study, with a small sample size, however, can provide foundations for further research.

Addressing enablers and barriers to accessing support through Community Reinforcement and Family Training

Presenter: Heidi Gray

Authors and affiliations

1. Mrs Heidi Gray, Rural Health Research Institute, Charles Sturt University
2. Dr Nicole Snowdon, Rural Health Research Institute, Charles Sturt University
3. Dr Nicola Ivory, School of Psychology, Charles Sturt University
4. Dr Matt Thomas, School of Psychology, Charles Sturt University
5. Prof Julaine Allan, Rural Health Research Institute, Charles Sturt University

Abstract

Background and aims: Concerned significant others (CSOs) affected by a family member's substance use frequently experience psychological, physical, social, and financial harms. Despite this burden, many CSOs do not access support, particularly in rural Australia where service availability may be limited. Community Reinforcement and Family Training (CRAFT) is an evidence-based intervention designed to support CSOs and facilitate treatment engagement among loved ones with substance use problems. This research aimed to identify barriers and enablers to support-seeking and CSOs' preferences when accessing support, and to examine the extent to which online practitioner-led CRAFT addresses these factors.

Methods: Semi-structured interviews were conducted with 26 rural Australian CSOs who had participated in a parent CRAFT trial. Interview data were analysed to identify barriers and enablers to support-seeking, explore CSOs' support needs and preferences, and examine participants' experiences of CRAFT.

Findings from these analyses were then integrated to examine the extent to which CRAFT addresses factors influencing support engagement.

Results: Participants ranged from 25 to 67 years, predominantly identifying as female (76.9%) and white/Caucasian (84.6%). All participants resided in rural Australia.

Findings indicated that access to support was influenced by personal, structural, and service-delivery factors, while CSOs expressed a need for professional support that recognised their own wellbeing and provided practical, effective assistance. Experiences of CRAFT aligned closely with

these identified needs and preferences. Participants valued the structured, skills-based nature of the program, the support provided by practitioners, and the accessibility of online delivery. CRAFT was perceived to address several barriers to support engagement while meeting key support preferences through validation of CSOs' experiences, practical coping strategies, and a focus on their own wellbeing. Participants also reported improvements in wellbeing and relationships with their loved ones.

Implications: Online practitioner-led CRAFT appears well-positioned to address barriers to support-seeking among rural Australian CSOs while providing the professional support, practical strategies, and recognition of CSOs' own needs identified as important by participants. Expanding access to CRAFT may improve support engagement and outcomes for CSOs affected by another person's substance use.

Lightening Talks

Identifying Effective Hypertension Screening and Follow-Up Strategies for Rural and Remote Australians

Presenter: Catherine Sanford

Authors and affiliations

1. Ms Jacki Hanniver, Royal Flying Doctor Service
2. Dr Naimh Chapman, The University of Sydney
3. Dr Dean Picone, The University of Sydney
4. Ms, Danielle White, Broken Hill University Department of Rural Health, The University of Sydney
5. Dr Aliza Lord, Broken Hill University Department of Rural Health, The University of Sydney
6. Dr Riaz Uddin, Broken Hill University Department of Rural Health, The University of Sydney

Background and aims: Hypertension is the leading modifiable risk factor for cardiovascular disease, yet half of Australians with hypertension are undiagnosed. Rural and remote populations experience a disproportionate burden of hypertension and cardiovascular disease. Most cases of hypertension are identified in primary care; however, rural Australians also face reduced access to primary healthcare services. Community-based screening is effective in identifying high blood pressure (BP), however, evidence shows that, even when services are readily available, most people do not follow-up with a health professional. This study aims to identify effective, acceptable and scalable community-based settings for hypertension detection in rural and remote communities and to co-design structured, locally relevant follow-up pathways that support blood pressure management.

Methods: This mixed-methods study will be conducted in Far West New South Wales and comprises three phases: community consultation; community-based blood pressure screening; and action planning workshops with health care providers Consultations with community representatives and primary healthcare providers will inform screening implementation. Screening will occur in workplaces, schools, and community events across Broken Hill and surrounding communities. Adults aged 18 years and older will be recruited. Blood pressure will be measured according to the internationally recognised May Measurement Month protocol. Brief post-screening interviews will explore barriers to care and the acceptability of screening and follow-up approaches. A one-month follow-up survey will assess healthcare engagement after screening. Workshop discussions with local healthcare providers and service managers will use the Theoretical Framework of Acceptability to co-design feasible referral and management pathways. Quantitative data will be analysed using descriptive and comparative statistics, while qualitative data will undergo thematic analysis.

Expected outcomes: The study is expected to identify which community settings most effectively detect previously undiagnosed or uncontrolled hypertension in rural populations. It will generate new evidence regarding the acceptability of community-based screening and identify factors influencing follow-up care. The project will also produce community-informed and health service-endorsed pathways to improve access to hypertension management in rural and remote settings.

Implications: This study will provide practical evidence on where and how community-based screening can be most effectively implemented and how acceptable follow-up pathways can be integrated with existing health services. The findings will inform future large-scale implementation and evaluation of rural hypertension screening and management models, supporting improved cardiovascular health outcomes and health equity for underserved communities.

Targeted community screening for pre-diabetes and type 2 diabetes mellitus in Far West NSW: an equitable approach to increasing population coverage of individual health screening

Presenter: Heath Pillen

Authors and affiliations

1. Mr James Wells, Far West Local Health District

Background and aims: Rural primary care services currently rely on opportunistic screening to identify new cases of pre-diabetes and type 2 diabetes (T2DM). By itself however, this approach is inadequate in achieving sufficient population coverage, particularly amongst those that 'fall between the gaps' for opportunistic health checks and those that either avoid and/or encounter difficulties in accessing (culturally appropriate) primary care. Using data collected through community-based targeted health screening events performed across the Far West Local Health District (FWLHD), we sought to determine the diagnostic yield and reach of screening activities delivered to those with no known diabetes so to assess targeting effectiveness.

Methods: This descriptive study involved secondary analysis of data collected through organised community screening conducted by the FWLHD Integrated Care team from February 2025 until May 2026. Screening events were performed in high traffic public spaces, shopping centres, agricultural fairs, and cultural/community events; concentrated around the central service hub of Broken Hill and performed across small/medium rural towns and remote areas. During screening events, individuals were approached at random to participate in an assessment of diabetes risk using the AUSDRISK questionnaire, with point of care HbA1c tests offered to those with an AUSDRISK score ≥12. Demographic and service use data were collected while participants waited for their test result. Participants were counselled on test results and referral made where appropriate for further medical review.

Expected outcomes: The available data will provide important findings regarding diagnostic yield, providing an indication of how effective a screening program is at finding a new case. This is important for targeted screening, which seeks to reduce the number who need to be screened relative to population screening, with high diagnostic yield suggestive of efficient targeting. Diagnostic yield in this study relates to the: number of new cases of pre-diabetes (relative to total number of people screened), number of new cases of T2DM amongst those with either no known diabetes or pre-diabetes, and number of new cases of T2DM with HbA1c >7.0%. Diagnostic yield will be compared across settings and population groups to identify those likely to benefit most from screening and in what settings these groups can be accessed.

Implications: This study has the potential to establish the role of community-based targeted diabetes screening alongside opportunistic screening in primary care clinics, specifically identifying settings and population groups that are likely to benefit from screening and guiding decisions about which populations to screen.

Evaluation of CoreConnect: A collaborative training approach for strengthening the rural psychology workforce

Presenter: Matt Thomas

Authors and affiliations

1. Ms Nicole Sudmalis, Health in Mind & School of Psychology, Charles Sturt University
2. Ms Zora Todoroska, Marathon Health
3. Mrs Catherine Sanford, Broken Hill University Department of Rural Health
4. Mrs Kylie Irvin, Marathon Health

Background and aims: Rural and regional Australia continues to experience critical shortages in the mental health workforce. The development of the psychology workforce is constrained by the time and cost associated with training and supervising provisional psychologists, alongside persistent workforce maldistribution. In response to these barriers, CoreConnect was developed as a collaborative training program across four organisations in regional New South Wales. The program offered provisional psychologists free weekly online workshops, on topics that prepared them to achieve the required competencies and pass the national psychology exam. This study aimed to explore key stakeholders' perceptions of the program's effectiveness, including learning outcomes, workforce impacts, and areas for improvement.

Methods: A qualitative descriptive design was used. Data were collected from 17 provisional psychologists, seven supervisors, and six employers involved in the CoreConnect program. Participants completed open-ended surveys at 12 weeks, 6 months, and 12 months, and semi-structured interviews at approximately 12 months. Inductive thematic analysis was conducted to identify common themes related to experiences, outcomes, and recommendations for improvement of CoreConnect.

Results: Five key themes emerged. CoreConnect was perceived to enhance professional growth, confidence, and development of core competencies, while accelerating learning and improving preparedness for the National Psychology Exam. Participants highlighted strong applicability of learning to clinical practice, as well as increased peer connection and reduced professional isolation. Supervisors and employers reported time and cost efficiencies through shared training delivery and reduced supervisory burden. The program also supported workforce outcomes, including improved attraction, recruitment, and retention of provisional psychologists. Recommendations for improvement were used to drive continuous improvement and included greater emphasis on practical skill development, balancing training time with clinical workload, and increased opportunities for face-to-face engagement.

Implications: This evaluation has shown CoreConnect can improve the training efficiency of early career psychologists, creating greater numbers of employment opportunities and strengthening workforce development in rural communities. While the result of this study are promising, further evaluation is required to understand the effectiveness of the model in attracting and retaining early career psychologists. Further translation of the CoreConnect model has the potential to support national rural mental health workforce objectives and improve access to mental health care in rural and remote communities.

Carer Problematic Alcohol Use and Child Mental Health in Rural Australia

Presenter: Md Parvez Mosharaf

Authors and affiliations

1. Dr Mamun Huda, School of Rural Medicine, Charles Sturt University, Orange, NSW, Australia
2. Dr Catherine Keniry, School of Rural Medicine, Charles Sturt University, Orange, NSW, Australia

Background: Problematic alcohol use among primary carers may adversely affect children's mental health. In Australia, these impacts may differ between urban and rural areas due to differences in social, family, and service-access contexts. However, evidence on geographical differences in the prevalence of problematic alcohol use and its association with children's mental health difficulties symptoms remain limited in Australia. Understanding this relationship may inform targeted prevention and support strategies. We aimed this study to examine the prevalence of carer problematic alcohol use across major cities and rural Australia, and its association with children's mental health difficulties.

Methods: Data from 3,537 children in the K-cohort (Wave 6) from Growing Up in Australia: The Longitudinal Study of Australian Children, were analyzed cross-sectionally. Problematic alcohol use among primary carers was assessed as a binary exposure (yes/no), and geographic remoteness was classified as major cities or rural areas. Children's mental health difficulties symptoms were measured using the Strengths and Difficulties Questionnaire (SDQ). Carer problematic alcohol use prevalence was estimated overall and by remoteness. Regression analyses were conducted to examine associations between carer problematic alcohol use and child SDQ scores.

Results: Among the study children, about 49% were female, and 36.5% lived in rural areas. The overall prevalence of carer problematic alcohol use was 12.8% (95% CI: 11.7%, 13.9%) and was significantly higher in rural areas than in major cities (15.8% vs 11.0%; $p< 0.001$). Carer problematic alcohol use was significantly associated with child mental health difficulties symptom ($\beta = 0.94$; 95% CI: 0.33, 1.54; $p= 0.002$). The strength of the association was slightly higher in rural areas than in major cities, although the difference was not statistically significant.

Conclusion: Preliminary findings from this study highlight that carer problematic alcohol use is prevalent among Australian families and significantly higher in rural areas. It is associated with poorer child mental health outcomes, highlighting the need for support strategies that address carer alcohol use and child wellbeing, particularly in rural communities.

Country Kids on the Move: Regional Interhospital Transfers by the Newborn and Paediatric Emergency Transport Service (NETS)

Presenter: Saara Silvola

Authors and affiliations

1. Saara Silvola, Wagga Wagga Rural Clinical Campus, School of Clinical Medicine, University of New South Wales, NSW, Australia
2. Dr Emily Proudfoot, Department of Paediatrics, Wagga Wagga Base Hospital, NSW, Australia
3. A/Prof Kathryn Browning Carmo, The Newborn and Paediatric Emergency Transport Service, NSW, Australia

Background and Aims: NETS provides emergency stabilisation and interhospital transfer (IHT) of neonatal and paediatric patients in New South Wales (NSW) whose care needs exceed the capacity of the referring hospital. NETS addresses crucial healthcare needs particularly in the regional context, where access to paediatric intensive care services is limited. However, unnecessary transfers should be minimised considering the significant psychosocial and medical risks of IHT. It is currently unclear who is transferred and how local service provision could be improved to continue local management of selected patients. This research aims to describe and compare the transfer characteristics of patients transferred by NSW NETS.

Methods: A retrospective cohort study analysed 523 transfers. Data was extracted from the Newborn and Paediatric Emergency Transport Service database. Transfers were from 11 regional NSW Level 4 paediatric facilities, occurred during 2023 or 2024 and included 0-16-year-old participants. For comparative purposes, referral frequency was corrected for the size of the referring hospital (per 100 beds). Descriptive statistics characterised the dataset.

Results: A total of 523 patients were included in this study. Patients were most frequently transferred in a helicopter (n=281, 53.73%). There was substantial variation in the number of transfers per facility after correcting for hospital size. A neonatal intensive care unit accepted 52.77% of transfers (n=276), and 15.30% of transfers arrived at an emergency department (n=80).

Implications: The variation in the adjusted number of transfers between Level 4 referring facilities is possibly influenced by a multitude of factors extrinsic to the acuity of patient presentations. Such factors include medical, nursing, and allied health staffing, workload, and changing expectations of

families, all of which are difficult to quantify and are likely to fluctuate daily. Therefore, the referring hospital's capacity to manage a patient for whom transfer is being considered should be evaluated on a case-by-case basis with all factors considered. A subset of patients whose transfer may have been affected by these contextual factors include those who were accepted through an emergency department, given they are less likely to have fulfilled established medical intensive care admission criteria. Addressing local logistical factors, such as equipment availability, staffing and expertise, and the acuity of the ward, may therefore reduce the need for transfer in select patients.

Facilitators and Barriers of a Successful Hybrid Outpatient Telehealth Model in a Very Remote Aboriginal Community of Central Australia?

Presenter: Emily Saurman

Background and Aim: There is limited evidence on the role of telehealth to improve access to outpatient services for Aboriginal peoples living in very remote Central Australian communities. The aim of this study was to co-design, implement and evaluate the impact of telehealth on access to specialist healthcare in Central Australia.

Methods: A qualitative study was conducted using a Participatory Action Research approach. Yarns with community members and interviews with health care providers were undertaken between August 2023 and February 2026 in a very remote Central Australian community. Data were transcribed and thematically analysed.

Results: During the codesign phase it was established that telehealth was acceptable to consumers – who often preferred to remain in their community for care – when medical specialist consultations were coordinated and supported by trusted local primary health care (PHC) staff. Telehealth was acceptable to PHC staff when the technology was simple (i.e. access via clicking a single link). Critical enablers included enthusiastic clinic leadership and Aboriginal staff. Key challenges included ongoing IT issues such as poor audio quality, disruptions due to high PHC staff turnover, and limited professional development opportunities for Aboriginal staff supporting telehealth. Future needs identified included better IT infrastructure and IT support, and upskilling for Aboriginal staff, who were integral to telehealth's success.

Conclusion: A hybrid model of outpatient telehealth was successfully codesigned and implemented in a very remote Aboriginal community in Central Australia, where it was supported by PHC clinic staff whom community members trusted.

Rural IMPACT: a framework to determine rural site suitability for inclusion into Low-Infrastructure Immunophenotyping Clinical Trials

Presenter: Daniel Weber

Authors and affiliations

1. Mr Daniel Weber, University of Sydney School of Rural Health
2. Dr Natalie Smith, University of Sydney
3. Ms Sandra Taylor, Western Cancer Centre
4. Dr Andrew Jensen, Western Cancer Centre
5. Dr Florian Honeyball, Western Cancer Centre
6. Dr Rajat Rai, Western Cancer Centre
7. A/Prof Helen McGuire, University of Sydney

Background and Aims: Rural cancer patients are less able to access clinical trials, and experience poorer health outcomes. Biomarker immunophenotyping clinical trials require specialised infrastructure, governance, and multidisciplinary support, limiting the inclusion of rural sites, and

thus rural patients. The ability to comprehensively characterise and monitor immune cells is of particular relevance to cancer patients being treated with immune modulating therapies, to reveal underlying immune relationships to treatment response and risk of side effects. Utilising a low-infrastructure approach to trial design may help include rural populations into immunophenotyping clinical trials. This decentralisation may be supported by the creation of tools assessing site suitability to this approach.The aim of this project is to develop and validate a framework to assess the suitability of rural sites for inclusion into immunophenotyping trials with low-infrastructure workflows.

Methods: Two literature review identified frameworks were integrated with a protocol for conducting low-infrastructure blood immune monitoring, to create a suitability checklist covering the domains: Research Team, Infrastructure, Study Management, Data Collection/Management, Quality Oversight, and Ethics/Safety. The checklist was applied at four rural sites with clinician and staff input to determine usability and ability to determine site strengths and limitations (tool validation rather than site eligibility).

Results: The Rural IMPACT tool was implemented across all sites and demonstrated good validity and usability, enabling identification of existing capabilities and common barriers facing rural sites. Stakeholder feedback supported the checklist's relevance, and potential to facilitate structured discussions between rural sites and trial teams.

Conclusions: The Rural IMPACT tool provides a practical framework for assessing rural site readiness for inclusion into immunophenotyping clinical trials. Use of the framework may support greater understanding by all stakeholders of site suitability for low-infrastructure clinical trials, and aid promoting equitable access to trials for rural populations. Further validation and development is warranted.

Rural Research is Achievable: Radiation Therapists' Experiences Implementing a First Clinical Trial

Presenter: Rachael Beldham-Collins

Authors and affiliations

1. Mrs Rachael Beldham-Collins, WNSWLHD Radiation Oncology
2. Mrs Sandra Taylor, Dubbo health service
3. Mrs Denise Andree-Evarts, Western Cancer Care Centre
4. Ms Marissa Morey, Western Cancer Care Centre
5. Dr Susan Carroll, Western Cancer Care Centre
6. Dr Joseph Chan, Northern Sydney Local Health District
7. Mrs Catherine Osborne, Western Cancer Care Centre

Background and aims: Clinical trials are critical to advancing radiation therapy, yet participation from rural centres remains limited due to logistical and resource related barriers. Radiation therapists (RTs) in rural settings often assume additional responsibilities to support trial activities, potentially impacting workload and job satisfaction. This study explored RTs' perceptions and experiences following implementation of the first clinical trial at a rural radiation therapy centre.

Methods: An anonymous survey was emailed to all RTs at the rural centre that initiated its first clinical trial in mid-2025. The survey included 10 multiple-choice, 11 Likert scale, and 2 open-ended questions assessing experiences with trial implementation, workload impact, training adequacy, and support needs. Data were analysed using descriptive statistics and thematic analysis.

Results: Response rate was 92% (11/12). All RTs received trial related training, with 63.6% (7/11) participating in trial activities including patient consent, screening, treatment planning, data collection/entry, auditing, and trial coordination. Perceptions were positive: 71.4% (5/7) strongly

agreed/agreed clinical trial work was valued departmentally, though 28.6% (2/7) reported poorly defined role responsibilities. Staff shortages were the primary barrier, while clear protocols/workflow processes were key enablers. Five themes were identified regarding motivators and supports for sustained involvement: advancing equity of care, professional growth and development, adequate workforce capacity, dedicated resources and infrastructure, recognition and organisational support.

Conclusion: RTs demonstrated strong commitment to clinical trial implementation, motivated by equity of care and professional growth. Successful rural trial participation is achievable with investment in workforce capacity and research infrastructure, offering a model for expanding access in rural centres.

Feasibility and acceptability of continuous glucose monitoring for older adults with type 2 diabetes in a rural residential aged care facility: a mixed-methods pilot study

Presenter: Alex Hoyle

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1. Ms Amanda Taylor, Marathon Health
2. Ms Alison Amor, Marathon Health
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6. Dr Anna Knight, CSU School of Rural Medicine
7. Dr Mamun Huda, CSU School of Rural Medicine
8. Dr Catherine Keniry, CSU School of Rural Medicine

Background and Aims: Type 2 diabetes mellitus is common among older Australians living in Residential Aged Care Facilities (RACFs), where management is complicated by frailty, cognitive impairment, variable oral intake, staff workflows and reliance on capillary blood glucose monitoring. Continuous glucose monitoring (CGM) improves visibility of glycaemic patterns and support safer, more person-centred diabetes care; however, its feasibility, tolerability and acceptability in rural Australian RAC has never been investigated. The aim of this study is to evaluate the feasibility, tolerability and acceptability of CGM among older residents with type 2 diabetes in a rural RACF, and to explore resident, carer and staff experiences of implementation in routine care.

Methods: This investigator-initiated, single-centre mixed-methods pilot study is underway in a RACF in a small rural NSW town (MMM 5). Approximately 10 residents aged over 65 years with type 2 diabetes, up to 10 carers and approximately 20 nursing staff will be invited to participate. Residents will wear a Dexcom ONE+ CGM system for 84 days as an adjunct to usual care. Quantitative outcomes including device wear time, adverse events, glucose metrics, clinical indicators, patient-reported experience and outcome measures, and staff acceptability using the Theoretical Framework of Acceptability are being captured. Semi-structured interviews with residents, carers and staff will explore perceived benefits, burden, usability, workflow impacts and implementation requirements. Quantitative data will be summarised descriptively, and interview data will be analysed thematically.

Expected outcomes and implications: The study will generate preliminary evidence on whether CGM can be safely and practically implemented in a rural residential aged care setting in Australia. It is expected to identify resident and carer perceptions of benefit and burden, staff confidence and workflow impacts, and facility-level requirements including education, governance, policy and information technology infrastructure. Findings will inform the design of larger implementation

studies and support future integration of continuous glucose monitoring into diabetes care for older Australians living in residential aged care.

Mortality patterns of farmers compared to the general population in Australia from 2012 to 2021

Presenter: Carlos Mesa Castrillon

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Objective: This study aimed to compare the all-cause and specific-cause death rates of Australian farmers aged 20–74 years with those of the Australian general population from 2012 to 2021.

Methods: Data were extracted from the Australian Bureau of Statistics deaths collection, which includes the underlying cause of death according to the International Statistical Classification of Diseases (ICD-10). Death registrations were linked to the 2011 Census to identify occupations according to the Australian and New Zealand Standard Classification of Occupations. Direct age-standardised death rates and Standardised Mortality Ratios (SMRs) were calculated for all-cause mortality and major causes, with the 95% confidence interval (95% CI).

Results: There were 375 620 recorded deaths in Australia; of these, 60% were males. From all recorded deaths, 3835 (1%) had their occupation recorded as farmer. Of all farmers' deaths, 3010 (78.5%) were males, representing 1.3% of all male deaths in Australia. The overall age-standardised death rate (per 100 000) due to all causes for farmers (1505) was lower than the general population (2335) (SMR: 0.65, 95% CI 0.63 to 0.66). Both female and male farmers showed a lower age-standardised death rate (per 100 000) due to all causes compared to the general population counterpart (female [1050] and male [1701] farmers vs female [1839] and male [2850] general population); (SMR 0.60, 95% CI 0.58 to 0.62) and (SMR 0.57, 95% CI 0.53 to 0.61), respectively. The main causes of death (death rate per 100 000) for both female and male farmers were neoplasms (649 and 716), circulatory system (107 and 353), and all external causes (97 and 353), respectively. The general population had the same main causes of death (912 and 1155), (271 and 597), and (146 and 375), respectively.

Conclusion: Female and male farmers showed lower rates compared to the general population of Australia of age-standardised deaths due to all causes and lower rates for specific causes of mortality such as neoplasms, circulatory diseases, all external causes, respiratory diseases, diabetes and dementia, including Alzheimer's disease. Relevance: Novel data on female Australian farmers' mortality adds to the literature. We hypothesize that better public health measures or awareness in the farming population, population changes, underreporting, or data collection issues might explain the lower mortality rates. However, these findings support other international data showing that overall mortality rates among farmers are lower than those in the general population in the United States, France, Great Britain, and Sweden.

Pregnancy Outcomes in Women with Class I-III Obesity in Regional and Rural Australia: A 5-year Hospital-Based Retrospective Study

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Background/Aim: Obesity during pregnancy is an emerging global and national health concern and is associated with an increased risk of adverse maternal and neonatal complications. Despite well-known research into pregnancy outcomes associated with obesity there remains a lack of robust local evidence examining these outcomes across different obesity classes (Class I-III) in rural populations. This study aims to address this gap in local data by examining the prevalence and trends in maternal obesity and its associated pregnancy outcomes in a regional Australian cohort.

Methods: Using a retrospective cohort audit study design, we obtained data from the eMaternity electronic medical record system for women who gave birth at Wagga Wagga Base Hospital between January 2021 to December 2025. A total of 6,614 birth records were analysed. Maternal Body Mass Index (BMI) at antenatal booking was utilised as the primary exposure and was further classified into obesity Class I (30-34.9kg/m2), Class II (35-39.9kg/m2) and Class III (³40kg/m2). Pregnancy outcomes of interest included gestational diabetes, gestational hypertension, labour-related complications, preterm birth, birthweight, and stillbirth. Prevalence was estimated and trends examined using average annual rate of change. The association between maternal obesity and pregnancy outcomes was assessed using logistic regression, adjusted for maternal sociodemographic, health, and healthcare-related factors.

Results: The overall prevalence of maternal obesity was 31.9% (95% CI: 30.7–33.0). By class, Class I obesity was most common (15.3%), followed by Class II (8.7%) and Class III (7.9%). Obesity prevalence was notably higher among women in outer regional or remote areas (41.2%) compared to inner regional areas (29.6%). The highest prevalence observed in the most disadvantaged quintiles (Q1: 37.8%; Q2: 39.2%) compared to Q3–5 (27.6%). Obesity prevalence increased over the study period, from 29.1% in 2021 to 34.4% in 2025, representing an average annual increase of 3.2% points. The steepest rise was observed in Class II obesity (5.4 %). All obesity classes were significantly associated with increased odds of gestational diabetes and gestational hypertension, with risk escalating with obesity severity (GDM OR range: 2.30–3.79; gestational hypertension OR range: 1.44–1.96). Class I obesity was associated with reduced odds of labour complications (OR 0.77), while Class III was the only class significantly associated with high birthweight

Conclusion: Maternal obesity is prevalent and rising in regional Australia, with severity strongly associated with gestational diabetes, hypertension, and high birthweight. These findings underscore the urgent need for targeted antenatal interventions for women with obesity in regional and rural settings.