



HANDBOOK



13TH NATIONAL RURAL HEALTH CONFERENCE

24-27 May 2015, Darwin Convention Centre, NT

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WELCOME



“You have come by way of the Larrakia Land. You will hear the voice of Larrakia ancestors. When you leave, the Larrakia message will stay with you.”

—The late Reverend Walter Fejo

Welcome to Larrakia Country

The Larrakia people are the traditional owners of the Darwin region. We welcome you to our beautiful land and sea country. We have a deep, spiritual connection with our country and are responsible for making sure it is respected by all those that use it.

Our country runs from Cox Peninsula in the west to Gunn Point in the north, Adelaide River in the east and down to the Manton Dam area southwards.

Larrakia Nation Aboriginal Corporation was created in 1997 by the Northern Land Council to represent the interests of and act to further the aspirations of the eight Larrakia families. With a governing board of eight Larrakia people, it is a dynamic, membership-based organisation, and a major Aboriginal service delivery organisation in the areas of community services, homelessness support, rangers and arts and culture.

Larrakia Nation has won a number of awards for the quality of its service delivery, including the Australian Crime and Violence Prevention Awards in 2012 where it was a National Winner and the Homeless Awards in 2013 where it was the National Winner in the Indigenous Category.

Health and healing has been a longstanding part of the organisation’s vision for the Larrakia people as the foundation of a sustainable future for the Larrakia and for the Indigenous community in the Darwin region.



Meals on Wheels



Meals on Wheels



Heal Program



Night Patrol Program

WELCOME



Like its biennial predecessors, the 13th National Rural Health Conference has been designed with only one thing in mind: to make a contribution to better health and wellbeing for the people of rural, regional and remote Australia.

The conference belongs to those people and is managed on their behalf by the National Rural Health Alliance.

It is a chance to learn from people in other parts of the country, and to make new friends. It is an opportunity for the NRHA to give back to those who live and work in rural and remote areas and to thank them for supporting our national work.

It's a health conference but one that recognises the broad determinants of health and the critical role played in rural health and wellbeing by education, rural industries and a wide range of sectors and professions. All of us no doubt share the view that the benefits of life in this so lucky country should be shared fairly among all of those who call Australia home.

Please take advantage of the opportunities provided for delegates to submit proposals for recommendations to make our views known; this process allows some of the networking and talk to be converted to action. Together, we can be a voice to politicians and policy makers on behalf of all rural and remote Australia.

We hope you will be happy for the conference to keep you busy for three or four days. When people gather from widespread remote areas as well as from regional centres and capital cities, they expect to work hard and play hard. Time is precious so that is what you will be able to do in Darwin at this conference.

Thank you for making the effort to be here and we trust you will find it a personally and professionally rewarding experience.

Tim Kelly
Chairperson, NRHA

WELCOME



It is a pleasure to welcome you all to the 13th National Rural Health Conference.

The conference is a great opportunity for consumers and health professionals from all parts of Australia to exchange views and practical experiences about the means by which health and wellbeing in rural and remote areas can be improved. I would like to take this opportunity to thank you all for the contribution you make to rural, regional and remote communities around Australia.

Health is one of the community's foremost concerns. Good health is vital to us as individuals and is crucial to our country's prosperity. The health reform process is critical for sustainability and I recognise the particular challenges in rural and remote areas, in terms of both health status and access to services.

The Commonwealth Government is committed to improving health outcomes for rural, regional and remote Australians through increasing access to high-quality health services. The Government is investing:

- in additional intern training capacity in private hospitals and rural and regional areas
- in providing 500 additional scholarships for nursing and allied health professionals, targeted at rural professionals
- in doubling the Practice Incentive Payment for teaching in general practices, with a rural loading of up to 50% for practices in rural and remote locations
- in infrastructure grants to build on the teaching and supervision of the rural and regional medical workforce.

In addition, I was pleased to announce the introduction of the Modified Monash Model and changes to the District of Workforce Shortage system. The Modified Monash Model will replace the outdated and inadequate Australian Standard Geographical Classification system, and will ensure we get the right health professional with the right skills, to where they are needed most.

This conference is a key biennial event for the rural and remote health sector. It is a meeting place for many of the leaders of the sector, as well as an opportunity for showcasing programs and approaches that are working well. The 13th conference focuses on people, places and possibilities of a healthy life in more remote areas.

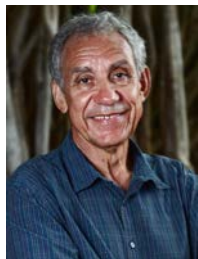
Because of its location in Darwin, this is the first National Rural Health Conference to have international sessions considering some of the successful approaches and outstanding challenges to health provision in countries to Australia's north.

The conference program covers many issues of importance to people in rural, regional and remote areas and I look forward to hearing the outcomes.

I wish you well for the conference and for your future work in the sector.

Fiona Nash
Assistant Minister for Health

WELCOME



As Conference MC it is my privilege to welcome you to the 13th National Rural Health Conference.

I share with you a commitment to the people, places and possibilities of remote and rural Australia. I am confident that this conference will help lead the way in reducing the health inequality between rural and urban Australia. Growing up in a semi rural area myself, I understand the health needs of living in remote communities—and the difficulty health service providers face in addressing these needs.

We all believe that the people who live in remote and rural Australia deserve the highest standard of health and wellbeing. In a country as developed as Australia, inaccessibility through distance is no longer an excuse. Health is a fundamental right for all Australians. That is why conferences such as these are integral not only to the reduction of health inequality, but also to the wider theme of spatial inequality.

To this end I encourage you to be involved in the development of recommendations from the conference which can be done through the Sharing Shed.

On a more general note, the helpers in green shirts are your 'go to' people should you require any help as the conference progresses.

I'd also like to more informally welcome you to the Northern Territory—I hope some of you take the chance to explore this part of the world before you return home.

Charlie King OAM
Conference MC

WELCOME



Welcome to Darwin for the 13th National Rural Health Conference. We invite you to use the four days of the conference to explore the *People Places and Possibilities* of rural health. I would like to offer a particular welcome to first time attendees. I hope that you are as inspired and energised as I was by my first National Rural Health Conference and all the following conferences I have been honoured to attend. To those of you who have been committed delegates to the conference over time welcome back, it's good to see you again.

Throughout this conference we hope you will be challenged and inspired, that you will identify problems and seek and offer solutions. The challenges that face rural and remote health and health services in reaching good health and wellbeing in rural and remote Australia is exceeded by the passion to reach this goal and the willingness to share your stories to help others.

A conference like this does not happen without the hard work and dedication of a wide range of people, from the staff in the office of the National Rural Health Alliance, to the committed volunteers of the Conference Advisory Committee through to you the delegates and presenters. The topics covered in the presentations, workshops, exhibitions, even the pop up market of this, the 13th National Rural Health Conference, will be as varied as each of your lived experiences of rural and remote health. To the first-time conference presenters I would like to assure you, you are among friends and we look forward to the information and stories you have to share with us.

Rural and remote health is your territory, please enjoy the possibilities of developing new relationships with people from a wide range of places from around the country and the region.

Nicole O'Reilly
Conference Convenor

CONFERENCE ADVISORY COMMITTEE

Thank you to the members of the 13th Conference Advisory Committee for their expert advice, local knowledge and good humour:

- Nicole O'Reilly (Convenor)
- Robyn Aitken (A/g Chief Nursing and Midwifery Officer)
- Helen Bowden (Pharmacy Guild)
- Rob Curry (Australian Physiotherapy Association)
- Nicholas Duell (Department of Health)
- Janet Fletcher (Remote Area Nurse)
- Sean Heffernan (Katherine West Health Board)
- Hugh Heggie (A/g Chief Remote Medical Practitioner)
- Felix Ho (National Rural Health Students' Network)
- Charlie King, Conference MC
- Anna Morse (Brien Holden Vision Institute)
- Richard Sager (Darwin Dieticians)
- Kieren Sanderson (Arts and Health Coordinator)
- Beverley Scott-Visser (AMSANT)
- Kylie Stothers (IAHA)
- Lynne Strathie (NRHA Council Member)
- Meredith Taylor (Rural and Regional Health Australia)
- John Wakerman (Flinders University)
- Diane Walsh (NT Medicare Local)
- Robyn Williams (Charles Darwin University).

National Rural Health Alliance Organising Group

Gordon Gregory, Peter Brown, Leanne Coleman, Josie Dunham, Kellie Sydlarczuk

Our valued suppliers

Frank Meany, One Vision; Andy Tattum, Plaspress; Debbie Phillips, DP Plus; Phil Dalley, TravelMakers; Bevan Hall, Paragon Printers Australasia

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www.health.nt.gov.au

www.health.nt.gov.au/Careers/index.aspx

jobs.nt.gov.au

See you again in Darwin in October 2015 at the National Medical Education and Training Conference
Registrations are now Open!

www.prevocationalforum2015.com



Making sure the Conference leads to real changes on the ground

There are a thousand good ideas in Australia's rural and remote health sector about how to improve health and wellbeing.

Hundreds of them will be knocking around, looking for oxygen at the Convention Centre in Darwin. Some of these good ideas will be your own.

The challenge is to round them all up, pool those that are most practicable and most important, and make sure they get delivered to people in a position to act on them. In this way the Conference can be much more than a talk-fest. It can lead to incontrovertible, evidence-based suggestions about what needs to be done, why, and by whom. When followed up after the event by organisations and individuals keen to promote them, the pressure builds for changes to be implemented.

This is where the Conference recommendations come into it. The process for developing these is based on you and your ideas. The gathering and ranking of ideas is undertaken through the Sharing Shed. This is an online portal accessible to all Conference delegates through their individual passcode.

It is designed to be user-friendly. The most difficult part of using the Sharing Shed is remembering your passcode! If you fall foul of that, ask someone in a green shirt to direct you to the registration desk where you can be reminded of it.

Use your mobile device or find a computer somewhere around the Convention Centre. Do it at the NRHA's booth in the Exhibition Hall. Go online and see the recommendations already put there by other delegates. Comment on them. Vote on the ones you agree with. See what is listed as a developing theme or a priority issue: does it concur with what you have heard and thought in the various sessions and informally at tea breaks? Follow on Twitter and Facebook to see what is running from the Conference on those platforms. Put in your own recommendation.

Behind the scenes, the Conference Recommendations Group is beaver away to spot emerging themes, combine similar recommendations together, and make a list. Check your program to see the times at which there are presentations about the recommendations process and about the recommendations themselves in plenary sessions. The chairs of all concurrent sessions will post recommendations from their sessions to the Sharing Shed.

A good recommendation should be SMART: specific, measurable, achievable, realistic and timely.

For instance:

State/Territory Governments should provide additional funding in their next jurisdictional budgets for outreach by specialist cancer clinicians from Regional Cancer Centres for work in smaller communities. The geographic areas for which each Regional Cancer Centre is responsible should be mandated by governments on the basis of community consultation and existing community 'flows' (roads, traffic, commerce). The additional funding should be sufficient to reduce by 10 per cent a year the number of people in their jurisdiction required to travel to the Regional Cancer Centre.

Towards the end of the Conference, Lesley Fitzpatrick will lead plenary sessions through draft recommendations. On the last day we seek all delegates' understanding in producing a set of 'agreed recommendations'. They are strictly Conference recommendations. People who are at the Conference as a delegate for an organisation or as a public servant should not worry that the recommendations agreed in any way reflect the views of their organisation or department. They do not even reflect the views of the NRHA until they have been subject to its normal due process.

You should view the agreed recommendations in the context of this sort of caveat:

These recommendations reflect the generally agreed views of delegates at the 13th National Rural Health Conference, but not necessarily the full or particular views of any of the bodies represented by individuals at the Conference.

Further details about the Sharing Shed, the process for selecting concurrent session papers, and other aspects of the recommendations process are provided later in this handbook.

Get involved. Make a difference. Do it loudly.
Or do it quietly by accessing the Sharing Shed in the privacy of your digs. Trust your colleagues.



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Northern Territory Government

The Department of Health, the largest government department in the Northern Territory, is responsible for provision of comprehensive public health care services across more than 1.3 million square kilometres. The Territory faces complex health care delivery challenges with over 22% of the total population living in very remote areas. There is high burden of chronic diseases, transportation of patients over long distances can be a complex logistical undertaking and health care delivered in a safe manner to a culturally diverse population remains a priority. The Department works in partnership with a wide range of non-governmental health care providers and provides direct primary health care services to over 50 remote communities.

www.nt.gov.au/health

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Darwin NT 0800

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arts.office@nt.gov.au

Northern Territory Government Department of Arts and Museums

Arts NT supports, develops and promotes growth of the creative arts sector for the benefit of the Territory, visitors, the community and economy through providing advice, partnerships, and providing financial and infrastructure support.

Through its programs, Arts NT activates responsive and appropriate mechanisms for the development of the Northern Territory's artists and organisations. Key programs include the NT Arts Grants Program and the Australian Government Regional Arts Fund which distribute funding through the advertised rounds. Funded projects further the vision of exploring, expressing and showcasing Northern Territory identity through arts and culture.

Arts NT participates in national arts and culture policy working groups, research and evaluation projects that impact on how the arts make a positive contribution to healthy and creative communities. Arts NT's role in cross agency advice and collaborative projects within the NTG and all spheres of government aims to ensure the Territory's position in the Australian context is strengthened and supported.

Arts NT aims to ensure that all Territory residents have access to a variety of arts and cultural activities either as audience or as active participants.

<http://artsandmuseums.nt.gov.au/arts>

SHARING SHED LOUNGE SPONSOR



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National
University**

Australian Primary Health
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Australian National
University
CANBERRA ACT 0200

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Australian Primary Health Care Research Institute

APHCRI, the Australian Primary Health Care Research Institute, is funded through the Australian Government Department of Health to competitively commission priority driven primary health care research, build the capacity of the primary health care research workforce and help implement research findings into health policy and services.

APHCRI commissions research through a network of nine Centres of Research Excellence and a number of short-term research projects on specific topics. We have an in house research team known as APHCRI@ANU, which undertakes research funded through a range of sources and is focused on the study of variation in health care delivery.

<http://aphcri.anu.edu.au/>

ARTS AND HEALTH PARTNER



Barkly Regional Arts
65 Staunton Street
Tennant Creek NT 0861

08 8962 2799,
admin@barklyarts.com.au
@barkly_arts

Barkly Regional Arts

Barkly Regional Arts (BRAs) is an aspirational art provider (producer and presenter), established as a not-for-profit association in 1996 to serve the people of the Barkly region (320,000 km²), through a multi-art program, including the iconic Desert Harmony Festival, a major regional event that contributes to the artistic, community and economic life of the Barkly region.

Our program-driven, multi-arts, multicultural program was developed over time in response to communities, where one art form was not enough to address need. Our various programs integrate and feed off each other, offering artists and audiences enriched experiences in a region hungry for the opportunity to consume and express their artistic drive through a range of mediums.

www.barklyarts.com.au

<https://www.facebook.com/barkly.arts>

CONFERENCE DINNER SPONSOR



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The Fred Hollows Foundation

The Fred Hollows Foundation is inspired by the life and work of Professor Fred Hollows who championed the right of all people to high-quality and affordable eye care and good health. The Foundation continues that work, as partners and leaders, in remote and underserved Aboriginal and Torres Strait Islander communities across Australia.

www.hollows.org

CONFERENCE SATCHEL SPONSOR



Australian Indigenous
HealthInfoNet
Edith Cowan University
2 Bradford Street
Mt Lawley WA 6050

08 9370 6336
K.ride@ecu.edu.au
@HealthInfoNet

Australian Indigenous HealthInfoNet

The Australian Indigenous Alcohol and Other Drugs Knowledge Centre is a free web resource which brings together a comprehensive collection of culturally appropriate alcohol and other drug (AOD) materials for individuals and practitioners working to reduce harms from AOD use in Aboriginal and Torres Strait Islander communities.

Special features include: portals for community members and health workers; a section on fetal alcohol spectrum disorder; and a section dedicated to workforce welfare. We have also developed an iPhone app (AODconnect) providing access to a national directory of alcohol and other drug treatment services.

www.healthinfonet.ecu.edu.au

www.aodknowledgecentre.net.au

<http://www.facebook.com/AustralianIndigenousHealthInfoNet>

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Carers Australia
Unit 1
16 Napier Close
Deakin ACT 2600

02 6122 9900
@CarersAustralia

Carers Australia

Carers Australia is the national peak body representing Australia's 2.7 million unpaid carers who provide unpaid care and support to family members and friends with a disability, mental illness, chronic condition, terminal illness or who are frail aged.

We advocate on behalf of Australia's carers to influence policies and services at a national level, and work collaboratively with our partners and member organisations, the network of state and territory Carers Associations, to deliver a range of national carer services.

Our vision is an Australia that values and supports the contribution that carers make both to the people they care for and to the community as a whole.

www.carersaustralia.org.au

<https://www.facebook.com/carersaus>



beyondblue
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Hawthorn West VIC 3122

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beyondblue

Most people in Australia have some experience with anxiety and depression, whether it is personal or via family, friends or work colleagues. *beyondblue*'s work is aimed at achieving an Australian community that understands anxiety and depression, empowering every person in Australia, at any life-stage, to seek help.

beyondblue raises awareness, reduces stigma and ensures people have access to the information they need to support recovery, management and resilience.

beyondblue works in partnership with health services, schools, workplaces, universities, media and community organisations, as well as people living with anxiety and depression, their friends and family, to bring together expertise and provide tools and resources.

www.beyondblue.org.au

<https://www.facebook.com/beyondblue>



07 4781 9300
admin@nwrh.com.au

North and West Remote Health

North and West Remote Health has been a pioneer in the provision of outreach health services since 2001. Our current service region incorporates 14 Local Government Areas and 32 communities; a footprint we look forward to expanding.

As a vibrant, not-for-profit organisation employing multidisciplinary teams to deliver comprehensive primary health care services in remote and Indigenous communities, North and West Remote Health offers flexible and solution-focused services in chronic disease treatment and prevention; social emotional wellbeing; complex case management; recidivism reduction programs; aged care and disability; allied health; and mental health.

www.nwrh.com.au

CONFERENCE SUPPORTERS



Larrakia Nation Aboriginal
Organisation
PO Box 1098
Nightcliff NT 0814

08 8948 3733
reception@larrakia.com

Larrakia Nation Aboriginal Corporation

Larrakia Nation Aboriginal Corporation (LNAC) it is the representative, membership-based organisation for the Larrakia people, the traditional owners of Darwin and is also a major service provider for Aboriginal people in the region in the areas of community services, homelessness support, rangers and arts and culture.

The Larrakia had a vibrant traditional society based on a close relationship with the sea and trade with neighbouring groups such as the Tiwi, Wagait and Wulna. These groups shared ceremonies, songlines and intermarried.

When the first settlers arrived in the Darwin area, the Larrakia provided them with food. Despite conflict and marginalisation, from the beginning the Larrakia participated in the cultural life of the early settlement, and lived in and around the city, before we were moved out to camps further away from the city. Many popular sites around Darwin also hold specific meaning for Larrakia people, such as Stokes Hill, Mindil Beach, Rapid Creek and Casuarina Beach.

www.larrakia.com



Careflight
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CareFlight

For 30 years, CareFlight has been saving lives by providing the highest standard of rapid response critical care. CareFlight's specialist teams use helicopters, aeroplanes and med-jets to bring the hospital to the patient, at high speed, giving patients the very best possible chance of survival and recovery. Our national footprint includes Australia's only dedicated rapid response trauma helicopter in Sydney, flying critically ill babies and children across NSW, a full aeromedical service for the Northern Territory Top End as well as an extensive education and training program, including MediSim trauma training for emergency services in their remote and very remote locations. CareFlight transports more than 5,000 patients each year.

www.careflight.org
<https://www.facebook.com/MyCareFlight>



Somerville

Somerville Community Services is a non-government, not-for-profit, youth, family and community welfare organisation. Somerville is a major local provider of community services in the Top End of the Northern Territory. Somerville is structured to provide:

- disability services: delivering supported accommodation for people with severe to profound disabilities requiring 24-hour care
- family services: delivering free counselling services, family support services, community programs and supported accommodation. We assist anyone who is experiencing a crisis or problem in their life
- financial services: our financial counsellors and money management workers help people of all ages who may be experiencing financial difficulties—families, couples, groups or individuals.

Somerville is financed by service club grants, public donations, government grants, business support, sponsorship and agency fundraising activities.

www.somerville.org.au

Somerville
PO Box 42644
Casuarina NT 0811

08 8920 4100
scs@somerville.org.au



Decision Assist

Rural, regional and remote communities are ageing along with the rest of Australia—but often health professionals serving these communities don't have access to the extensive medical advice available to their metropolitan colleagues.

Decision Assist is an exciting program that is enhancing the delivery of advance care planning and palliative care to older Australians, by providing education and support to GPs and aged care staff across Australia.

Funded by the Australian Government, it also includes specialised training workshops and improved linkages between palliative care and aged care services.

www.decisionassist.org.au

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03 9088 1252

@DecisionAssist



2013 winners, left to right: John van Bockxmeer, Craig Maloney, Alison Gibson and Jodie Mackell representing MIA.

Know someone in primary health care who deserves an award?

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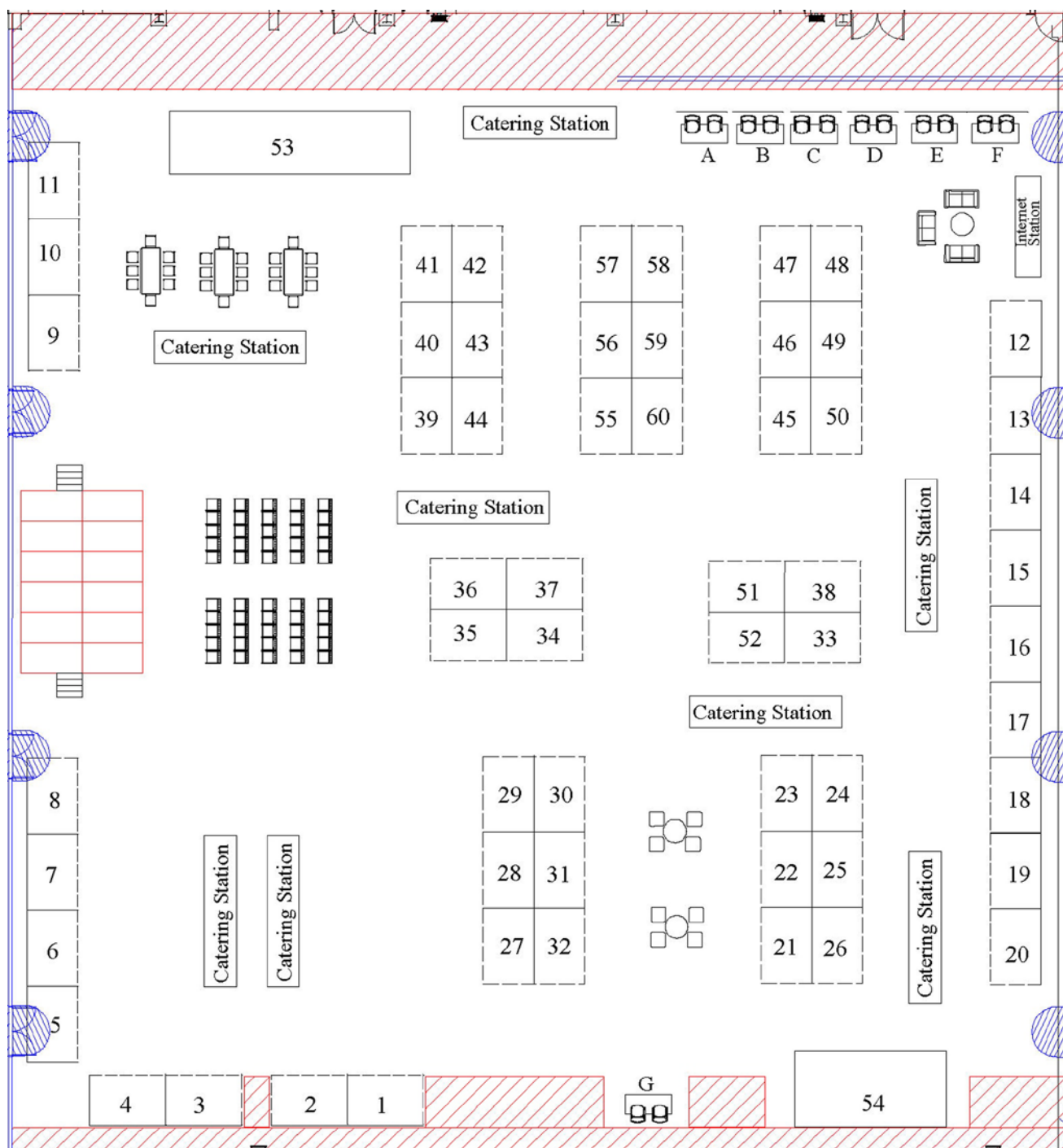
hestaawards.com.au

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Exhibition floor plan



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ABC Rural

60



**ABC
Rural**

ABC Rural is one of the largest groups of specialist primary industries on the world media scene, providing news and insights into the issues that matter to people, wherever they live across Australia. ABC Rural broadcasts a suite of radio programs on a daily basis on a number of radio networks, such as the "Country Hour"—Australia's longest running radio program. We also provide a comprehensive service online at abc.net.au/rural. Several programs will broadcast from the booth and reporters will file stories to stations across Australia during the conference.

W: www.abc.net.au/news/rural

Tw: @ABCRural

Andrology Australia

Table A



Andrology Australia (The Australian Centre of Excellence in Male Reproductive Health), funded by the Australian Government Department of Health, provides information and education to health professionals and the community on disorders of the male reproductive health system and associated conditions.

P: 1300 303 878

E: info@andrologyaustralia.org

W: www.andrologyaustralia.org

Tw: @AndrologyAust

FB: www.facebook.com/andrologyaustralia

AGPAL and QIP

21



Quality
Innovation
Performance

Australian General Practice Accreditation Limited (AGPAL) is the leading not-for-profit provider of accreditation and related quality improvement services to general practices in Australia. Part of the AGPAL Group of Companies, Quality Innovation Performance (QIP) is Australia's most comprehensive not-for-profit accreditation organisation, delivering accreditation and support services across the entire health and human services continuum. Visit our team members at booth #21 to learn more about accreditation.

W: www.agpal.com.au

W: www.qip.com.au

Tw: @AGPALQIP

Angel Flight

Table G



Angel Flight is a charity that coordinates non-emergency flights to assist country people to access specialist medical treatment that would otherwise be unavailable to them because of vast distance and high travel costs.

Ph: 1300 726 567 or 07 3620 8300

E: mail@angelflight.org.au

W: www.angelflight.org.au

Australian College of Rural and Remote Medicine

44



The John Flynn Placement Program and Bonded Support Program are initiatives of the Australian Government aimed at increasing and supporting the next generation of rural doctors. The programs are managed by ACRRM the GP college with a broader scope of generalist practice focused on rural and remote community health needs.

Ph: 1800 231 231

E: studentprograms@acrrm.org.au

W: www.acrrm.org.au

Tw: @ACRRM

FB: www.facebook.com/pages/Australian-College-of-Rural-and-Remote-Medicine-ACRRM/111524985598126

Australian Indigenous Health/InfoNet Table F



Managed by Health/InfoNet, the Australian Indigenous Alcohol and Other Drugs Knowledge Centre is a free web resource aiming to reduce harmful substance use among Aboriginal and Torres Strait Islanders by providing the evidence base to inform policy and practice. It provides relevant culturally appropriate information for those involved in reducing harmful substance use.

Ph: 08 9370 6336

E: aodknowledgecentre@healthinfonet.org.au

W: www.healthinfonet.ecu.edu.au

Tw: @HealthInfoNet

FB:

www.facebook.com/AustralianIndigenousHealthInfoNet

Australian Healthcare and Hospitals Association

49



The Australian Healthcare and Hospitals Association is the independent peak national membership body and advocate for the Australian health care system and a voice for accessible high-quality health care. Through its membership and networks, it facilitates collaboration between clinicians, academics, policymakers and government. The AHHA's broad cross-sector membership and networks deliver benefits to the whole community through knowledge sharing, service improvement and policy development. This is evidenced by its extensive programs, policy work, publications and research, all with the goal of ensuring better health care, higher standards, greater efficiency and improved conditions.

Ph: 02 6162 0780

E: admin@ahha.asn.au

W: ahha.asn.au

Australian National University

48



APHCRI, the Australian Primary Health Care Research Institute, is funded through the Australian Government Department of Health to competitively commission priority driven primary health care research. APHCRI website for details about previous commissioned research projects, future funding opportunities; and to become involved with international primary health care research networks.

W: aphcri.anu.edu.au

Tw: @aphcriNET

FB: www.facebook.com/TheAustralianNationalUniversity



The Australian Physiotherapy Association (APA) is the peak body representing the interests of Australian physiotherapists and their patients. With over 16,000 members, the APA has more than 300 members in volunteer positions, committees or working parties. The APA advocates on behalf of the profession and provides ongoing professional education through CPD programs.

W: www.physiotherapy.asn.au
Tw: @apaphysio
FB: www.facebook.com/AustralianPhysiotherapyAssociation



Black Dog Institute is dedicated to improving the lives of people affected by depression, bipolar disorder and suicide. Combining expertise in clinical management with cutting-edge research and evidence-based education and training, Black Dog rapidly translates quality research into life-saving clinical practice and public health policy.

E: education@blackdog.org.au
W: www.blackdoginstitute.org.au
Tw: @blackdoginst
FB: <https://www.facebook.com/blackdoginst>



Mental health and wellbeing is important for rural and regional communities. The Australian Psychological Society is proud to be an exhibitor and will be showcasing information for the public and health practitioners for psychological resources in community mental health.

Ph: 03 8662 3300
E: contactus@psychology.org.au
W: www.psychology.org.au
Tw: @APS_Media
FB: www.facebook.com/pages/Australian-Psychological-Society/137678812919186



An aeromedical charity established in 1986, CareFlight's mission is to save lives, speed recovery and serve the community by providing the highest standard of rapid response critical care. CareFlight's specialist teams use helicopters, aeroplanes and medi-jets to bring the hospital to the patient, at high speed, giving patients the very best possible chance of survival and recovery.

Ph: 02 9843 5100
W: careflight.org
Tw: @MyCareFlight
FB: www.facebook.com/MyCareFlight

CareFlight Northern Operations
Ph: 08 8928 9701
FB: www.facebook.com/CareFlightTopEnd



Carers NT offers services to carers to improve their quality of life. A carer is someone who provides **unpaid** care and support to family members and friends who are living with a disability, mental illness, chronic condition, terminal illness or who are frail. There are over 30,000 carers in the Northern Territory.

Ph: 1800 242 636

E: carersnt@carersnt.asn.au

W: www.carersnt.asn.au

FB: <https://www.facebook.com/pages/Carers-NT/166850410027250>



With campuses across the Northern Territory and in Sydney and Melbourne, Charles Darwin University is in the top 2% of world universities with great emphasis on innovative study and research. Our School of Health and School of Psychological and Clinical Sciences offer a strong range of programs, including nursing, health sciences, social work, clinical psychology and pharmacy.

W: www.cdu.edu.au

Tw: @CDUni

FB: www.facebook.com/CharlesDarwinUniversity



The Centre for Remote Health (CRH) is a joint centre of Flinders University and Charles Darwin University. The mission of CRH is to contribute to the improved health outcomes of people in remote communities of the NT and Australia, through the provision of high-quality tertiary education, training, and research.

Ph: 08 8951 4700

E: crh@flinders.edu.au

W: www.crh.org.au

FB: www.facebook.com/pages/Centre-for-Remote-Health-Alice-Springs/115513938515997



The Continence Foundation of Australia is the peak national body representing the interests of 4.8 million Australians affected by incontinence, their carers, families and clinicians. The Foundation, established in 1989, is a not-for-profit organisation dedicated to improving the quality of life of all Australians affected by incontinence.

Ph: 1800 330 066

W: www.continence.org.au

Tw: @AusContinence

FB: www.facebook.com/AusContinence

L: <https://www.linkedin.com/company/continence-foundation-of-australia>



The core business of CRANApplus is to educate, support and represent all health professionals working in the remote sector of Australia. We are the only member-based, national health organisation that has remote health as its sole focus, making us the remote health experts.

Ph: 07 40476400
 E: ceo@crana.org.au
 W: crana.org.au
 Tw: @CRANApplus
 FB: www.facebook.com/CRANApplus



The Department of Health is the leading employer of health and community service professionals and the largest public employer in the Northern Territory. Working with Department of Health will offer you unique and diverse career opportunities where you can make a real difference to the lives of others and probably your own. The Department of Health, the largest government department in the Northern Territory, is responsible for provision of comprehensive public health care services across more than 1.3 million square kilometres. This ranges from secondary and tertiary care services from hospitals and health services in Darwin and Alice Springs to primary health care services to majority of remote health communities.

W: www.health.nt.gov.au



Dairy Australia is the dairy industry-owned service company, whose members are farmers and industry bodies. 80% of adults are missing out on the health and nutritional benefits of consuming recommended dairy serves, including milk, yogurt and cheese—so “Start and end the day with dairy; it’s Legendairy”.

Ph: 03 9694 3709
 E: mcameron@dairyaustralia.com.au
 W: www.legendairy.com.au



The National Diabetes Services Scheme (NDSS) is an initiative of the Australian Government administered by Diabetes Australia. The NDSS delivers diabetes-related products at subsidised prices and provides information and support services to people with diabetes. Registration is free and open to all Australians diagnosed with diabetes.

W: www.diabetesaustralia.com.au/
 Tw: @DiabetesAus
 FB: www.facebook.com/DiabetesAus



The Organ and Tissue Authority (OTA) works with states and territories, clinicians and the community sector to deliver the Australian Government's national reform program to improve organ and tissue donation and transplantation outcomes in Australia. The DonateLife Network comprises DonateLife organ and tissue donation agencies and hospital-based staff in 72 hospitals across Australia.

W: www.donatelife.gov.au

Tw: @DonateLifeToday

FB: www.facebook.com/DonateLifeAustralia



Epilepsy Action Australia is a leading national service provider offering vital and often life-saving support and services to more than 800,000 Australians who will be affected by epilepsy in their lifetime. Our highly skilled educators and service consultants combined with our range of online self-management tools and courses assist thousands of children, adults and their families and professionals across Australia.

Ph: 1300 37 45 37

E: epilepsy@epilepsy.org.au

W: www.epilepsy.org.au/

Tw: @Action4Epilepsy

FB: www.facebook.com/epilepsyactionaustralia



eHealthNT is a collaborative partnership of the Northern Territory Department of Health, the Aboriginal Medical Services Alliance Northern Territory (AMSANT) and the Northern Territory Medicare Local (NTML). eHealthNT is focused on advancing health care delivery by developing and implementing eHealth solutions and services to assist health care providers in the Northern Territory with securely storing, sharing and transmitting important patient care information.

Ph: 1800 247 430

E: mehr.ths@nt.gov.au

W: www.ehealthnt.nt.gov.au



Federation University Australia (FedUni) is Australia's only regional, multi-sector university and a pivotal provider of post-secondary education for regional Victoria. With close links to industry, business, communities and technology, FedUni's health qualifications are innovative and flexible and will provide you with the skills and knowledge to gain employment in the health professional field of your choice.

Ph: 1800 333 864

E: info@federation.edu.au

W: federation.edu.au/health

Tw: @FedUniAustralia

FB: www.facebook.com/FedUniAustralia



**The Fred Hollows
Foundation**

www.hollows.org

The Fred Hollows Foundation is inspired by the life and work of Professor Fred Hollows who championed the right of all people to high-quality and affordable eye care and good health. The Foundation continues that work, as partners and leaders, in remote and underserved Aboriginal and Torres Strait Islander communities across Australia.

Ph: 08 8920 1400

E: fhf@hollows.org

W: www.hollows.org.au

Tw: @FredHollows

FB: www.facebook.com/TheFredHollowsFoundation

HCA

Healthcare Australia

Healthcare Australia (HCA) is dedicated to providing high quality skilled staff to rural and remote facilities Australia wide. Our commitment to Indigenous and Torres Strait Islander health is strong with a focus on sourcing staff for this craft. Our aim is to grow the rural and remote workforce by catering to the individual requirements of our staff and clients offering a national passport and outback adventure.

Ph: 1300 885 728

E: hcarnr@healthcareaustralia.com.au

W: www.healthcareaustralia.com.au

Tw: @HealthcareAus

FB: <https://www.facebook.com/HealthcareAustralia>



Leading interoperability and the incorporation of health IT standards, HealthConnex offers applications for government organisations, hospitals, primary care, specialists, Indigenous health, allied health, aged care, mental health and disability organisations. We build and support leading eHealth solutions that enable organisations to deliver health and care coordination services more efficiently, with solutions tailored to fit your environment. Our product suite addresses:

- Health Services Directory (HSD)
- Secure messaging for eReferral, SCTT, ONI and more (Argus, ConnectingCare Secure Messaging)
- Acute and Community Service Coordination (Communicare, TCM)
- Aged Care Facility Management
- Mobile workforce (ConnectingCare Worker).

Ph: 03 8317 8100

E: admin@healthconnex.com.au

W: healthconnex.com.au



The Health Education and Training Institute (HETI) is at the core of advancing the workforce capability of NSW Health, to improve the health of NSW and the working lives of staff through education and training. HETI supports the professional development of clinical and non-clinical staff, trainers, educators and supervisors across the state.

Ph: 02 9844 6551

W: www.heti.nsw.gov.au

Tw: @NswHeti



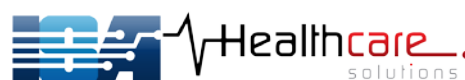
Healthdirect Australia manages telephone and online services providing Australians with access to health information and advice on appropriate care, when and where they need it. Funded by federal, state and territory governments, our services include:

- healthdirect
- after hours GP helpline
- Pregnancy, Birth and Baby
- mindhealthconnect
- My Aged Care
- National Health Services Directory

Ph: 02 9263 9000

W: www.healthdirect.gov.au

FB: www.facebook.com/HealthdirectAustralia



ISA Healthcare Solutions focuses on the intersection of health care and technology. ISA has clinicians, health administrators, management consultants and technologists working together at the cutting edge of health technology, whether this is advising health care clients on long-term technology strategy or delivering innovative software, med-tech or ICT infrastructure solutions today.

Ph: 08 6250 9170

E: info@isahealthcare.com

W: www.isahealthcare.com



HESTA is the super fund for health and community services, with more than 800,000 members and \$30 billion in assets. HESTA was established in 1987 to help its members—85% of whom are women—achieve the retirement they deserve. More people in health and community services choose HESTA for their super. Learn more at hesta.com.au.

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Ph: 1800 813327

E: hesta@hesta.com.au

W: www.hesta.com.au

Tw: @HESTANurseAuds

FB: www.facebook.com/pages/HESTA/353973258039374



Larrakia Nation Aboriginal Corporation (LNAC) it is the representative, membership-based organisation for the Larrakia people, the traditional owners of Darwin and is also a major service provider for Aboriginal people in the region in the areas of community services, homelessness support, rangers and arts and culture.

Ph: 08 8948 3733

E: reception@larrakia.com

W: www.larrakia.com

FB: www.facebook.com/larrakia.on.the.net



With over 2300 students, state-of-the-art new facilities, and a vibrant research culture focused on addressing the big issues for rural communities, the La Trobe Rural Health School is delivering on its mission to be Australia's most outstanding, unique and innovative rural health school.

Ph: 03 5444 7411

W: www.latrobe.edu.au/health/about/schools/la-trobe-rural-health-school

Tw: @latrobe

FB: www.facebook.com/latrobe/?src=hff



NCFH makes a difference to farmers lives by improving the health, wellbeing and safety of farm men and women, their families and communities. We do this through Australia's only Agricultural Health and Medicine course for rural professionals, research and specialised services such as AgriSafe clinics and Sustainable Farm Families™ programs.

Ph: 03 5551 8533

E: nafh@wdhs.net

W: www.farmerhealth.org.au

Tw: @FarmerHealth

FB: www.facebook.com/pages/National-Centre-for-Farmer-Health/223061351124818

Mount Isa Centre for Rural and Remote Health

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Mount Isa Centre for Rural and Remote Health

MICRRH's North and Central West QLD GP and Rural Generalist Support Program aims to provide excellent training support to fellowship level in a supported academic environment. Our region provides experience in family medicine, ED, O&G, paediatrics, Indigenous health, sexual health, public health, anaesthetics, occupational and retrieval medicine and acute internal medicine. Support includes accommodation, generous conditions, a strong focus on teaching and supervision and world-class teaching facilities.

Ph: 07 4745 4500

E: micrrh@jcu.edu.au

W: www.micrrh.jcu.edu.au

FB: www.facebook.com/JCUNursingMICRRH

National Health Performance Authority

4



National Health Performance Authority

The National Health Performance Authority is an independent government agency that monitors and reports on hospitals and primary health care organisations. Our reports provide information about health care services at a local level with the aim of stimulating and informing efforts to improve the health system. We also publish data online. Visit our booth to learn more about how public reporting can drive improvements in health.

Ph: 02 9186 9210

E: enquiries@nhpa.gov.au

W: www.myhospitals.gov.au

www.myhealthycommunities.gov.au

Tw: @NHPAreporting

A phone solution for people
who are deaf or have a
hearing or speech impairment



An Australian Government Initiative

The National Relay Service is a government-sponsored phone service for people who are deaf or have a hearing or speech impairment. Relay calls reduce social isolation and allow users to have successful phone conversations with less misunderstanding. NRS users can ring anyone from anywhere in Australia, anytime.

Ph: 1800 555 660
TTY: 1800 555 630
E: helpdesk@relayservice.com.au
W: www.relayservice.gov.au
Tw: @relayservice
FB: www.facebook.com/nationalrelayservice



The National E-Health Transition Authority was established in 2005 by the Council of Australian Governments (COAG) to help transform Australia's health system by building the foundations for a national eHealth infrastructure. NEHTA's purpose is to lead the uptake of eHealth systems of national significance and to coordinate the progression and accelerate the adoption of eHealth by delivering urgently needed infrastructure and standards for health information. We work collaboratively with consumers, health care providers, the health care industry, the information and communications technology industry, policy makers and funders towards a safe, secure and efficient health system that will deliver better health outcomes for all Australians. NEHTA is jointly funded by the Australian Government and all State and Territory Governments.

Ph: 02 8298 2600
E: help@nehta.gov.au
W: www.nehta.gov.au
Tw: @eHealthAus



NATIONAL RURAL
HEALTH
ALLIANCE INC.

The National Rural Health Alliance is Australia's peak non-government organisation for rural and remote health. Its vision is good health and well being in rural and remote Australia. Member bodies representing health consumers, professionals, service providers and educators, work collaboratively in the Alliance towards achieving this goal. Fundamental to the Alliance's work is the belief that, wherever they live, all Australians should have the opportunity for equal health outcomes and equivalent access to comprehensive, high-quality and appropriate health services.

Ph: 02 62854660
E: nrha@ruralhealth.org.au
W: www.ruralhealth.org.au
Tw: @NRHAlliance
FB: www.facebook.com/NRHAlliance



Newcastle
University



EMVIGR
EMPOWERING GAMES

Newcastle University and EMVIGR Ltd will present our experience of the development and use of online physiotherapy using video games and a cloud-based platform providing the tools for remote service delivery and patient management. We will also present patient and therapists' views comparing their experience of conventional therapy and online therapy.

Ph: +44 191 2821386
W: www.ncl.ac.uk
emvigr.co.uk
Tw: @StudentsNCL
FB: www.facebook.com/newcastleuniversity



Northern Territory General Practice Education (NTGPE) is the only regional training provider (RTP) delivering general practice education and training in the Northern Territory. Our vision to train and support doctors throughout the Northern Territory in becoming outstanding general practitioners is driven by the health needs of communities.

Ph: 08 8946 7079
E: reception@ntgpe.org
W: <http://ntgpe.org>
Tw: @NTGPE
FB: <https://www.facebook.com/ntgpe>



The NT Medicare Local's mission is to lead the development of an equitable, comprehensive primary health care system, and an engaged health workforce, driven by community needs. We do this through commissioning health services that are integrated across the health system. Our vision is improved health and wellbeing for all Territorians.

Ph: 08 8981 5899
E: ntml@ntml.org.au
W: www.ntml.org.au
Tw: @NTMedicareLocal



North and West Remote Health is a vibrant, not-for-profit organisation employing multidisciplinary teams to provide health and wellbeing services in remote Central and North West Queensland. A pioneer in the provision of outreach health services since 2001, our current service region covers 36.7% of the state, incorporating 14 local government areas and 32 communities and we look forward to expanding this footprint across rural and remote Australia.

(Currently trading as Central and North West Queensland Medicare Local; transitioning to North and West Remote Health as at 1 July 2015.)

Ph: 07 4781 9300
E: admin@cnwqml.com.au (1 July: admin@nwrh.com.au)
W: www.nwrh.com.au
Tw: @cnwqml



We believe that everybody deserves quality support whenever they need it—regardless of geography or circumstance. On the Line provides 24/7 support to the community via telephone, online chat and video. Through our remote counselling services, including MensLine Australia and the Suicide Call Back Service, we provide vital professional support to tens of thousands of people each year.

Ph: 03 8371 2800
E: enquiries@ontheline.org.au
W: www.ontheline.org.au
Tw: @OntheLineAus



Optometry Australia is the peak professional body representing optometry and optometrists in Australia. We promote community eye health through our support and leadership of the optometry profession. We work to enhance timely access to quality eye care for all Australians, regardless of where they live.

Ph: 03 9668 8500
 E: aaanat@optometry.org.au
 W: www.optometry.org.au
 Tw: @OptometristsOz
 FB: www.facebook.com/OptometristsAssociationAustralia



As Australia's premium nursing agency, we are dedicated to providing you with temporary and permanent staffing solutions across the industry. From large public and private hospitals to small community care businesses, we have a strong understanding of what you really need from a recruitment partner and employer—someone who understands your critical skills shortages and the complexity of legislation and regulations on your business or your unique needs as a nurse working in rural and remote Australia.

Ph: 1300 658 899
 E: health.contracts@randstad.com.au
 W: randstadcare.com.au
 Tw: @randstad_au
 FB: www.facebook.com/randstad.au



The POCD team are specialists in the implementation and use of Point-of-Care (PoC) tests in rural and remote health care. Our diverse product range includes the Icon FBC system, Samsung chemistry and electrolyte analyser, Datospir spirometers, INR monitors, DOA tests, and much more.

Ph: 1800 640 075
 E: admin@pocd.com.au
 W: www.pocd.com.au
 Tw: @pocd



Red Dust is a not-for-profit health development organisation that delivers health and wellbeing programs to young people in remote Northern Territory communities. Our programs promote interactive learning through sport, music, art and dance facilitated by role models and community champions. Our current programs are:

- the Healthy Living Program
- the Alcohol Education and Community Empowerment Program
- the Strong Young Women's Program.

For more information, please contact the Red Dust Programs Manager.

Ph: 0499 994 330
 E: admin@reddust.org.au
 W: www.reddust.org.au
 Tw: @reddustoz
 FB: www.facebook.com/reddustrolemodels



Remote Area Health Corps (RAHC), established in 2008 by the Australian Government Department of Health, attracts, orientates and supports health professionals to make the transition to remote practice in Aboriginal communities in the Northern Territory and assist in addressing the shortfall in primary health care services.

Ph: 08 8942 1650

E: enquiries@rahc.com.au

W: www.rahc.com.au

FB: www.facebook.com/RemoteAreaHealthCorps



RURAL HEALTH
CONTINUING EDUCATION

STREAM ONE

The Rural Health Continuing Education (RHCE) Program—Stream One is an Australian Government initiative to support medical specialists in rural and remote Australia by increasing access to education, training and continuing professional development.

Ph: 02 9256 5419

E: admin@ruralspecialist.org.au

W: www.ruralspecialist.org.au



RVTS is an Australian Government funded program that provides GP training to doctors in Aboriginal and Torres Strait Islander and remote and rural communities throughout Australia. The program is a recognised pathway to vocational registration, providing three to four years of training towards fellowship of ACRRM and/or RACGP.

Ph: 02 6057 3400

E: rvts@rvts.org.au

W: www.rvts.org.au

Tw: @RVTSgpTRAINING

FB: <https://www.facebook.com/RVTSgpTRAINING>



RHDAustralia aims to reduce death and disability from acute rheumatic fever (ARF) and rheumatic heart disease (RHD) in Australian Aboriginal and Torres Strait Islander people. Funded by the Commonwealth, RHDAustralia was established in 2009 as the National Coordination Unit to support the control of RHD in Australia.

Ph: 08 8946 8654

E: info@rhdaustralia.org.au

W: www.rhdaustralia.org.au

Tw: @RHDAustralia



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Roche offers you a broad variety of PoCT systems with more than 30 parameters, which allows you to support your patients with rapid results for their general and major general health concerns. The accurate results correlate well to the specific laboratory methods and provide peace of mind for you and your patients. Our broad product portfolio enables you to perform tests from a wide range of parameters such as HbA_{1c}, lipids, coagulation, cardiac, blood glucose, urine and clinical chemistry testing in your own office/institution.

Ph: 02 9860 2222

E: australia.dia_cardiology@roche.com

W: www.roche-australia.com

Tw: @Roche



The PIHSP is a collaboration of rural R&D corporations that is committed to achieving significant benefits to industry through the implementation of targeted and high-impact RD&E projects. This partnership aims to deliver healthy, safe and productive working lives in the primary industries through investment in RD&E to drive sustainable improvements to work health and safety outcomes.

Ph: 02 6271 4100

W: www.rirdc.gov.au

Tw: @RIRDC

FB: www.facebook.com/pages/Rural-Industries-Research-and-Development-Corporation/140843249274819



Formed over 86 years ago, the iconic Royal Flying Doctor Service (RFDS) has a mission to provide excellence in aeromedical and primary health care across Australia. The RFDS work to reduce the health care gap for rural Australia, with 280,000 patient contacts, 82,305 telehealth consultations and 16,096 remote health clinics delivered in the last year alone.

Ph: 02 6269.5500

W: www.flyingdoctor.org.au

Tw: @RoyalFlyingDoc

FB: www.facebook.com/royalflyingdoctorservice



Sybella Mentoring Services, Australia is the premier rural mentoring service for professionals taking on employment opportunities in isolated areas. Sybella Mentoring assists staff transitioning to the bush by delivering supportive, structured programs, encompassing relevant issues. Our mentors are experienced rural psychologists, who use evidence-based positive psychology practices to coach staff, relieve stress and enhance retention.

Ph: 1800 069 968

E: admin@sybellamentoring.com.au

W: www.sybellamentoring.com.au

FB: <https://www.facebook.com/sybellamentoring>

The Australian Council on Healthcare Standards

5



Established in 1974, the Australian Council on Healthcare Standards is recognised as the leading health care accreditation body in Australia and as an authority on the implementation of quality improvement systems. We work with health care professionals, consumers, government and industry stakeholders to develop and continually review health standards.

Ph: 02 9281 9955
E: achs@achs.org.au
W: www.achs.org.au
Tw: @ACHSaccred
FB: www.facebook.com/ACHS40

Therapeutic Goods Administration

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Australian Government

Department of Health

Therapeutic Goods Administration

The Therapeutic Goods Administration (TGA), part of the Department of Health, is Australia's national regulator of medicines, medical devices, blood and tissues. We undertake a range of assessment and monitoring activities to ensure products supplied, imported, exported, manufactured and advertised in Australia meet acceptable standards of safety, quality and efficacy.

Ph: 1800 020 653
E: info@tga.gov.au
W: www.tga.gov.au

The Royal Australian College of General Practitioners—National Rural Faculty

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RACGP



National Rural
Faculty

The RACGP NRF recognises the specific issues in rural and remote areas and provides advocacy and support for GPs in these communities. The NRF currently has over 12,000 members, including 6,028 GPs Australian registered GPs in rural and remote Australia. The NRF works hard to ensure future government reforms and programs are responsive to the unique challenges faced by GPs in supporting rural and remote communities.

Ph: 1800 636 764
E: rural@racgp.org.au
W: www.racgp.org.au/yourracgp/faculties/rural
Tw: @RACGP
FB: www.facebook.com/TheRACGP

University of Southern Queensland

10



The University of Southern Queensland (USQ) has forged a reputation as one of Australia's leading providers of on-campus and online (distance) education programs in Australia. With more than 75 per cent of students studying via distance or online, our delivery of external education resources continues to lead the way. USQ's School of Nursing and Midwifery is dedicated to providing a service to local, rural and international communities of health care professionals by embedding critical thinking, safe practice, and clinical judgement based on research into the learning journey.

Ph: 07 4631 2100
E: study@usq.edu.au
W: www.usq.edu.au



The Varley Group is Australia's largest specialised vehicle manufacturer, supplying appliances for many government organisations and private industries, both domestically and globally. Varley's manufacturing specialties include various types of mobile health solutions, such as clinical vans, oral health units, mobile dialysis clinics, mobile blood donor centres and mammography facilities. The Varley Group is a significant Australian manufacturer and employer, with factories in Newcastle, Brisbane, Sydney, Melbourne and Ballarat.

Ph: 02 4964 0400
E: enquiries@varleygroup.com
W: www.varleygroup.com

Western Desert Dialysis

Table E



Western Desert Nganampa Walytja Palyantjaku Tjutaku Aboriginal Corporation (aka The Purple House) in Alice Springs is a not-for-profit, non-government, Indigenous-governed, community-controlled health organisation specialising in remote dialysis, social support, and a social enterprise that addresses some of the issues associated with kidney disease.

Ph: 08 8953 6444
E: wellbeing@wdnwpt.com.au
W: www.westwendedesertdialysis.com/soc



beyondblue Support Service

Talk it through with us, we'll point you in the right direction

Three ways to contact us



Call 1300 22 4636
24 hours a day, 7 days a week



Chat online 3pm to 12am
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Get a response in 24 hours

Exhibition incentive competition

Visit 33 exhibitors to go into the draw to win an iPad

Our exhibitors want to meet you! Please have a chat with them.

Delegates who have at least 33 exhibitors sign the matrix below in the appropriate place will go into the draw to win an iPad.

Make sure you put your name below the matrix. Tear it out. Put it in the Exhibition Incentive Competition entry box at the registration desk.

The winner will be announced on the final day of the conference. You must be present to win.



First prize is an iPad—to be drawn on the final day

Exhibitors to sign in the box the same number as their booth

1	2	3	4	5	6	7	8	9	10
11	12	13	14	15	16	17	18	19	20
21	22	23	24	25	26	27	28	29	30
31	32	33	34	35	36	37	38	39	40
41	42	43	44	45	46	47	48	49	50
51	52	53	54	55	56	57	58	59	60

TA	TB	TC	TD	TE	TF	TG
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Name: _____

Mobile: _____

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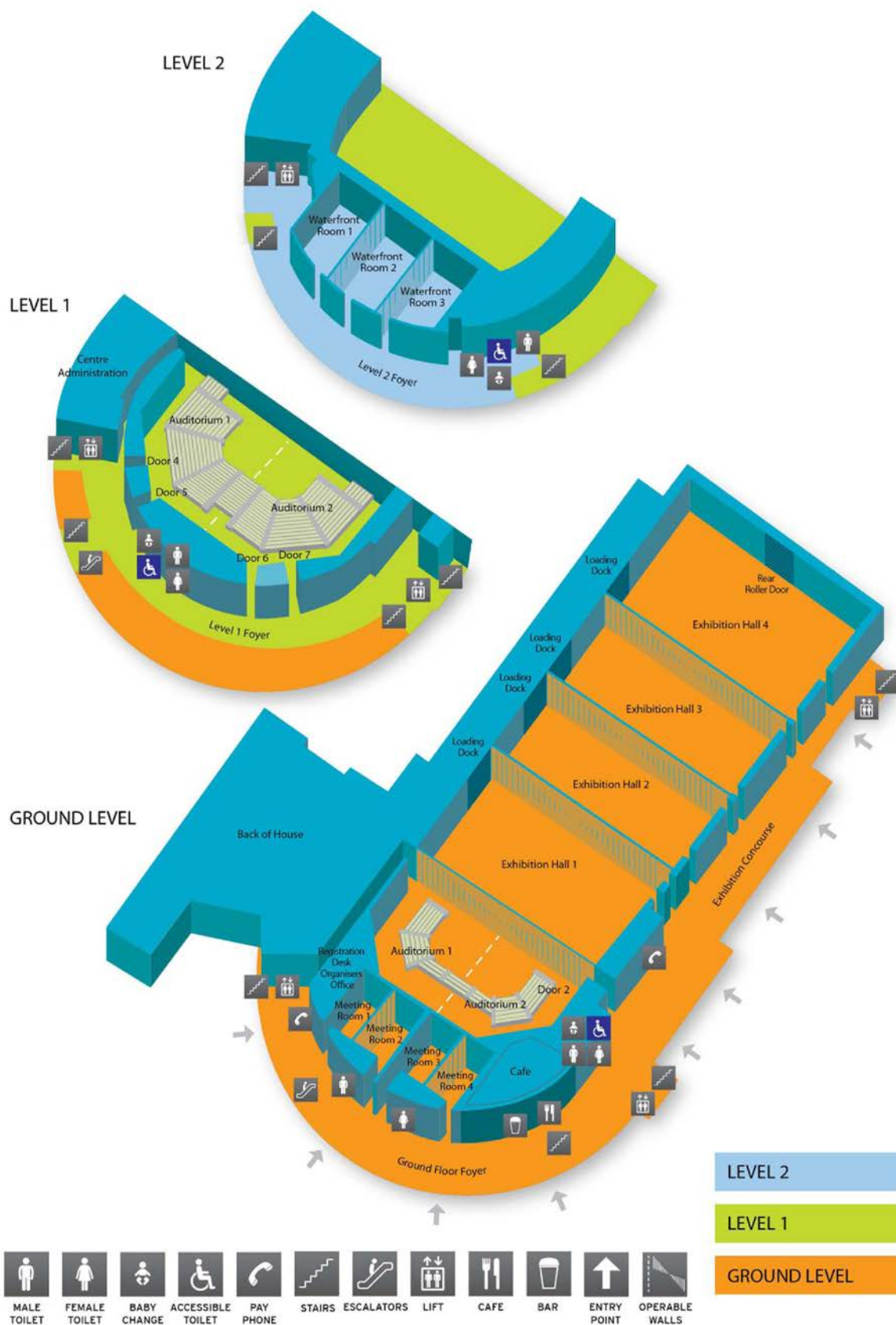
- » NO water, basin, soap or towels required
- » pH balanced
- » Alcohol, soap and latex free
- » Wipes contain moisturisers and emollients to nourish the skin
- » Does not promote microbial growth



TEL 1300 653 673 humantechologies.net.au

INFORMATION

Venue map



General information for delegates

The Darwin Convention Centre is situated in the Darwin waterfront precinct, Stokes Hill Road, Darwin.

Telephone: 08 8923 9000
Website: www.darwinconvention.com.au

Registration and information desk

The registration and information desk for the 13th National Rural Health Conference is located on the ground floor of the Darwin Convention Centre and will be open during the following hours:

Sunday 24 May 2015	8.00 am – 3.45 pm (closed during the opening session from 4.00 pm)
Monday 25 May 2015	8.00 am – 5.00 pm
Tuesday 26 May 2015	8.00 am – 5.00 pm
Wednesday 27 May 2015	8.00 am – 3.00 pm

Registration materials including your name badge, dinner ticket, Sharing Shed password, conference satchel, handbook and program may be collected from the registration desk during the times listed above.

Alliance Council and staff are here to help. If you have any questions at all please don't hesitate to ask one of the helpful staff in the green shirts.

Your name badge is your entry to all conference sessions. Please wear it at all times.

First conference session

The conference will begin with an Opening Ceremony at 4.00 pm on Sunday 24 May 2015 in the main auditorium.

Conference sessions

All conference sessions and associated events are being held at the Darwin Convention Centre and the Adina/Vibe Hotel which is a two-minute walk across the waterfront. A venue floor plan is provided on page 40 and in the conference program.

Exhibition hall

The Exhibition Hall is located in Halls 1 and 2. Morning tea, lunch and afternoon tea will be served in the Exhibition Hall each day.

Social functions

As a full delegate your conference name badge is your entry to all conference sessions, including the Welcome Reception, Exhibitor Evening and the Conference Dinner.

The Welcome Reception will be held on Sunday evening following the Opening Session in the Exhibition Hall.

The Exhibitor Evening will be held on Tuesday evening 26 May 2015, also in the Exhibition Hall.

Conference Tropical Dinner and Awards Night

The Conference Dinner is being held at 7.00 pm on Monday evening 25 May 2015 in Halls 3 and 4 on the ground level of the Convention Centre. Pre-dinner drinks will be served in foyer from 7.00 pm to 7.30 pm. The dress code is Darwin tropical rig.

Entry to the dinner will be by the dinner ticket you received with your name tag. Please bring it along with you.

Speakers' preparation room

The speakers' preparation room is located on Level 1, just outside the entry to the Auditorium. Staff at the registration desk will be happy to point speakers in the right direction. All speakers should report to the speakers' prep room with their presentation (preferably on a thumb drive) as soon as possible after their arrival.

Twitter

The National Rural Health Alliance Twitter account is @NRHAlliance and delegates are encouraged to use the #ruralhealthconf hashtag. If you would like some help setting up a Twitter account you can ask one of the friendly staff at the NRHA exhibition booth.

Messages

A notice board is located beside the registration desk. Please check this each day for your personal messages and tell your colleagues if you see a message for them.

Mobile phone courtesy

For the comfort of others it is requested that delegates ensure their mobile phones are set to silent during all sessions.

Internet access and wifi

Internet access is available in the Sharing Shed Lounge located in the Exhibition Hall, sponsored by Australian Primary Health Care Research Institute (APHCRI). The lounge provides internet access for all delegates to submit their recommendations via the Sharing Shed and for general internet use. There is also free wireless internet access throughout the Convention Centre.

Parking

The Darwin Convention Centre has 300 on-site car parks with access to the Centre via elevator. The car park is under cover and security patrolled. The cost of parking is \$5 per day.

Transport to and from the airport

Airport shuttle. Darwin Airport Shuttle (DAS) operates a transfer service for delegates to and from the airport and/or their accommodation or the Convention Centre. DAS meets all scheduled flights 24 hours per day, 7 days a week. Each coach departs within 15 minutes of its first passengers collecting their luggage and boarding the coach and will drop off passengers at all hotels in the CBD and the Convention Centre as per DAS's usual drop-off schedule.

Delegates can present themselves to the DAS desk in the arrival hall at the Darwin Airport (next to the baggage carousels), where they will be welcomed, placed on the manifest and directed to the next departing coach. Delegates can also be picked up from all Darwin accommodation or the Darwin Convention Centre to return to the airport.

Pre-bookings are not required for this service but are preferred as extra coaches can be scheduled according to arrival numbers. The estimated airport shuttle rates from 1 April 2015 will be \$19.00 per person one way or \$34.00 per person open return.

To book an airport transfer online go to: www.darwinairportshuttle.com.au or simply book and pay at the airport desk on arrival.

For further information please contact the Airport Shuttle team on 08 89815066 or email admin.support@darwinairportshuttle.com.au

Taxis. Taxis are available from the taxi rank which is located directly in front of the Darwin Airport Terminal. Taxi pricing is charged by meter and you can expect to pay around \$25.00 to \$30.00 for a trip between the airport and the Darwin CBD district. A \$3.00 exit toll also applies on exit from the Taxi rank at the airport.

Blue Taxi Company
Phone: 08 8981 3777 or 13 TAXI (138 294)

Darwin Radio Taxis
Phone: 131 008

Public bus service. Darwin's public bus service operates around the CBD and suburbs but does not drop off at the Convention Centre. Delegates can catch a bus to the CBD and walk over the footbridge to the Convention Centre.

For further information about Darwin's public bus service go to:
www.transport.nt.gov.au/public/bus/darwin

Climate in Darwin

Darwin enjoys a winter-free tropical climate averaging 30°C (86°F). From May to September the days are mild, characterised by gentle southeast trade winds and blue skies; the nights are balmy and cool. Casual clothing is a mark of Darwin lifestyle, but smarter attire is expected in the hotels and restaurants. Pack light, comfortable clothing, good walking shoes and a hat. The Darwin Convention Centre is very well air-conditioned and delegates are advised to wear layered clothing to keep warm whilst in the Centre.

Travel and accommodation

If you have any last-minute enquiries please feel free to contact Travel Makers for all your travel needs. Travel Makers can be contacted in Canberra by:

Phone: 1800 838 408

Email: geoff@travelmakers.com.au or
aree@travelmakers.com.au

Online: www.travelmakers.com.au/conferences.aspx

A guide to concurrent sessions

This overview is to help you scan the concurrent sessions and to decide which you will attend. They appear in the program in this format:

11.00 am – 12.35 pm CONCURRENT SESSION Z									
	Z1 Stream theme	Z2 Stream theme	Z3 Stream theme	Z4 Stream theme	Z5 Stream theme	Z6 Stream theme	Z7 Arts stream: theme	Z8 Stream theme	Z9 Colloquium: theme
	Meeting room Chair:	Meeting room Chair:	Meeting room Chair:	Meeting room Chair:	Meeting room Chair:	Meeting room Chair:	Meeting room Chair:	Meeting room Chair:	Meeting room Chair:
11.00	Paper title Presenter	Paper title Presenter	Paper title Presenter	Paper title Presenter	Paper title Presenter	Paper title Presenter 	Paper title Presenter 	Paper title Presenter	4 Colloquium papers 4 Presenters
11.25	Paper title Presenter	Paper title Presenter 	2 Soapbox papers 2 Presenters	Paper title Presenter 	Paper title Presenter	Paper title Presenter	Paper title Presenter 	Paper title Presenter	Discussion session with delegates and presenters
11.50	Paper title Presenter 	Paper title Presenter	Paper title Presenter	Paper title Presenter	Paper title Presenter	Paper title Presenter	Paper title Presenter  	Paper title Presenter	
12.15	Paper title Presenter	Paper title Presenter	Paper title Presenter 	Paper title Presenter	2 Soapbox papers 2 Presenters	Paper title Presenter	Paper title Presenter 	Paper title Presenter  	
12.35	Session concludes								
LUNCH									Location



First-time presenters



'Top 20' abstracts



Peer-reviewed paper



Arts in health



Top ranking abstract



International presentations

Each concurrent session consists of nine or ten streams, generally consisting of a combination of 10-minute 'soapbox' presentations and 20-minute papers.

At the end of each 20-minute paper, or of two 10-minute soapbox presentations, there will be a 5-minute break to allow delegates to move between streams (ie from one room to another) should they wish to do so. Those attending paired soapbox presentations are asked to remain until both have concluded in order to minimise disruption.

There will also be colloquiums, consisting of 5-7 brief presentations (with no 5-minute breaks), then discussion among presenters and with the audience. The colloquium Chairperson will manage discussion in such a way as to result in strong, well-developed recommendations for policy change. Delegates in the colloquiums are expected to stay for the full 95 minutes.

The concurrent session chairs and scribes are asked to work with other delegates to post one or two recommendations in the Sharing Shed via the laptop in each room before they depart the scene.

Recommendations process

One of the strengths of the biennial National Rural Health Conference is its capacity to generate recommendations from conference delegates who are vitally involved in Australia's rural and remote health sector as practitioners, managers, students, policy makers, academics and consumers. The conference community, of itself, represents a significant investment in rural health—as well as meeting the costs to attend the conference, individuals and agencies invest their time and share their experiences and support for one another at this important biennial gathering. In addition to this commitment, they bring a wealth of knowledge, insights and ideas which are invaluable to the development of good recommendations and the shaping of policy.

To honour this investment and potential, delegates are encouraged to participate in the process of policy and program development through the conference recommendations process. This can lead to action at various levels, including through advocacy for them by national bodies like the NRHA.

The National Rural Health Conference recommendations play a key part in setting the rural and remote health sector's agenda for subsequent years.

Following its successful adoption two years ago at the Adelaide conference, the recommendations process for Darwin is facilitated through the *Sharing Shed*—a website that enables delegates to submit, comment on and vote for, recommendations.

Access to the *Sharing Shed* is via <http://ruralhealth.org.au/sharingshed>

The recommendations process is as open and inclusive as practicable and delegates are encouraged to submit recommendations for consideration at any time during the conference. Delegates can access the *Sharing Shed* via their laptops, tablets and smart phones—or on a number of computers at the Convention Centre. These will be located in the Sharing Shed Lounge, at the conference registration desk, and in the NRHA exhibition booth where staff will be available to assist delegates with submitting their

recommendation. All conference delegates will have received individual log-in details for this purpose. Delegates who have lost their password may re-obtain it from the registration desk.

Computers in the concurrent session rooms will also have links to the *Sharing Shed* to enable concurrent session chairs and scribes to enter recommendations that have been generated in their sessions. There are unique log-in details for each concurrent session. Also in the *Sharing Shed* conference delegates are able to lodge 'votes' to indicate support for their preferred recommendations. By these means it is possible to include all delegates in the process on an equal footing with paper-givers.

Please note: The *Sharing Shed* is publicly viewable, but only conference delegates can submit and vote on recommendations.

As in previous years, a Conference Recommendations Group will review the recommendations received, take account of the level of support indicated by delegates, collate ideas spread across similar proposals, and present priority recommendations in plenary sessions for comment and feedback from delegates. The Group will also generate recommendations on issues that emerge during the conference but have not been entered into the *Sharing Shed*.

Delegates will be providing feedback from the conference via Twitter, Facebook and other social media forums. These will all be monitored by the Conference Recommendations Committee.

The Conference Recommendations Group will be convened by Lesley Fitzpatrick and will include Gordon Gregory, Anne-marie Boxall and Catherine Neilson. John Humphreys will provide expert advice to the Group.

Lesley Fitzpatrick will progressively inform delegates through a number of plenary sessions of key themes emerging from received recommendations and invite input from delegates on those that appear to be gathering support as conference priorities. As well as this process a couple of recommendation roundtables will be held during the conference at which the Recommendations Group will meet with interested delegates to further develop the priority recommendations. The process will culminate during the plenary session on Wednesday when



Lesley will ask the delegates to consider and formally endorse the Priority Conference Recommendations before they are presented to governments.

At that final run through of the recommendations, delegates will be encouraged to view them in this light:

These recommendations reflect the generally agreed views of delegates at the 13th National Rural Health Conference, but not necessarily the full or particular views of any of the bodies represented by individuals at the conference.

Everyone at the conference is encouraged to make their views known and to propose recommendations for action at any level: for example for local, state or national governments, professional associations, universities and/or community groups. Media work at the conference will reflect the tenor and content of the recommendations that emerge.

After the conference the Priority Recommendations and all others are grouped by theme and circulated to organisations concerned with rural and remote health and wellbeing. They are encouraged to consider the recommendations pertinent to their own interests and to act on those that they wish to progress.

Recommendations—FAQs

Q What is the status of the recommendations?

A The recommendations are conference recommendations, not NRHA recommendations. Like other bodies, the Alliance will pass the recommendations on to its Council for consideration. The Alliance may formally endorse some, or all, of them and work to progress those that are endorsed over the next two years through its policy development, advocacy and lobbying activities.

Q What happens to the conference recommendations?

A They are promoted through the media and by other means, and through targeted sends to organisations and individuals able to act on them. Agencies are encouraged to promote the recommendations that relate to their own area of interest. Those of them supported by all member bodies in the Alliance help inform its work agenda.

Q What has happened to the recommendations from previous conferences?

A Some of them have been fully implemented, some have helped inform policy developments, and others have gone nowhere. Following conferences, the Alliance maintains a checklist to monitor the progress of recommendations. Partly as a result of the recommendations from previous conferences there have been submissions on such things as speech pathology, skin cancer, motor vehicle accidents, mental health programs and the development of Northern Australia. The Alliance has produced new Fact sheets relating to some of the issues discussed in conference recommendations, and has further developed its proposals on health workforce redistribution.

Q What makes a good recommendation?

A A good recommendation is SMART: specific, measurable, achievable, realistic and timely. It is a proposal for action directed at a person or agency in a position to act on it, with some indication of how the costs will be met and what the timeline should be. It should accurately reflect responsibility for the issue of concern. When implemented, a good recommendation will lead to improved health outcomes.

Q How are recommendations prioritised?

A The Recommendations Group will audit all recommendations received and identify priority themes based on content, timeliness, urgency, achievability, cost-effectiveness and level of interest indicated by input and response, with due regard for a broad coverage of issues. Recommendations from colloquiums will be accorded some higher priority. Conference delegates are able to contribute to prioritisation in plenary sessions.

Review and selection process for concurrent session papers

The closing date for the receipt of abstracts for the 13th Conference was 28 November 2014. Over 400 abstracts were received for around 200 paper and workshop places in concurrent sessions.

All abstracts were then subject to a 'blind' selection process which included ranking by the Abstract Review Committee. The purpose was to select abstracts on the basis of their potential value, their quality, their particular association with rural and remote (cf national or metropolitan) health, and their relevance to the selected conference topics.

Our thanks to the members of the abstract ranking group:

- | | | | |
|---------------------|------------------|---------------------|-------------------------|
| • Robyn Aitken | • Hugh Heggie | • Deirdre | • Lesley Russell |
| • Phil Anderton | • Damien Hickman | McLaughlin | • Richard Sager |
| • Lisa Bourke | • Felix Ho | • Irene Mills | • Kieren Sanderson |
| • Helen Bowden | • Helen Hopkins | • Dane Morling | • Beverley Scott-Visser |
| • Anne-marie Boxall | • Nicky Hudson | • Anna Morse | • Lyndon Seys |
| • Peter Brown | • Tim Kelly | • Greg Mundy | • Bruce Simmons |
| • Sam Crossman | • Sabina Knight | • Tara Naige | • Gordon Stacey |
| • Rob Curry | • Tanya Lehmann | • Catherine Neilson | • Kylie Stothers |
| • Wendy Downs | • Tony Lower | • Shannon Nott | • Lindy Swain |
| • Alison Fairleigh | • Susan Magnay | • Nicole O'Reilly | • Sandra Thompson |
| • Jane Farmer | • Geri Malone | • Megan Passey | • John Wakerman |
| • Terry Findlay | • Mary Martin | • Andrew Phillips | • Diane Walsh |
| • Pauline Glover | • Jo McCubbin | • Louise Roufeil | • Robyn Williams. |
| • Christina Hagger | • Ellen McIntyre | • Camilla Rowland | |

Authors of abstracts selected for a place on the conference program were asked to prepare a full paper for inclusion in the conference proceedings. Successful authors were offered a general or peer-reviewed paper presentation (20 minutes) or a general or peer-reviewed soapbox presentation (10 minutes).

The peer-reviewed system was for those who wanted their paper to be potentially eligible for inclusion in the Department of Education's Higher Education Research Data Collection (HERDC) and who therefore submitted their paper for a formal review process. Their papers were subject to 'blind' review by two independent expert referees.

To be accepted as a peer-reviewed paper, the paper produced from the abstract needed to:

- be clearly expressed, using correct grammar and spelling
- show evidence of a literature search, including up-to-date materials, and reference the material appropriately (the Vancouver System being preferred)
- be analytical rather than only descriptive (eg of a program undertaken, a service developed etc)
- refer to the theoretical context or contextual framework in which the study was undertaken, and report on the work in the context of that framework
- show that the evidence related to the issue discussed had been considered
- present a coherent discussion of a topic that does not fracture into a number of issues thus clouding the intent of the paper
- demonstrate an emphasis on, and/or a relevance to, current health issues in rural and/or remote Australia.

The Conference Advisory Committee acknowledges the input of its expert referees and thanks them for their time.

Awards and Scholarship

Louis Ariotti Memorial Award

The Louis Ariotti Memorial Award is named in honour of the legendary Queensland bush practitioner who passed away in October 2008. Louis Ariotti contributed significantly to improved rural health both throughout his personal service and through great leadership in the sector.

The Award of \$10,000 recognises innovation and excellence in a contribution to rural and remote health in the areas of research, policy, leadership, workforce issues and service development. One grant is offered every second year.

The Louis Ariotti Memorial Award recipient for 2013 was Professor Lucie Walters.

Infront Outback Research Grants

The Infront Outback Research Grants are seeding grants to support research in rural or remote health. The grants program was established in conjunction with the Cunningham Centre and the Infront/Outback (the Biennial Australian Rural and Remote Health Scientific Conference). Two grants of \$10,000 each are awarded every second year.

The Infront Outback Research Grant recipients for 2013 were Leanne Craigie and Ben Ryan.

Des Murray Scholarship

The Des Murray Scholarship was established by the NRHA in 2000 to recognise Des Murray's major contribution to the rural and remote health community, and as a reminder of the man and his work. Des was for many years a key player at Commonwealth level in the development and administration of rural health policies in Australia. He then worked for the NRHA and continued to devote himself to improving health and wellbeing in rural and remote areas.

The scholarship enables a young person from a more remote area to attend the conference.

Friends Unsung Hero Award

Many people work tirelessly for their community and make enormous contributions on local issues. Communities in rural and remote areas are much the richer for their contribution, yet often we don't know who these people are. For this reason we call them Unsung Heroes—local people who work hard and expect little reward.

The purpose of the *Friends Unsung Hero* award is to recognise one (or two) of these people—and in particular someone who has made a very special contribution to the health and wellbeing of a remote, Indigenous or rural community.

The Unsung Hero for 2015 will be announced during the Conference.

Evaluating the 13th conference

Tell us what you thought!

We'd love to know what you thought of the conference: what worked well, what didn't, and how might we make the next one even better.

Here's how you can let us know:

- ask for and complete the hardcopy evaluation form available from the registration desk
 - complete our online survey (to be emailed to you in the week following the conference)
 - send us an email (conference@ruralhealth.org.au), give us a call (02 6285 4660), or have a chat with us during the event (we're the ones in the green shirts)
- and/or
- contribute a report for publication in *Partyline* or one of our other publications.

We encourage you to complete the survey and give us your thoughts while they're still fresh in your mind.

Those who complete the survey (and identify themselves in their response) will go into the draw to win a great prize.

Many thanks in advance.

The Conference Team

Join or renew your 2015/2016 membership of Friends in Darwin at 2014/2015 prices.

Show your commitment to rural and remote communities by joining Friends of the Alliance or by renewing for 2015/2016. If you would like to join or renew at the Conference, go to the Alliance booth or see the staff at the registration desk and you will be able to join at this year's rate.

Already a *Friend*? - How can you get more involved?

The *Friends* Advisory Committee (FAC) is comprised of two representatives from each State and Territory and two members of the Alliance Council. The usual term for Committee members is two years, with the option to nominate for subsequent terms. Elections for State and Territory representatives take place soon after each biennial National Rural Health Conference.

State and Territory representatives are elected from within the membership of *Friends* by the members in each particular jurisdiction. The Chair of *Friends* is elected by the FAC from within its membership, and serves as a member of Council of the Alliance for the duration of the term.

The FAC meet via teleconference soon after every second Council meeting and promote and facilitate communication on rural/remote health issues in the community; and engage in activities that raise the profile of the Alliance and its work.

If you would like to know more, head to the *Friends* page of the Alliance website <http://ruralhealth.org.au/friends> or track down one of our *Friendly* staff at the Conference!

Getting *Friendly* in Darwin

The aim of this pre-conference event is to offer delegates the opportunity to meet a few *Friendly* faces prior to the event and get an understanding of how the program works (for first timers). It will give delegates a chance to meet their state Friends Advisory Committee (FAC) representatives, make some new contacts, and exchange business cards.

Following a brief introduction of the FAC – who we are and what we do - the event will run like a 'speed dating' session: introduce yourself to a new *Friend*, have a chat, then a bell will go and you move on to meet another *Friend* etc.

Everyone welcome!

Friendly giving

If you are a current member of *Friends* don't forget to pop into the Alliance booth to pick up your special gift!

PHOTO & POETRY COMPETITIONS



This competition provides the opportunity to highlight life in rural and remote Australia through the art of photography and poetry.

Entries were open to members of the rural and remote health community and the top 20 entries are displayed in the Convention Centre foyer. All delegates are encouraged to vote for their favourite photo and poem – you will have received a voting slip when you picked up your name tag from the registration desk. **The winners will be announced on the final day of the Conference. Winners in each category will receive \$500, and second place \$250.**

FRIENDS HAMPER

Show off produce from the people
and places of your local community!



Peaches, pineapple, preserves and pillow cases. These are just some of the wonderful things produced by the people of remote and rural Australia.

Friends were invited to bring something non-perishable from their local area to go into the *Friends* hamper.

A lucky *Friend* will win the hamper on the final day of the Conference.

NRHA booth activities

Come and make new friends or drop in to see old ones at the NRHA Booth (numbers 28 and 29).

When you're in the exhibition hall, pull up a chair at the Alliance booth and have a friendly chat to a member of the NRHA Council, staff or *Friends* Advisory Committee.

What else can you do at the booth?

- drop off your contribution to the *Friends* Hamper
- enter the #loverural Facebook selfie competition
- pick up your free #loverural shirt
- have your photo taken in front of the #loverural poster
- join Friends of the Alliance
- meet the Editor of the *Australian Journal of Rural Health*.

Have your say at the Sharing Shed

At the Alliance booth (as well in the Sharing Shed Lounge and at the registration desk) you can access the *Sharing Shed* to make a conference recommendation or comment or vote on those already there.

The *Sharing Shed* is on the internet and easily accessible on your smart phone or tablet. Alliance staff members are on hand if you need help.

#loverural

With a tweet, photo, selfie or short video ... tell the world what you love about life in rural and remote Australia. The #loverural campaign is one way you can celebrate and promote the things that make rural Australia a great place in which to live and work.

If you are yet to post on a social media platform using our #loverural hashtag, visit us at the booth and have your photo taken doing the *loverural* hand symbol, or even just write a #loverural message that we can post for you!

The National Rural Health Alliance looks forward to meeting you at our booth.



#loverural



13th Conference Dinner 'A TASTE OF THE TROPICS'

7.00 pm for 7.30 pm, Monday 25 May 2015

Halls 3 and 4, Darwin Convention Centre

Dress: Darwin Tropical Rig

Music by The Kicks and The Kicks Soul Revue

Sponsored by



THANK YOU to HESTA

for again supporting this wonderful evening of dancing, celebrating, good food - and *more* dancing!

The dinner will give you the chance to meet and mingle with *people*, known and unknown, from *places* all around Australia and the region. This networking will help delegates plan for future action on some of the *possibilities* for better health and wellbeing in remote and rural areas.

The night will also include a presentation ceremony for the winners of the *Friends Unsung Hero* and the *Des Murray Scholarship*.

The Kicks and The Kicks Soul Revue

Tonight, the dance floor awaits and The Kicks and The Kicks Soul Revue know how to start a party! An all local performance, showcasing the best music from the last 40 decades. Vocalists Natalie Pellegrino and Jimmy Sogalrey bring the most demanding motown and soul sounds to life in 'The Kicks Soul Revue', a modern 9 piece soul/motown/funk band that will leave you wanting more! Luckily, Natalie and Jimmy always have a little extra music to give.



Arts and health —a winning partnership

Taking full advantage of the rich and vibrant culture of the Northern Territory, the 13th National Rural Health Conference arts and health program will have two primary streams: Northern Territory Indigenous Arts and Health Showcase; and Being Well: Creative engagement with Arts and Health.

The National Rural Health Conference acknowledges the support of The Regional Arts Fund—an Australian Government initiative supporting the arts in regional, remote and very remote/isolated Australia. The Regional Arts Fund is delivered in partnership with the Northern Territory Government.



We warmly welcome our partnerships with Larrakia Nation and Barkly Regional Arts which have helped to enrich the arts and health stream.

The Northern Territory Indigenous Arts and Health Showcase brings together an exciting range of projects, people and activities to present the cultural and artistic context of Indigenous health practice and create opportunities for delegates to meet, talk and connect.

In addition to a welcome ceremony, **Larrakia Nation**, representing Indigenous owners of Darwin, will present cultural and health activities including concurrent sessions on its award winning health service programs: 'arts in the grass' and 'care coordination'. Tony Lee will lead a (men only) didgeridoo workshop in which delegates will learn more about the cultural significance of the didgeridoo and master the art of circular breathing to create different tones. Pandanus weaving from the Gunga weavers (originally from Arnhem Land) will be featured in a workshop which will allow delegates to make a mat, basket, dilly bag or fish trap using pandanus leaves, which have been dried, stripped and dyed using local plants. Visit the Larrakia Nation pop-up shop for authentic Aboriginal art, carvings, jewellery, woven goodies, t-shirts, books, postcards and more. You can also slip on a headset and listen to different Aboriginal stories at Radio Diaries interactive display.

Visit Bagot Indigenous Community: Take a bus ride across town to Darwin's oldest town camp and visit the Child Australia Out of School Hours Care service at Bagot Community. The program caters to children and families and works holistically to improve outcomes across the community. Meet the OSHC team and some of the children who live at Bagot Community and discover how creative activities are part of daily life. Child Inclusive Learning and Development Australia (Child Australia) is a not for profit organisation dedicated

to improving developmental outcomes for children through education, early childhood services, family support and advocacy. At Bagot Community, Child Australia runs a Families and Children Service to support children's development and build family capacity.



Out of School Hours Care service: Jade and Lareece

Barkly Regional Arts will present a 'pop up gallery' that will allow conference delegates to experience the unique music, visual arts, dance, language and stories of the vibrant Barkly region. Short films, live performances by Indigenous musicians, and two arts and health exhibitions: Digital Mapping—an interactive online map and photographic display of Canteen Creek created by Dion Beasley (Cheeky Dog artist), and Conversation Plates—a disability ceramic exhibition telling the story of the Barkly will showcase the achievements of Barkly artists. Barkly Regional

Arts, a multi-arts organisation, provides an interface between Indigenous and mainstream cultures to reaffirm core Barkly Regional Arts values including: a celebration of and respect for cultural diversity and recognition of a unique Indigenous culture.

The Mulka Project is a Yolngu multimedia archive and production centre based at the Buku-Larrnggay Mulka Art Centre, an Indigenous community controlled art centre of Northeast Arnhem Land. The name 'Mulka' (meaning a sacred but public ceremony, and, to hold or protect) was given to the project by Buku-Larrnggay Mulka artists, who funded and now lead the project. The mission is to sustain and protect Yolngu cultural knowledge in Northeast Arnhem Land under the leadership of community members. The Mulka production house and archive is managed by Yolngu law, governance and culture. The Mulka project employs and trains Yolngu people of all ages: it makes audio-visual resources available for secondary students, provides workplace training for graduates, creates income streams for Homeland communities, and employs cultural advisors, curators and translators. The project is a media training ground for future Indigenous leaders. Visit the Mulka showcase and Buku-Larrnggay Mulka artists in the foyer throughout the conference.

Gift of Life Theatre performance and Q&A: Gift of Life is a play commissioned and produced by Artback NT in collaboration with Donate Life NT. Written by Darwin based playwright, Ben Graetz, this educational and moving performance has toured through the NT and Western Australia over the past three years. Gift of Life utilises a combination of traditional theatre and educational drama. Gift of Life is a 30-minute performance designed for non-theatre spaces. It has been staged at primary and high schools, detention centres, shopping centres, remote health clinics and art centres.



Gift of Life rehearsal: Ella Watson-Russell and Lynette Lewis Hubbard. Photographer: Tony Rive

Shellie Morris is an ambassador for the Fred Hollows Foundation who travels widely creating songs with young people in an effort to reduce the incidence of trachoma in Indigenous communities. As a supporter of the Foundation, she has worked with many young people to create songs in language that talk about how to live a Thumbs Up! life—a healthy, strong and long life. Shellie has written thousands of songs during her career in conjunction and collaboration with communities around Australia. She has also worked with The Jimmy Little Foundation to promote the vision of the late Dr Jimmy Little for Australian First Nations people to live to longer, healthier lives. She has an unshakable passion for working in communities and an excellent reputation as a facilitator and friend to many communities. She speaks a little of 14 Indigenous languages and has worked in more than 40 remote communities around Australia.



Shellie Morris

Being Well: creative engagement with Arts and Health celebrates the spirit, talent and cultural diversity of arts and health practice from around rural and regional Australia with a big focus on the vitality, diversity and richness of the multicultural NT

Darwin Rondalla: Early Filipino rondallas (string bands pronounced, in the Filipino style, as RON-DHAL-YA) in Darwin paved the way for a proliferation of string bands in the 1930s. Antonio Cubillo of Calapi, Bohol, Philippines and his sons started the rondalla tradition in Darwin. Brenda and Donny are the great-grandchildren of Antonio - Brenda plays guitar and percussion. Donny plays guitar and ukulele. Bong Ramilo co-founded the Darwin Rondalla in 1993 to play the music for “Keep Him My Heart: A Larrakia-Filipino Love Story”, a play written by Gary Cubillo Lee about the Cubillo family. He plays ukulele. Felino Molina has been with the Rondalla since 1993, as soloist and Musical Director. He plays banduria, octavina, and mandolin. Miguel Molina is the youngest and one of the newer members of the Rondalla. He plays bass and guitar.



Darwin Rondalla

Desak Putu Warti was born into an extended artistic family in Pengosekan Ubud, Bali. She graduated from the prestigious Sekolah Tinggi Seni Indonesia (STSI) and became a well known traditional dancer and dance teacher. She arrived in Darwin 1991 and has since attained degrees from the CDU (Arts and Teaching), is now an established dance teacher and frequently performs as an individual artist and with her group, Tunas Mekar Balinese Collective.



Desak Putu Warti

My Sisters' Kitchen 'Feast of Stories': Share a feast of personal stories from the My Sisters' Kitchen Caravan. This installation invites you to take a seat at a dining table to hear personal stories from the lives of My Sisters' Kitchen (MSK) participants, using food as the stimulus to recall memories. Follow the remarkable journeys of these women from refugee and migrant backgrounds, discover a new Darwin and marvel at how food and the arts can support and inspire women. Presented by StoryProjects with Darwin Community Arts, Dixi Joy Bankier and My Sisters Kitchen.



My Sisters' Kitchen

Imagine Me: Discover Imagine Me, a powerful photographic project that gives people living with Spinal Cord Injury a voice to express and to visualise their experiences. Developed by Sue Murray, this project is about inspiration and resilience. By assisting people with disability to explore their imagination, Imagine Me fosters greater community understanding toward people living with disability. **Sue Murray** studied at the National Art School and the Rhode Island School of Art and Design and began her creative studio practice working in the traditional form of documentary photography where the photographer interprets their subject. Major projects include a nursing home in the USA where she was resident photographer for two years and for which she won an award from Time Magazine New York. On return to Australia Sue began exploring the subject's participation in the making of their image which is integral to the impact of Imagine Me.



Brett Henman

Negative Guilt (digital poem): Panos Couros works primarily with sound, text and digital imagery to create sound design for theatre; writing for multimedia; video/sound installation and mixed/trans media works. Since early 2013 he has been the executive director at NT Writers Centre in Darwin. Negative Guilt is a poem about being an HIV negative man, working in the HIV sector, having been cured of Hep C, and the complexity of emotions and thoughts that this brings. It is also a poem about intimacy.

Learn to Swing Dance to 1940s Big Band Music:

Get ready to dance the night away at the Conference dinner by taking a dance workshop with Quito Washington, who will show you moves you previously only dreamed of!!! Quito has been promoting swing dancing in Darwin since 2000 and with Swing Dance NT has been the leading force in carving out a niche for swing dancing in Darwin on the national scene.



Angela Atkinson and Quito Washington

Corrugated Iron Youth Arts: Performance Menu is a multi-art form showcase in culinary terms—the audience gets to make a selection from a theatre menu and watch a performance up close. Performers will make their way through the venue presenting a delightful array of circus, performance, comedy and music. Corrugated Iron Youth Arts is the premier youth arts organisation in the Top End. Currently in its 30th year of operation, Corrugated Iron provides innovative and challenging performing arts experiences that express the diversity of young people living in the Northern Territory.

Belonging in a New Land—cultural performances hosted by Melaleuca Refugee Centre Torture and Trauma Survivors Service of the NT:

Many new settlers have fled persecution and war to rebuild their lives in Darwin from countries including Burma, Nepal, Afghanistan, Iran, Sri Lanka, Somalia, Liberia, South Sudan, and the Democratic Republic of Congo. For many people of refugee background who find themselves so disconnected from their country of origin, maintaining cultural traditions through dance and music is a vital element in affirming their heritage and cultural identity. But cultural practice is dynamic and many new and unique cultural expressions are emerging as performers from different cultural backgrounds come together in friendship and artistic collaboration. Melaleuca Refugee Centre has been providing services to Darwin's refugee community for 19 years, providing specialist trauma recovery services to some of the most vulnerable and resilient people in the world. We are proud to present three exciting and high energy performances by community-based musicians, dancers, cultural custodians and innovators. Expect to leap into the circle to join at least one of these performances!



Congolese Dancers. Photographer Steve Hebblethwaite.

Jellyfish installations: Find yourself intrigued and beguiled by Aly De Groot's jellyfish installations. Aly shows an innovative and unique interpretation of basketry processes and is becoming increasingly celebrated as one of Australia's leading contemporary fibre artists. Her recent achievements include winning the prestigious TOGART Contemporary Art Prize in Darwin, where the judges praised her woven crocodile form for its 'combination of whimsy, potency and material resolution'. A large public artwork (pictured) commission for the City of Darwin sees her woven jellyfish interpreted as large cast forms residing permanently at the East Point Nature Reserve. As

a recipient of a Charles Darwin University Post Graduate Research Scholarship, Aly's PhD topic, Underwater Basket Weaving, explores issues surrounding basketry and ecology.



Beautiful Monster, Aly de Groot, monofilament (fishingline) 2013. Image: Darren Clark

CemeNTstars (theatre group of people with disabilities) now in their sixth year of production will present a mixed ability performance dealing with the day-to-day difficulties of communication faced by people living with a disability—a playful look at the ambiguities of language, communication and signing.



CemeNTstars (Darwin Community Arts drama workshops for young people with disabilities)

Still Belting Out! Seniors Citizens' Choir was formed by Paolo Fabris choir conductor and vocal studies lecturer at Charles Darwin University. Established in 2014, Still Belting Out! is a non-auditioning choir that performs choral music with a fun and welcoming attitude.

The Grey Panthers—dance performances by Darwin's Seniors' dance troupe: Come and see what keeps the batteries going in this group of senior performers as they take us on a journey that evokes the humour, courage and beauty of living in their later years. This unique Seniors' Dance Troupe explores what it means to be part of the aging Australian population and the role of the elder in contemporary Northern Territory life. With most participants over the age of 60, the Grey Panthers are 'successful', 'productive', 'healthy' and 'positive' role models for active ageing and life long learning. They perform regularly for special one-off events, usually charitable, and especially for older adult, and health specific organisations such as the Arthritis Foundation, University of the Third Age, and Rotary and Lions Clubs, and the Anti-Cancer Foundation, and Darwin Hospital. They were guest performers at the 2014 National Rehabilitation Nurses conference. They are regular performers on Darwin's arts and cultural calendar, including the very popular Portrait of a Senior Territorian Art Award. This amazing group shows us what happens when you commit to long term extended relationships and links into your community.



Grey Panthers. Photographer: Jess Devereux

The **Power of Story** concurrent session presents a glimpse of the role films and videos can play as part of contemporary arts and health practice.

Red Dust Role Models highlights music videos produced as part of its health promotion programs to remote communities.

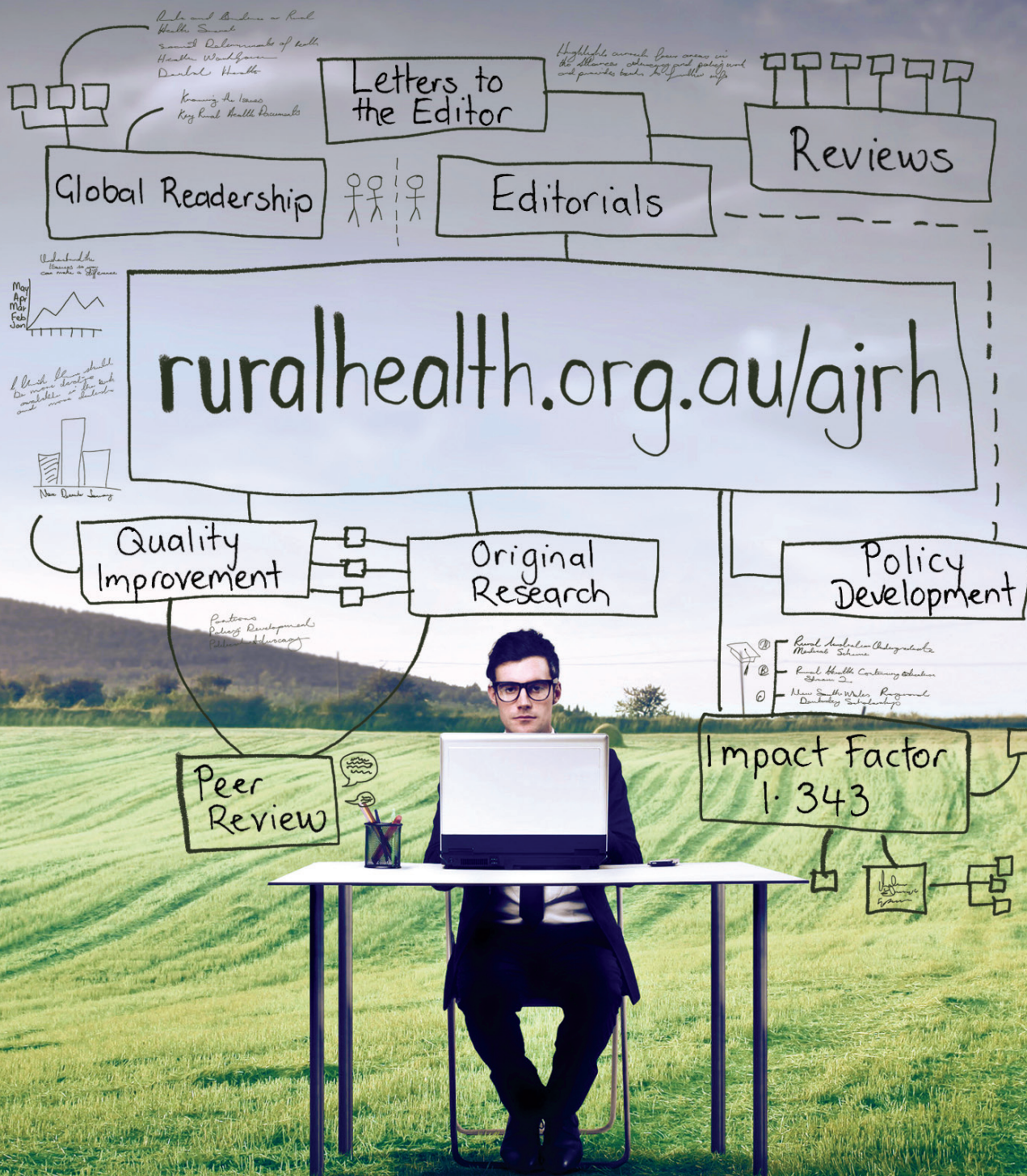
In Focus: Aboriginal Men's groups documents the work of Ross Morgan a drug and alcohol worker for the Wandarma Aboriginal Drug and Alcohol Service in south-east NSW to establish three men's groups.

Tin Town Trackers is a wonderful collaboration of Desert Pea Media and Western NSW Medicare Local to showcase the students of Coonamble High development of a music video promoting a strong mental health message.

Who we are in Charleville is a groundbreaking film by high school students with a very positive message about community strength and development.

Beyond Blue's stark video *The Invisible Discriminator* delivers a strong anti-discrimination message.

Experience the significant possibilities video can play in arts and health!



Multidisciplinary research to develop rural practice in all health disciplines

AJRH

The Australian Journal of Rural Health

Think... research... write... edit... publish...



NATIONAL RURAL HEALTH ALLIANCE INC.



NORTH AND WEST REMOTE HEALTH

When planning the delivery of allied health and well-being services in remote Australia consider North and West Remote Health, pioneering the delivery of outreach health services since 2001.

North and West Remote Health is a vibrant, not-for-profit organisation employing multidisciplinary teams currently servicing 14 Local Government Areas and 32 communities.

WHY CHOOSE US?

CONNECTED AND ACCESSIBLE

An established network of health and wellbeing professionals within Central and North West Queensland and the lower Gulf for over 14 years.

MULTI-DISCIPLINARY AND HOLISTIC

Our diverse team of health professionals work cohesively to achieve the best outcomes for our clients.

FLEXIBLE AND SOLUTION FOCUSED

We understand the needs of our clients can vary greatly so we will design services to suit individual requirements and circumstances.

COMPREHENSIVELY EQUIPPED

We harness a wide array of equipment necessary for service delivery in remote outback conditions including compulsory four wheel drive training for our employees.

EMPLOYER OF CHOICE

Mobile and flexible, our team-based environment is rich in development opportunities. Committed to building capacity at a local level, we match individual potential with career development.

Pre-conference events

Rural Emergency Skills Training (REST)

Australian College of Rural and Remote Medicine

22–23 May 2015
Travelodge Mirambeena Resort
64 Cavenagh Street, Darwin

A series of realistic scenarios and workshops directly relevant to the pre-hospital, small rural hospital and private rural practice environment. Uses clinical knowledge and protocols for training in adult and paediatric medical emergencies and trauma.

REST is a face-to-face, hands-on course relevant to: doctors and other health professionals requiring emergency care up-skilling or new in rural practice e.g. International Medical Graduates, Registrars in training programs. Places are limited to 20 participants.

Rural Emergency Obstetrics Training (REOT)

Australian College of Rural and Remote Medicine

23 May 2015
Adina/Vibe Hotel, Darwin

One day workshop focusing strongly on the practical demonstration and explanation of emergency obstetric skills to support the rural clinician; conducted by rural GPs and Midwives experienced in rural medicine.

REOT is suitable for non GP Obstetricians; Practice Nurses; Allied Health Workers; IMGs, Registrars, GP Obstetricians or Midwives seeking up-skilling. Places are strictly restricted to 21 people per day.

Bus tour to Nauiyu Nambiyu Community

National Rural Health Alliance

Saturday 23 May 2015
7.00 am to 7.00 pm

The National Rural Health Alliance is pleased to offer Conference delegates the opportunity for a full day bus tour to Nauiyu Nambiyu (Daly River) Community on the Saturday before the Conference begins. The tour is being organised with the assistance of local Primary Health Care Manager and Friend of the Alliance, Janet Fletcher, and Gary Higgins MP, Member for Daly, NT, and Minister for

Sport and Recreation; Senior Territorians; Environment; and Minister assisting the Minister for Arts and Museums.

Medisim Trauma Care Workshop

Careflight Inc

Saturday 23 May 2015
9.00 am to 5.00 pm
Darwin Convention Centre

Regional, rural and remote first responders are often the first people on scene at major trauma incidents. What they do in the first 5, 10 or 20 minutes can make the difference between a full or limited recovery, or life and death. CareFlight will be holding a MediSim Trauma Care Workshop to provide high quality trauma training for rural first responders that will be delivered by doctors, nurses and paramedics.

The improvement challenge: how local health performance information creates opportunities to improve rural and remote health outcomes

AHHA and NHPA

Sunday 24 May 2015
9.00 am to 3.00 pm
Waterfront 1, Darwin Convention Centre

This is a workshop designed to help rural and remote health service managers, clinicians, consumers and researchers make better use of data to improve patient experiences and outcomes.

The workshop will focus on data and evidence available to Local Health/Hospital Networks and to the new Primary Health Networks that are due to begin operations on 1 July 2015. The workshop will also explore both international and Australian experiences with performance measurement and will equip participants with a greater understanding of the local health data available to them and how it may be best used for improving health service and health care performance.

NDIS opportunities and possibilities: delivering the NDIS in rural and remote areas

Saturday 24 May 2015
9.15 am to 3.30 pm
The Hilton Hotel, Darwin

A practical workshop run by disability experts who will assist you to:

- identify the NDIS funding opportunities
- examine successful service models and the organisational change required by the NDIS
- explore the key worker model for disability services in rural and remote areas
- discuss best-practice Indigenous disability service delivery.

Explore the operation of the NDIS with some of Australia's leading disability experts and the leaders of the NDIS in the NT. This is a practical workshop designed to give you the tools and resources to succeed with the NDIS. But don't just take our word for it—see what our Adelaide workshop participants had to say:

“vast knowledge and experience—articulate experts—inclusive of all ideas”

“I have a whole list of actions to take back with me ...”

“friendly, interesting, passionate, genuine”

“excellent experience”

“real life examples ... thank you for your passion, time and support ...”

“I really like your passion and plain speaking. It makes more sense to me ...”

Cultural responsiveness: an action based approach to cultural safety

AIDA, IAHA, NACCHO, NATSIHWA

24 May 2015
10.00 am to 3.00 pm
Darwin Convention Centre

It is essential that health professionals are both clinically competent and culturally responsive in order to positively affect the health and wellbeing of Aboriginal and Torres Strait Islander people. This interactive workshop, delivered collaboratively by Indigenous Allied Health Australia, Australian Indigenous Doctors' Association, National Aboriginal

and Community Controlled Health Organisation and the National Aboriginal and Torres Strait Islander Health Worker Association, will build participants' ability to be culturally responsive to the unique needs of Aboriginal and Torres Strait Islander peoples, with a particular emphasis on those living in rural and remote locations.

Participants will have the opportunity, in a safe environment, to engage in self-reflection and practical activities that will enhance their ability to take culturally responsive action. This course is for all rural and/or remote health professionals interested in providing culturally safe and responsive care with Aboriginal and Torres Strait Islander people.

Medicines in the bush multi-disciplinary workshop

Pharmaceutical Society of Australia

24 May 2015
10.00 am to 3.30 pm
MR1, Convention Centre

Managing medicines in rural and remote settings is challenging for health professionals and their clients. This workshop will explore some of the challenges and the solutions to medication access and management. Topics will include Aboriginal health, innovative service models and program delivery, renal disease and management of complex chronic disease.

The rural health guide to social media: learn how to survive and thrive online

National Rural Health Alliance

24 May 2015
10.00 am to 3.00 pm
Adina/Vibe Hotel, Darwin

Social Media presents fantastic opportunities for remote and rural health professionals and consumers to overcome personal and professional isolation. Social media can expand their professional networks, keep them up-to-date with the latest news and developments in their areas of interest, and provide a dynamic interactive vehicle for communicating with the community.

The first half of this workshop will be a taster for remote and rural health professionals who are interested in Social Media but don't know where to begin. The second half of the workshop will focus on more advanced topics including how to set up a blog, how to use social media for continuing

professional development, and how to create content including presentations and videos to share through social media.

Fundraising Possibilities through storytelling about the People and Places of your organisation

National Rural Health Alliance

24 May 2015

10.00 am to 3.00 pm

Adina/Vibe Hotel, Darwin

This interactive workshop includes Why, How and When to fundraise and templates for a fundraising toolbox. Participants will be equipped to develop an integrated fundraising strategy for their organisation covering direct marketing, events, capital campaigns, volunteer and stakeholder engagement and social media. Working in teams, participants will develop a fundraising campaign for use back at their organisation.

The second part of the workshop will enable participants to develop stories to market their organisations to stakeholders and all types of philanthropic supporters. Guidance on structure, methods and outputs of stories for newsletters, speeches, websites, brochures etc including practical tips and templates will help participants working in teams to develop a communication plan that could be used by their organisation.

David Zerman believes that working and volunteering in the not-for-profit sector is the best activity anyone can be involved in.

His career has been mainly in journalism, ethical public relations (which he believes is not an oxymoron) and fundraising, where he has worked on and led annual and capital campaigns that have raised more than \$202 million in the last 25 years. David is driven to improve health and educational opportunities in Australia and internationally.



Despite his Master of Public Health, Graduate Diplomas in International and Comparative Law, Public Policy and Media Studies and having completed the Executive Program for Non Profit Leaders at Stanford University's Graduate School of Business and the Senior Executive Program at Harvard University's Kennedy School of Government he believes his greatest education was probably obtained during his 10 years as CEO of the

Victorian Section of the RFDS when he spent a lot of time in rural and remote Australia.

As Fundraising Epidemiologist and CEO of Possibility Australia he specialises in working with not-for-profits across Australia to develop and strengthen communities through easy strategic fundraising based on supporter relationships and meaningful storytelling.

His best stories include thanking a donor for sending \$2 worth of stamps every month for more than 30 years and having to return a \$1 million donation. But that's another story for participants at the pre-conference workshop!

Sarah Barzel, the Facilitator of Greatness and Director of Training and Community Engagement with Possibility Australia believes reading and community based strategic problem solving are keys to strengthening rural and remote communities.



After graduating from Melbourne University, Sarah worked as a secondary teacher before moving overseas where she was an educator, university lecturer and author both in Brazil and Israel. Sarah obtained her MA and TESOL Certificate from Trenton State College in New Jersey and is a Nationally Accredited Trainer (Cert IV) in Australia.

Both in Australia and overseas Sarah has been continually involved in voluntary language teaching to new migrants and refugee settlement of families in their new countries. As a result of her international career, Sarah, who is the author of three multilingual books and more than 100 web based education learning programs, is fluent in Portuguese, Hebrew, French, Polish and of course English.

A voracious reader, Sarah hopes participants at this Congress might be interested in starting Skype based book clubs for adults and children in their communities.

Sarah, who is one of a handful of Australians who have completed the Certificate in Fundraising Management from Indiana University's Centre on Philanthropy has worked as a University lecturer and as the Education Coordinator of a major Victorian Museum.

As a fundraising specialist focusing on creativity and innovation she has successfully obtained government and trust and foundation grants and is currently working on a multi-million aged care appeal in rural Victoria.

Getting *Friendly* session

Hosted by Friends of the Alliance

Sunday 24 May 2015

1.00 pm to 2.00 pm

Level 2, Darwin Convention Centre

If this is your first time at a National Rural Health Conference, you are encouraged to attend this session. This is your opportunity to find out how to get the most out of attending the event while at the same time meeting some new Friends.

You will:

- get an understanding of Friends of the Alliance
- understand the Conference program and how to navigate it
- meet other Friends of the Alliance, including your State representatives.

Don't forget your business cards!

Writing for Publication

Australian Journal of Rural Health

Sunday 24 May 2015

1.00 pm to 3.45 pm

Darwin Convention Centre

For new and published authors looking for answers:

- How does peer review work?
- What does an editor contribute?
- How does my research influence policy solutions?
- What is happening in global publishing?

The editors of the Australian Journal of Rural Health will answer these and many more questions. The workshop includes the popular hands-on session in which they will offer practical advice on how to edit your own manuscript to increase its chances of publication.

Continuing professional development

Australian College of Midwives

The 13th National Rural Health Conference is an Australian College of Midwives CPD Recognised Course. An allocation of 20 CPD Points (Plenary = 1.5; Day 1 = 6.5; Day 2 = 6; Day 3 = 6) has been approved for midwives who complete this activity.



Australasian College of Health Service Management

ACHSM Australasian College of Health Service Management

Brilliant Leadership For Healthy Communities

This NRHA biennial conference (2015) is endorsed by the Australasian College of Health Service Management (ACHSM) according to approved criteria. Attendance attracts 1 Continuous Professional Development (CPD) point per hour as part of ACHSM's CPD Programme.

Australian College of Rural and Remote Medicine

Australian College of Rural and Remote Medicine are pleased to accredit the 13th National Rural Health Conference for 24 core points – ACRRM code E1502NRHA. College of Rural and Remote Medicine are pleased to accredit the Preconference Workshop – 'MediSim Trauma Care' at the 13th National Rural Health Conference, Darwin for 12 core points + 12 EM MOPS and 12 ANAE MOPS – ACRRM code E1501NRHA.



Pharmaceutical Society of Australia

Pharmaceutical Society of Australia

Pharmacists are able to self-record CPD credits associated with their attendance at the 13th National Rural Health Conference. Please check the Pharmacy Board of Australia guidelines for further information on self-recording CPD credits.

BIOGRAPHIES

Keynote speakers

Bruce Bonyhady



Mr Bruce Bonyhady AM is Chairman of the National Disability Insurance Agency Board.

Mr Bruce Bonyhady was formerly the President of Philanthropy Australia and also formerly the Convenor of the Independent Panel appointed to advise the Productivity Commission and government during the Inquiry into long-term care and support for Australians with disability. He is a Member of the Disability Investment Group and the Reference Group for the Pension Review. He was Deputy Chair of the National Disability Insurance Scheme Advisory Group to the Council of Australian Governments and former Chairman of Yooralla.

Mr Bonyhady has also held a number of senior positions in the funds management industry and insurance industry in Australia and internationally. He is Chairman of Acadian Asset Management Australia Limited and a Director of Dexus Wholesale Property Limited. His former roles include senior positions in the funds management industry, including Managing Director of ANZ Investments and Executive Vice President at BT Funds Management. His earlier career was as an economist and econometrician in the private sector and the Commonwealth Treasury.

He is the father of three adult sons two of whom have disabilities. Mr Bonyhady was appointed as a member of the Order of Australia in 2010 for services to people with disabilities, their families and carers and to the community.

Kathy Burns



Kathy Burns is Artistic Director, Barkly Regional Arts (BRA). Living and working in the Northern Territory for the past five years with Barkly Regional Arts, Kathy has created innovative, exciting and engaging arts programs for remote Barkly communities. Since 2011 Kathy has been working in very remote Indigenous communities implementing arts programs ranging from music, film, visual arts, dance and theatre for all ages. As the Artistic Director, Kathy creates all program projects across the multi-arts organisation, ensuring quality engagement and innovative opportunities for the community and service organisations to be involved.

Credible projects include: creation of 'Media Mob' youth media project, 'Lady Beats' female music project, 'Pinarra Aku' children's language radio show, 'Digital Mapping' disability mapping website and the implementation of live webcasting in Tennant Creek and very remote Barkly communities. Kathy is also the Festival Manager of the Desert Harmony Festival (since 2012) that engages all Barkly communities and gives people from all over the world access to its cultural arts festival via the web.

Project collaboration highlights: Oz Opera Orchestra and the Winanijikari Music Centre for Oz Opera's Don Giovanni, National Rural Health Alliance for ExStream heart (virtual tour of BRA), ABC Heywire Video Postcards, Griffith University and the Winanijikari Music Centre cultural music exchange program, Mungkarta Community Living Culture

documentary and NDIS ceramics project.

Previous roles include: Management of private acting college; The Actors Workshop (2005-09), Principal CLIVE Host Presenting course for professional actors, models and sporting personalities (2009-2011), Tutor Australian Theatre for Young People (2009-2011).

Lindsay Cane



Lindsay Cane is an experienced CEO and Company Director with broad skills and experience in leading, managing and inspiring organisational development and growth within the NGO sector. She has held the position of CEO Royal Far West, a NSW-based NGO that provides health services to children living in rural and remote parts of the state, since July 2011.

Lindsay has a proud history of working within the health care, sporting and community development sectors. She has previously led organisations such as Netball Australia, The Asthma Foundation (NSW) and the Australian Physiotherapy Association. She is also a skilled industry consultant and has provided strategic management, business development and executive coaching services to a range of health, charity, drug and alcohol, sporting and community development agencies.

Recognised as a strong organisational leader, Lindsay has previously been a finalist in the Telstra Business Women's Awards and is a graduate of the Sydney Leadership program.

In addition to her role with Royal Far West, she continues to support a range of organisations. She is a graduate member of the Australian Institute of Company Directors, Director of the Confederation of Australian Sport and a member of Women on Boards Australia. She also volunteers her time to a number of community development projects.

Alan Cass



Professor Alan Cass is Director of the Menzies School of Health Research in Darwin. From its base in Darwin, Menzies employs over 250 staff across Australia and the Asian region.

Having trained as a renal physician, Prof Cass has pursued a research career with particular interest in the prevention and management of chronic disease and Indigenous health. His research includes work exploring the social determinants of health, qualitative research aiming to understand people's views about health and illness and challenges in accessing care, investigator-led clinical trials and health services research exploring the barriers and enablers to translation of research findings into practice.

He has regularly worked with governments and NGOs to develop plans for the prevention and management of kidney disease, especially to address its devastating impact on Indigenous Australians in remote areas.

Geoff Clark



Dr Geoff Clark is an international public health and development specialist with considerable experience in managing major health care reform in complex and challenging environments globally. He has provided support and direction in strategic implementation of national health care plans with a focus on health service delivery, legislation, policy development and communicable diseases in a variety of countries including Indonesia, Uganda, China, Myanmar and Papua New Guinea. Dr Clark currently holds the position of Director, Health Programs and Performance for the Australian Aid program in Canberra. In this role he is responsible for the A\$100 million Australian Aid global health programs. Dr Clark holds postgraduate qualifications in public health, law and health management.

Megan Davis



Professor Megan Davis is a Professor of Law and Director of the Indigenous Law Centre, UNSW and a Commissioner of the NSW Land and Environment Court. Megan is also a UN Expert Member of the United Nations Permanent Forum on Indigenous Issues (UNPFII) (state member) and holds portfolios including Administration of Justice and Gender and Women. In 2012, Megan was the Rapporteur of the UNPFII Expert Group Meeting on violence against Indigenous women, held in New York; and was elected again in 2013 as Rapporteur of the UNPFII Expert Group Meeting on Indigenous Youth. In 2015 Megan

was the Rapporteur of the UNPFII Expert Group Meeting on an Optional Protocol on the UN Declaration on the Rights of Indigenous Peoples. Megan teaches, writes and researches in the areas of Public Law (Constitutional Law) and Public International Law. In 2011, Megan was appointed by the Federal Government to the Expert Panel on the Recognition of Aboriginal and Torres Strait Islander Peoples in the Constitution and continues to be involved in legal discussions on the constitutional issues relating to the referendum model. In addition, Megan specialises in legal issues pertaining to violence against Indigenous women.

Julian Disney AO



Julian Disney is Professor of Law and Social Justice, and Director of the Social Justice Project, at the University of NSW.

He is the founder and National Chair of Anti-Poverty Week, Chair of the Energy and Water Ombudsman scheme in NSW, Convenor of TaxWatch and on the Board of Governors of the Committee for the Economic Development of Australia.

He has been Chair of the Australian Press Council, the National Affordable Housing Summit, the National Community Tax Forum, the International Council on Social Welfare and the Australian Council on Social Service. He has also been Coordinator of the Welfare Rights Centre in Sydney and a Law Reform Commissioner.

He has chaired national and state government inquiries into affordable housing and employment assistance, and been a member of government advisory committees in areas such as economic development, social security, employment, housing and literacy.

He has been a policy consultant to community and business organisations and a frequent speaker at national and international conferences and in the media.

He was appointed an Officer of the Order of Australia (AO) for services to the development of economic and social welfare policy, and to the law.

He was raised in Adelaide, now lives in Sydney and is married with two adult children.

John Elferink MLA



John Elferink was born in the Netherlands and moved to Australia in 1969, his family settling in Darwin.

After graduating from Casuarina High School, John joined the Northern Territory Police Force as a cadet. He rose to the rank of Sergeant and served in both Darwin and Alice Springs.

While in the police force John also obtained a Bachelor of Arts by correspondence and now also holds a Bachelor of Laws.

In 1997 he was elected to the rural seat of MacDonnell and served there until 2005. In 2008 he was elected to the seat of Port Darwin.

John's vision for the Northern Territory is for it to be an area of growth, with a prosperous economy and where crime is a rarity rather than constant.

John is also driven to deliver better health outcomes for Territorians, regardless of whether they live in urban or remote areas of the Northern Territory. Since being appointed as the Minister for Health, John has travelled across the Territory meeting professionals and experts in the health sector, and has developed an interest in building the capacity of the mental health.

He lives with his wife and two daughters in Darwin.

Katrina Fong Lim



Katrina Fong Lim was born in 1961 in Darwin; the fourth daughter of respected local couple Alec and Norma Fong Lim. Alec was a business man who eventually became a very popular Lord Mayor in the 1980s. Katrina completed primary and secondary education in Darwin, matriculating from Darwin High School in 1979. She was an AFS Exchange Student to the USA for the 78/79 school year.

Katrina had worked for 13 years with the Commonwealth Public Service undertaking a variety of jobs for a range of Departments. She left the Public Service to work in the not for profit sector. Katrina has worked in this sector for 20 years including at the YWCA, Crafts Council, NT Centenary of Federation and the Australia Day Council NT.

Katrina completed both a Bachelor of Business with a double major in Marketing and Human Resource Management and Master of Professional Accounting from the University of Southern Queensland by external studies.

She has also operated a small business initially delivering Financial Management Training to builders through the Master Builders Association NT.

She lives with her husband Tony Waite in Nightcliff.

Hensley Garae

Dr Hensley Garae is the Director of Hospital and Curative Services in the Vanuatu Ministry of Health.

Tony Hobbs



Dr Anthony (Tony) Hobbs joined the Therapeutic Goods Administration (TGA) in February 2013 as the Principal Medical Adviser.

Previously he was a general practitioner in rural NSW and former Chair of the Australian General Practice Network. Dr Hobbs has made a significant contribution to Australia's health system as Chair of the External Reference Group that in 2008–09 developed Australia's first national Primary Health Care Strategy. Dr Hobbs has had extensive experience on boards, committees and advisory councils, including National Health and Medical Research Council, university and cancer, diabetes and kidney health, advisory groups.

Dr Hobbs has a First Class Honours Medical degree from the University of Sydney, and postgraduate qualifications in Gynaecology and Obstetrics, Child Health and Tropical Medicine and Hygiene from Australia and the United Kingdom. Dr Hobbs is also a graduate of the Australian Institute of Company Directors, and has been involved with the National Prescribing Service on its diagnostic evaluation advisory group.

His wealth of experience and expertise adds significantly to the contribution of the TGA to Australia's health system.

Stephen Jones



Stephen Jones was first elected to the federal parliament in 2010 representing the NSW regional electorate of Throsby centred around Wollongong, where he was born and raised. He was re-elected in 2013.

In 2012, Mr Jones put forward the first Private Member's Bill to be debated in the Federal Parliament with the intention to legalise same-sex marriage. The Bill was defeated in the House of Representatives.

In 2013, Mr Jones was appointed by Opposition Leader Bill Shorten as the Shadow Parliamentary Secretary for Regional Development and Infrastructure, and in 2014 was appointed to the Shadow Ministry by Mr Shorten as the Shadow Assistant Minister for Health.

Mr Jones' shadow portfolio responsibilities include Regional Health and Indigenous Health policy matters as well as oversight over seven health regulatory agencies including: the Therapeutic Goods Administration, Food Standards Australia New Zealand and the National Blood Authority. Mr Jones currently serves on the Standing Committee on Health, Joint Select Committee on Constitutional Recognition of Aboriginal and Torres Strait Islander People and Labor's Caucus Committee on Social Policy.

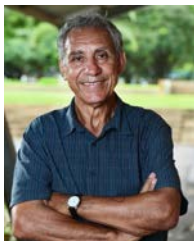
Mr Jones holds a Bachelor of Arts degree from the University of Wollongong and a Bachelor of Laws degree from Macquarie University.

Mr Jones worked in the community sector for various front line disability services, health services and youth projects.

Prior to entering the Federal Parliament he worked as an industrial officer with the Australian Council of Trade Unions (ACTU) and as the

Secretary of the Community and Public Sector Union (CPSU).

Charlie King



Charlie King is a well-known Territorian. As host of ABC Radio's *Territory Grandstand* he is well known for his love of all things sport. Charlie has covered everything from calling AFL football matches through to covering Olympic Games in Beijing and London. He has won numerous awards, including National ABC's Awards, Darwin City Councils NT Person of Year award and the NAIDOC Indigenous person of the year and Elder of the year awards. This year Charlie was a recipient of an Order of Australia Medal, recognising his contribution to Aboriginal people through the media and for his work in campaigning to end family and domestic violence. Charlie's true passion is working to make change in our communities through respectful relationships and advocating for safe communities. He has developed the No More Campaign, which uses sport to engage men to look at solutions to family violence and child abuse. Charlie is a Gurindji man and believes that Aboriginal people must have a voice and that local people will be the drivers of change on communities.

Rob Knowles



Mr Rob Knowles is a farmer and company director.

Mr Knowles has been Chair of Mental Health Australia, a member of the National Health and Hospital Reform Commission, Chair of the Mental

Illness Fellowship of Australia, Chair of the Royal Children's Hospital Campus Council and a member of the Board of the Brotherhood of St Lawrence.

He is a former Victorian Minister of Health, Housing and Aged Care and has a strong interest in services for people with a lived experience, their families and support people.

Stevenson Kuartei



Stevenson Kuartei works with Pacific Family Medical Supply, Eye and Medical Clinics in Koror, in the Republic of Palau. From 2008 to 2012 he was Minister for Health for the Republic and prior to that Director of its Bureau of Public Health of Palau. Stevenson studied in the US and at Fiji School of Medicine. He is licensed to practice medicine and optometry in Palau. He has a wealth of experience in strategic health planning and public policy design. Since 1994 Stevenson has served as Chairman of the Palau Health Professional Licensure Board; Chairman of the Palau Off-Island Medical Referral Committee; been a Member of the Palau Institutional Board; President of the Palau Medical Society; a Member of the Pacific Basin Medical Association; and Chief of Medical Staff for the Belau National Hospital.

In 2004 he served as Chairman of the Committee on Traditional Healing for the 9th Festival of Pacific Arts. That same year he served as Vice President of the Second Palau Constitutional Convention; as Chairman, Committee on Fundamental Rights, where 'preventive health was made a fundamental rights for Palauan citizens'; and as Chairman of the Post ConCon Education Committee to teach the public on 22 Proposed Constitutional Amendments. His hobbies are reading, writing and fishing.

Peter Macdonald



Peter Macdonald is the President and Founder of Australian Doctors International (ADI). ADI is a non-profit, non-government, health care and development aid organisation run by volunteers aimed at strengthening primary health services in Papua New Guinea.

He has over 40 years of experience in general practice and is also an accomplished politician.

In 1999 Peter joined Médecins Sans Frontières and went to Iran to work with Afghan refugees in the border region of Mashhad. In 2000 under the auspices of Timor Aid he conducted several missions for returning refugees in East Timor. During this time Peter also made several visits to PNG to establish ADI and conduct clinical work.

His achievements over the past decade include: NSW State Member for Manly (1991-1999); Director of Plan International Australia (1999 to 2004); Mayor of Manly (2004-2008).

Peter is currently contracted to the South Australian Department of Health to provide locum medical services to remote communities.

Clement Malau



Dr Clement Malau is Associate Professor and Dean at the Faculty of Health Sciences, Divine Word University, Madang, Papua New Guinea.

As Head of the Faculty of Health Sciences, Dr Malau is responsible for

all academic programs at the Divine Word University. In keeping with PNG's developing status, Dr Malau has a strong interest in aligning the University's programs with the human resource needs of the country. A large part of his work is to enhance the relationship between the government and the university to develop quality human resources that are needed by the health sector in Papua New Guinea with particular emphasis on rural communities.

Dr Malau was formerly Secretary for Health in PNG (2007–2011) and was closely involved in corporate and national health planning. He has worked for the Burnet Institute as a public health management specialist (2003–2007) and has managed public health projects in Papua New Guinea, East Timor and New Caledonia. He trained as a doctor and has Master degrees in Medicine in Community Health (PNG) and in Public Health (Harvard).

Bronte Martin



Bronte Martin is the Nursing Director (Trauma & Disaster), managing inpatient trauma services at Royal Darwin Hospital and NCCTRCs deployable field hospital. She holds a Masters of Nursing Practice (Emergency & Trauma) and has senior experience in Emergency, Critical Care, Trauma, Aviation and Retrieval Nursing specialties. Bronte is also an Instructor for AusMAT, EMST, EMSB, MIMMS, Emergotrain and Trauma Nursing Programs throughout Australasia.

As founding member of the NCCTRC team, Bronte has been active in the establishment of key clinical acute health care partnerships in Emergency and Disaster Management response within the south-east Asian region; and has widely presented her work in many professional forums at both a National and International level. Most

recently Bronte deployed with AusMAT Field Hospital as Team Alpha clinical co-lead in response to Philippines Typhoon Haiyan.

Additionally, Bronte has been a member of the Royal Australian Air Force Specialist Reserve for the past 14 years with numerous Operational experiences, previously deploying to Solomon Islands in 2004 and more recently to Afghanistan in 2010; following which she was the recipient of the Australasian Military Medicine Association 2011 Weary Dunlop Prize and NATO Commanders Commendation for her work.

Shellie Morris



2014 NT Australian of the Year and NAIDOC Artist of the Year, Shellie Morris is one of Australia's finest singer songwriters and her voice and heartfelt music has seen her grace the stage from the Commonwealth Games in Glasgow in 2014 to Vancouver Winter Olympics, Japan and London.

In 2014, she performed at Showcase Scotland, MIDEM in France, WOMAD NZ, The Queen's Baton and she toured China. Shellie has featured with award-winning Black Arm Band, has collaborated with Melbourne Symphony Orchestra and has worked on a musical film with Casey Bennetto (Paul Keating the Musical).

She grew up in Sydney and reconnected with her family in Northern Territory 17 years ago with the encouragement and support of her adopted family. Since then she has worked with over 40 different communities, performing singer-songwriter workshops and learning different languages and styles. As an Ambassador for the Fred Hollows Foundation she has helped raised awareness for the organisation and assisted their fund-raising.

In 2009 she travelled with Brazilian legend Gilberto Gil through different communities collaborating with musicians along the way as he featured in a documentary that tracked his journey.

Her own recordings are *Shellie Morris*, *Waiting Road*, *Cloud 9* She is featured on Black Arm Band's *Murundak* and *Hidden Republic* amongst others.

From her work on the big stages with John Cale, Sinéad O'Connor and Gurrumul Yunupingu to sitting round a campfire with a guitar, her music speaks of shared experience and backgrounds.

Shellie won the 2012 national Music in Communities Award from the Music Council of Australia. She is a two-time winner of Female Musician of the Year at the NT Indigenous Music Awards and her language album *Ngambala Wifi Li-Wunungu* (Together We Are Strong) created with the Borroloola Songwomen won 2012 and 2013 National Indigenous Music Awards. In 2013, Shellie won a Deadly Award for her community commitment.

Fiona Nash



NSW Nationals Senator, Fiona Nash was elected to the Australian Senate in 2004 and her term began on 1 July 2005. She lives with her husband David on a property at Crowther near Young in the south-west of NSW and they are the parents of two teenage boys, Will and Henry.

Her experience with the party includes branch chairman, state executive, delegate to Federal Council, to National Party Whip in the Senate and her current position as Deputy Leader of the Nationals in the Senate.

Senator Nash's parliamentary roles have included Shadow Parliamentary Secretary for Water Resources and

Conservation, Shadow Parliamentary Secretary for Regional Education and she is now the Assistant Minister for Health.

John Paterson



John Paterson was appointed Chief Executive Officer for AMSANT (Aboriginal Medical Services Alliance of the NT) in 2006, and has held senior management positions within government and Aboriginal community organisations for more than twenty-five years. He is affiliated with the Ngalakan tribe from the Ngukurr region, south-east Arnhem Land.

John graduated from Edith Cowan University with a Bachelor of Social Science in Human Service. He is also a graduate and Fellow of the Australian Rural Leadership Foundation. John is a member of the CEOs Group of Aboriginal Peak Organisations NT (APO NT) and chairs the NACCHO eHealth Expert Group. He is also a former Top End Hospital Network Council member.

His interest includes mentoring Indigenous youth, strengthening Indigenous governance structures and gardening. John is also President of the Darwin Buffaloes Football Club.

Bronwyn Pike



The Hon Bronwyn Pike is a former Victorian Minister for Housing, Aged Care, Community Services, Health, Education, Skills and Workforce Participation. Her 13 year parliamentary career included 11 as a Minister, making her the longest

serving female minister in Victoria's history.

Prior to entering parliament in 1999, Bronwyn headed up the Uniting Church welfare program in Victoria, now known as UnitingCare, which provided children, youth, family and aged care services. She trained as a secondary school teacher and taught in Adelaide and Darwin and at RMIT.

Having left Parliament in 2012, Bronwyn is working with Telstra Health, Renewal SA, and a range of NGOs. She commenced in the role as Board Chair of Western Health on 1 July 2014.

Carole Reeve



Carole Reeve currently lectures at the Centre for Remote Health in Alice Springs and has a long background in remote primary health care services as a practitioner, manager, researcher and advocate for rural and remote health issues. She has specific academic interests in improving remote health services and public health strategies for reducing health inequities.

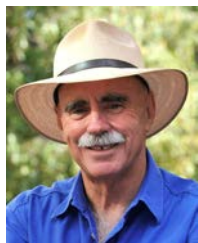
It was during her time working in a government district hospital in Tanzania that she developed an interest in public health and tropical medicine and moved with her family to Townsville to do the masters in public health and tropical medicine. She has spent the last 10 years working across northern Australia providing health services and evaluating primary care and public health programs.

Jacki Schirmer



Jacki Schirmer is a Senior Research Fellow appointed jointly between the Faculty of Health and Institute for Applied Ecology at The University of Canberra. Her research explores the relationship between the wellbeing of people and the wellbeing of the places they live and work in, and she works in a team focused on understanding how changes in rural and regional Australia affect the wellbeing of the people who live there. Her work focuses in particular on understanding the social and health impacts of changes in primary industries (agriculture, fishing and forestry), and the nexus between engaging in action to improve environmental health and human wellbeing.

Warren Snowdon



Warren Snowdon represents the people of Lingiari, the most interesting and diverse electorate in Australia, covering all of the NT outside of metropolitan Darwin and Palmerstone, an area one-sixth of Australia's land mass.

He has won the seat of Lingiari in every election except one since 1987, having previously worked as a school teacher in the NT and for Nganampa Health Council in the Pitjantjatjara country of SA. He held a research position with ANU in the early eighties leading to publication of *A Certain Heritage* (with Dr HC Coombs and Dr Brandl), Canberra: Centre for Research and Environmental Studies, ANU, 1983.

Warren was appointed to the new position of Minister for Indigenous Health following the success of Labor in the national election of 2007, the first and still the only Minister to have held that portfolio.

Warren is currently the Shadow Parliamentary Secretary for Indigenous Affairs, the Shadow Parliamentary Secretary for Northern Australia and the Shadow Parliamentary Secretary for External Affairs,

Stephanie Trust



Dr Stephanie Trust is a Kidja Woman, Ngowadjadi skin whose Aboriginal name is Ugalji. Dr Trust was born and raised in the East Kimberley, went to school in Wyndham and Halls Creek before heading to Perth for Years 11 and 12.

Dr Trust initially trained as an Enrolled Nurse before converting this to Aboriginal Health Worker (AHW) training and worked as an AHW in the Kimberley and Pilbara region of Western Australia for approximately 12 years. In 2000 Dr Trust travelled to Perth to undertake a life-long dream to become a doctor.

Dr Trust is a Fellow of the Royal Australian College of General Practitioners and is a general practitioner based in Kununurra and, until recently, was the Medical Director at the Kimberley Aboriginal Medical Services Council Inc in Broome. Dr Trust is a Board member of the Australian Indigenous Doctors' Association, the Kimberly-Pilbara Medicare Local, the Kimberly Stolen Generation Aboriginal Corporation and is a Cultural Mentor and Advisor for WAGPET.

Amanda Vanstone



The Hon Amanda Vanstone hosts Counterpoint, a weekly program on Radio National and is a regular contributor to *The Age* newspaper.

The former Federal politician and Ambassador to Italy, she is currently Chair of the Royal Flying Doctor Australia, Chair of Vision 2020 Australia, and a member of the board of the Port Adelaide Football Club. She is also on the Board of Governors of the Institute for International Trade based at Adelaide University. She served on the National Commission of Audit from November 2013 to March 2014.

Amanda entered Federal Parliament in 1984, as a Senator for South Australia. At that time she was the youngest member of the Senate. She was re-elected in 1987, 1993, 1998 and 2004.

She served as a Minister in the Australian Government from the 1996 election until January 2007. Except for a period of just over three years as Minister for Justice and Customs all her Ministerial positions were in Cabinet. She is the longest serving female Cabinet Minister since Federation.

In 2007 she was appointed as Australian Ambassador to Italy and to San Marino and Australia's Representative to the UN Food and Agriculture Organisation and the UN World Food Program for three years.

John Wakerman



Professor John Wakerman is the Associate Dean, Flinders Northern Territory. He is a Public Health Medicine specialist and general practitioner, with a long background in remote primary health care services as a medical practitioner, senior manager and researcher. He has specific academic interests in remote health services research and remote health workforce education and training. He also has a strong interest in utilising evidence for advocacy related to rural and remote health issues. He has held previous positions as the Inaugural Director of the Centre for Remote Health, a Joint Centre of Flinders University and Charles Darwin University, in Alice Springs, and is a past Chair of the National Rural Health Alliance. He is currently Deputy Chair of the Central Australian Health Service Board, a member of the NHMRC Health Care Committee and of the Australian Therapeutic Goods Advisory Council.

Mark Wenitong



Dr Mark Wenitong (Adjunct Associate Professor, James Cook University, School of Tropical Public Health) is from Kabi Kabi tribal group of South Queensland. He is a Aboriginal Public Health Medical Officer at NACCHO, and the Senior Medical Advisor at Apunipima Cape York Health Council. His work entails clinics, clinical governance and strategic primary health care planning. He was the Senior Medical Officer at Wuchopperen Health Services in Cairns for the previous nine years. He has also worked as

the medical advisor for OATSIH in Canberra. He was the acting CEO of NACCHO for a period in 2012. He has worked in PHC in East Timor, and has worked in community development with World Vision in Papunya NT.

He is a past President and founding member of the Australian Indigenous Doctors Association and is a member of the National Health and Medical Research Committee - National Preventative Health Committee, the National Lead Clinicians Group, a ministerial appointee to the National Aboriginal and Torres Strait Islander Health Equity Council, the National Independent e-Health Advisory Committee, and chairs the Andrology Australia - Aboriginal and Torres Strait Islander Male Reference group, sits on several other committees. He is a Council Member of the Australian Institute of Aboriginal and Torres Strait Islander Studies and a Board member of the Central Australian Aboriginal Congress health service. He sits on the National Health Performance Authority PHC committee.

Dr Wenitong has been heavily involved in Aboriginal and Torres Strait Islander health workforce. He has received the 2011 AMA Presidents Award for Excellence in Healthcare, and inducted into the Queensland Aboriginal and Torres Strait Islander Health Council Hall of Fame, and more recently, was one of the chief investigators awarded the MJA best research journal article for 2012.

Ian Wronski



Professor Ian Wronski is Deputy Vice Chancellor of the Division of Tropical Health and Medicine at James Cook University. Ian's professional background is in Medicine, with postgraduate qualifications in Policy and Management from Harvard University, Public Health and

Epidemiology from Harvard University, Tropical Medicine from Liverpool.

Ian was the first Director of Health Services of the Kimberley Aboriginal Medical Services Council and a practicing procedural clinician in the Kimberley region until 1992. Over the two decades he has worked at JCU, Ian has led the development of programs in medicine, veterinary science, dentistry, pharmacy, public health and tropical medicine, the rehabilitation sciences and the research institute, the Australian Institute of Tropical Health and Medicine. Ian was recently appointed to the Order of Australia 'for distinguished service to tertiary education, particularly through leadership and research roles in Indigenous, rural and remote health, and to medicine in the field of tropical health.'

Throughout his career, Ian has had leadership roles at national and state level in several sectors relating to key aspects of policy. These include health workforce development in public and Indigenous health, rural and regional development, and education. Ian currently chairs the Australian Council of Pro Vice Chancellors and Deans of Health Sciences, and the Queensland Clinical Education and Training Council; and is a board member of the Independent Hospital Pricing Authority—Teaching, Training and Research Committee, the Townsville Health and Hospital Board and Executive Subcommittee and the Health Professions Education Standing Group of Universities Australia. Ian is also a board member of the APEC-Life Sciences Innovation Forum (LSIF).

Concurrent and poster presenters

Tammy Abbott

Tammy Abbott is from the Western Arrernte and Luritja/Pintipi tribes of Central Australia. She grew up in Alice Springs surrounded by family from remote communities such as Papunya and Ntaria (Hermannsburg). Tammy is a Senior Research Officer with Ninti One and works on projects across remote Australia including local community action planning, wellbeing, income management and rough sleeping. She specialises in community engagement and enjoys working with Aboriginal community researchers as part of her projects. In her experience employing community researchers who have expert knowledge of language, culture and community, helps to ensure the best possible outcomes for communities from research.

Robyn Aitken

Robyn Aitken is a PhD prepared nurse with 30 years of experience, including clinical patient care, clinical management, education and research, policy and professional leadership. For the past nine years Robyn has been living and working in the Northern Territory, immersed in the challenges of remote and Indigenous Aboriginal health. She has held leadership roles at Charles Darwin University, Flinders University and the Centre for Remote Health and now holds professorial fellowships at these institutions. Her work in the Territory is informed by her scholarly achievements and knowledge and experienced gained interstate and overseas. Robyn joined the NT Department of Health in 2013 and has been acting Chief Nursing and Midwifery Officer since March 2014. In this role she has instituted an oral history project in collaboration with the NT Archives Centre: 'Nurses and midwives caring for our community—stories across time'. The paper Robyn will present at the NRHA conferences arises from the first work within this project, which has focused on the experiences of nurses and midwives during and after Cyclone Tracy.

Julaine Allan

Dr Julaine Allan is a rural research practitioner working in the non-government drug and alcohol field. Julaine's research aims to improve services for people who need them, particularly those experiencing poverty and disadvantage.

Owen Allen

Owen Allen is a physiotherapist of 34 years, practising mostly in rural Queensland in both private and public sectors. Between 1994 and 2009 Owen was involved with the rural health movement through Queensland and National committees and organisations. In 2008, Owen began looking at introducing creativity into his practice with older people, and facilitating local arts-in-community events. Through the work, Owen has found himself in a growing network of North Queensland regional dancers; and significant dance leaders as Liz Lea of Canberra Dance Theatre and DANscienCE Festival, Glen Murray of

MADE (Tasmania), David McMicken, Tracks NT, Erica Rose Jeffrey (Dance for PD, Brisbane). Owen has begun an association with Art as Action, Boulder Colorado and as a creative consultant with Future Flash (Climate Change Education Program, Gainesville, Florida). Through these projects, Owen has developed an inclusive facilitatory approach to contemporary theatre dance as a practice. By 2016, he will be ready to take the program, The Art of Movement, to any rural community in Australia.

Sophie Alpen

Sophie is an arts/medicine student at the University of New South Wales. She has completed an Indigenous studies major through Nura Gili at UNSW and hopes to integrate critical race theory to the health environment. She grew up in Griffith, NSW, and is now happily completing the final phase of her degree at the UNSW rural clinical school in Albury. Sophie has been involved in writing policy and promoting Indigenous and rural health through her roles at the National Rural Health Students' Network and Australian Medical Students' Association over the years. Sophie hopes to continue with research opportunities along side clinical practise. If she were not doing medicine she would be a beekeeper with a cactus farm.

Janelle Amos

Janelle is an occupational therapist, with a Masters in Remote Health Practice, who has worked in a number of rural and remote communities across Queensland and north-west New South Wales. She has always had a love for rural and remote health with a particular interest in innovative service delivery models within the not-for-profit and private sector. In more recent years Janelle has been a busy stay at home mother to four young children. Through this experience she has developed a passion to support health professionals located in rural and remote environments through the competing demands of maintaining registration, while choosing to stay at home with their young children.

Judith Anderson

Dr Judith Anderson has been a registered nurse in rural Australia for more than 20 years, working in a variety of settings. Her background has been strongly focused on improving health outcomes for people living in rural and remote areas and the provision of nursing education. In 2010, she completed her PhD on change management in small rural health services. Judith has also had a history of working in mental health services, aged care, management and in community engagement in rural health services. Currently Judith works for Charles Sturt University, as the courses director for the School of Nursing, Midwifery and Indigenous Health, where she coordinates undergraduate and postgraduate nursing courses. She is currently supervising several PhD students, including one studying the development of caring behaviours in recently graduated nurses. At

Charles Sturt University, Judith has been involved in teaching nursing and paramedic students for several years and has undertaken research about student experiences in learning and how this can be improved. This overall history has led to a further interest in researching the impact of teaching methods, particularly the engagement of carers and consumers to present the lived experience of mental health issues on students.

Mitchell Anjou

Mitchell Anjou is a Senior Research Fellow, Academic Specialist in Indigenous Eye Health at the University of Melbourne. After completing his optometry and research masters degrees, he worked for the Australian College of Optometry for over twenty years as Clinic Director and Senior Fellow in the Optometry Department of the University of Melbourne. Mitchell is an appointed member of the Registration and Notifications Committee of the Optometry Board of Australia, Fellow of the Australian College of Optometry, founding member of the Public Health Optometry Group, Director of the Optometry Council of Australia and New Zealand and was honoured in 2013 as a Member in the Order of Australia award for significant service to optometry and public health. Mitchell's research interests include eye care and health systems and policy and his current work particularly focuses on Aboriginal eye health.

Luke Arkapaw

Luke Arkapaw graduated from the Queensland University of Technology in 1999 with a Bachelor of Applied Science (Optometry). He worked in private practice for two years in Dunedin (New Zealand) before becoming employed as the optometrist in the ophthalmology department of the Dunedin Public Hospital (2001-2009). In this role he was responsible for low vision and speciality contact lens clinics, primary and secondary screening of diabetic fundus photographs, and teaching ophthalmology registrars how to perform refractions. During these years Luke was also involved in an undergraduate medical student training program as a Clinical Lecturer with the Otago School of Medicine. Luke has made several trips to Tonga as a member of an eye-based medical mission team, and spent most of 2009 travelling through the Middle East, Central America and the Caribbean engaging in short term volunteering opportunities with his optometry skills. Returning to Australia at the end of that year, he set up a locum business to service rurally located practices, before joining the Aboriginal Vision Program of the Brien Holden Vision Institute, Public Health Division (formerly ICEE) as a Project Development Officer in the Northern Territory where he continues to work as a practitioner, researcher and educator. Luke holds a second Bachelor degree in Applied Theology, and a Master of Public Health.

Mark Ashcroft

Mark Ashcroft is a Senior Manager at Alpine Health, a multi-purpose service located in North East Victoria. Mark has over 25 years' experience in the health care industry, including in Victoria, interstate and in the NHS (Scotland). Mark is a registered nurse and registered midwife and has

completed Masters Degrees in Management (coursework) and Commerce (coursework and minor thesis) and is currently undertaking a PhD. His topic is 'Innovation implementation in healthcare: a resource based view'.

Stuart Auckland

Stuart Auckland is the Program Coordinator for the Community Health Development Program Area at the Centre for Rural Health at the University of Tasmania. Stuart holds a Bachelor of Agribusiness Degree and a Master of Applied Science in Rural Community Development. Prior to working in Rural Health Stuart was employed in the agricultural and natural resource management sector. Stuart has extensive experience in rural community development and is involved in a number of food security action research and evaluation initiatives. The scope of his food security research work ranges from small scale community projects to larger scale multi sectoral initiatives. Stuart also has a strong interest in rural health partnership models and community based governance structures.

Jannine Bailey

Jannine Bailey is a research officer in Rural Health at the Bathurst Rural Clinical School, University of Western Sydney. She graduated with a BSc. (Hons) in Biomedical Science from the University of Western Sydney followed by a PhD in Biomedical Science (Microbiology) from the University of Sydney in 2006. Since that time she has worked as a research associate on various projects concerned with gastrointestinal health, the impact of the microbial flora on host health and the incidence of antibiotic resistance within the community. While still maintaining an interest in these areas, as a research officer in rural health her primary focus is on the broader health issue of obesity, particularly in rural young adult males. Other areas of particular interest are patient experiences with managing diabetes care and bibliometric research.

Gail Baker

Gail is the Clinical Coordinator at the Australian Catholic University's Brisbane campus and is an experienced educator in midwifery and nursing within the tertiary setting. Gail is experienced in course development and curriculum writing and was instrumental in the implementation of the Bachelor of Midwifery program at ACU overseeing the first intake in 2008. Gail has coordinated the Bachelor of Midwifery, the Graduate Diploma of Midwifery and this year the introduction of the Bachelor of Midwifery Graduate Entry programs. Gail was pivotal to the introduction in 2009 of the Bachelor of Midwifery Away from Base program designed to support the education of Indigenous students from rural and remote areas of Australia and is proud to see the success and growth of this innovative program. Gail is committed to ensuring that students are exposed to quality clinical experiences and to this end has developed strong collegial relationships with industry partners. Gail is a passionate midwife dedicated to the education of the future generation of midwives through quality teaching, respect, and leadership.

Frances Barraclough

Frances is a registered nurse with a distinctive and diverse background in nursing, education and management across rural areas. She is particularly interested in innovative health care models to meet the needs of rural communities. She has recently completed her Master of Philosophy, which examined the role of nurse practitioners in primary health care settings. Frances is currently employed by University of Sydney and works at the University Centre for Rural Health, North Coast.

Elizabeth Barrett

Dr Elizabeth Barrett is currently a medical adviser with the NSW Rural Doctors Network (RDN). She has a medical degree from the University of NSW and further qualifications in family planning and health management and a Masters Degree in Public Health. She is a Fellow of the Faculty of Public Health Medicine, RACP. After clinical practice, Dr Barrett worked in public health and senior health management positions in rural and metropolitan NSW. In addition to her current role at RDN, she is a surveyor for the Australian Council on Healthcare Standards. Dr Barrett's previous commitments include President of Quality Management Services, membership of the Optometrical Board of NSW, membership of the Charles Sturt University (CSU) and University of Western Sydney Advisory Councils and the CSU Ethics Committee. She has been engaged in research for the Australian Medical Workforce Advisory Committee, The National Health Strategy and Hepatitis B prevalence and management in Western NSW. Dr Barrett has undertaken rural health consultancies in China and Queensland and occasionally works as a relief hospital Director of Clinical Services.

Terry Battalis

Terry Battalis is the President of the Pharmacy Guild of Australia, Northern Territory Branch, a National Councillor and the current Chair of the CPRIA Advisory Group (Community Pharmacy for Rural and Indigenous Australia) and the Chair of the Guild's Engagement and Advocacy Committee. He is a pharmacy owner in the Northern Territory and remote Western Australia, heavily involved in Aboriginal health with experience in the Section 100 Remote Area Aboriginal Health Service program. Terry is past Chair of the Rural Pharmacists Australia (RPA) and was also the RPA representative on the National Rural Health Alliance. Terry is also the current Chair of the Pharmacy Premises Committee in the Northern Territory.

Kristine Battye

Kristine Battye is the managing director of KBC Australia, a public policy consulting company she established in 2001 specialising in policy analysis, program evaluation and strategic advice to governments and non-government organisations. The focus of much of Kristine's work is in health service planning, service modelling, workforce planning and policy development, and program evaluations and reviews. Kristine has predominantly

worked in the rural, remote and regional health and community services sectors, and has undertaken a number of state and national projects to review the delivery of health services and programs to rural and remote Indigenous communities. Kristine has a particular interest in education, training and development to prepare a health workforce for rural and remote practice.

Nelson Berko

Nelson Berko graduated from the University of Newcastle with a Bachelor of Nutrition and Dietetics in 2014. Nelson is passionate about working in strength based and culturally appropriate ways with Australia's most disadvantaged populations, to improve health inequities within Australian society. As part of his Nutrition and Dietetics degree, Nelson moved to rural NSW to take part in a year-long professional placement with the University of Newcastle Department of Rural Health (UoNDRH) in Tamworth, NSW. Here he gained professional practice experience in rural health settings, while participating in community engagement programs throughout the year with the UoNDRH community engagement team. Nelson's undergraduate rural health experience, particularly within community controlled health services and programs, has inspired him toward a career working with and learning from Indigenous Australian communities. He believes the adoption of a health care model that reflects the holistic, health concepts of Indigenous Australian culture will not only improve the health of Indigenous Australians, but also greatly improve the health of the wider Australian community.

Graham Bidstrup

Graham 'Buzz' Bidstrup has enjoyed a 40-year career in the Australian music industry. After completing tertiary studies in engineering he joined The Angels, playing drums and touring Australia, Europe and the USA many times. Buzz co wrote and co produced The Angels' most successful song, the chart topping hit 'No Secrets'. He left in 1981 and was in demand as a record producer, session player and film music composer and producer. Buzz was also a founding member, co-producer and co-manager of successful Australian bands The Party Boys and GANGgajang in 1984. In 1999 he began a new chapter in his career as manager and music director for iconic Australian Indigenous entertainer Dr Jimmy Little AO. Buzz guided Jimmy's career until Jimmy's passing in April 2012 and helped Jimmy establish The Jimmy Little Foundation (www.jlf.org.au) in 2006 and Uncle Jimmy Thumbs up Ltd (www.thumbsup.org.au) in 2008. Both are not-for-profit organisations working to bring better preventative health initiatives to Indigenous Australians. The Thumbs up! program has been delivering music, health and community education programs into many communities throughout Qld, NT, WA, SA and NSW since 2009 working in partnership with Federal, State and Territory Governments and other NGOs.

Claire Boardman

Claire Boardman is Deputy Director of RHDAustralia, based at Menzies School of Health in Darwin where she works with jurisdictions and Indigenous communities to

improve health care outcomes for those affected by acute rheumatic fever (ARF) and rheumatic heart disease (RHD). Prior to this appointment Claire was privileged to be working with Aboriginal and Torres Strait island communities in public health and infection prevention and control in the Torres Strait, Far North Queensland. In her public health capacity Claire has worked in complex disaster and developing nation settings and has a strong ongoing interest in health care economics, developing nation and Indigenous health issues. Claire has held a number of State and National appointments and is the immediate past President of the Australasian College for Infection Prevention and Control (ACIPC) and is a senior lecturer at Griffith University. In 2013 she won one of four prestigious Council of Executive Women scholarships to attend the Australian Graduate School of Management Women in Leadership course at UNSW which has assisted her in developing her leadership skills and executive presence and, in 2014 Claire was a NT finalist for the Australian of the Year Awards.

Carolyn Bourke

Carolyn Burke has a clinical background spanning 34 years and a strong commitment and love of rural nursing and midwifery, with experience at the heart of patient-centred care. She believes in a collaborative practice model, continuous quality improvement and supports innovation in health care for rural communities to obtain more care locally. Following 12 years in management as a Nurse Unit Manager, Nursing Director and Director of Nursing, Carolyn currently holds the position of Clinical Nurse Consultant – Telehealth Coordinator for the Darling Downs Hospital and Health Service. Her keen interest in service improvement together with the ability to engage and educate clinicians in Telehealth processes has seen an increase in the uptake of services across all specialities with the Darling Downs leading Queensland in service events and models of care. Carolyn is driven to achieve results by challenging the norm to enhance the patient's experience throughout the health care journey. TeleDentistry is just one new and exciting concept for residents in Aged Care Facilities within the Darling Downs Hospital and Health Service to receive oral health care without the need to leave their homes maintaining comfort and continuity of care.

Lisa Bourke

Lisa Bourke is Director of the University Department of Rural Health at The University of Melbourne in Shepparton, Victoria. Lisa is a rural sociologist with twenty-five years experience as a social researcher in rural communities. Her key research interests include rural health as a discipline, the wellbeing of rural young people, the inclusion of rural health consumers and the suitability of rural health services. Lisa is passionate about improving the quality of life of Aboriginal, Torres Strait Islander, rural and remote Australians.

Dianne Boxall

Dr Dianne Boxall is a lecturer in psychology from the Albury Campus of Charles Sturt University. She teaches industrial/organisational psychology, coordinates the

fourth-year research project subject, and supervises the research of postgraduate students. At the time of the Aboriginal Wellness Project Dianne was a Research Fellow in the Centre for Inland Health, working under the Memorandum of Understanding between the Wiradjuri Condobolin Corporation and Charles Sturt University. Her broad research areas focus on wellbeing, meaning, and self-identity; particularly for people and communities in inland Australia. Dianne's expertise in research design and wellbeing research has been recognised in collaborations on a wide variety of projects and funding applications, the research outcomes of which have been published and presented at national and international conferences.

Kim Boyer

Kim Boyer is a part-time Senior Research Fellow in Rural Health Policy and Service Planning at the University of Tasmania. She came late to academia from senior management positions in the Tasmanian Health Department, and as CEO of the Tasmanian General Practice Divisions. She has held a number of other key appointments, including Deputy Chancellor of the University of Tasmania, chair of the NHMRC Research Committee's Strategic Policy and Health Services Research Committees, and Chair of the Tasmanian Academy Board. She has a long commitment to rural health, and to a range of social justice issues. She currently volunteers as a Board member of the Link Youth Health Service, and as education and training coordinator for the non-government organisation Colony 47. She is also a keen racehorse owner and breeder, surfs (badly), and enjoys travelling, walking and wine and food.

Rachel Brindal

Rachel Brindal, BEd (Special Education—Hearing), MICD, is a senior consultant with the Royal Institute for Deaf and Blind Children (RIDBC) Teleschool. Rachel began her career as a teacher of the deaf in regional Queensland before working in the Pacific Islands developing deaf education practices in Tonga and Samoa. In 2009, Rachel joined the RIDBC Teleschool team based in Sydney, where she began supporting children with hearing loss and their families in regional and remote parts of Australia via telepractice. In 2012, she relocated to Darwin to establish RIDBC's first permanent site outside of NSW. Rachel and her colleagues at RIDBC Darwin are now providing services to families in the Top End through a blended service model; a combination of telepractice and in person sessions. These services include therapy, habilitation and a cochlear implantation program. Rachel is passionate about breaking down the geographical barriers by using technology to provide a client-centred high quality service model.

Joshua Broderick

Dr Joshua Broderick is a researcher and clinical psychologist. He presently works at the Child Behaviour Research Clinic at the School of Psychology, University of New South Wales Australia. He is project coordinator of the NHMRC Partnership Project *Access Early Intervention*, an innovative research program aimed at

developing and evaluating an e-health model of treatment for children with conduct problem in regional and rural areas of Australia. The project is a collaboration between The University of New South Wales Australia and Royal Far West, Manly.

Rodger Brough

Dr Rodger Brough is an addiction medicine physician who has worked as the alcohol and drug physician at South West Healthcare (formerly Warrnambool & District Base Hospital) since 1987. He is also a consultant with Turning Point's Drug and Alcohol Clinical Advisory Service. He is a fellow of the Australian College of Rural and Remote Medicine and the Australasian Chapter of Addiction Medicine and the Royal Australian College of Physicians. Over the past 30 years, following his term as an HMO at Warrnambool and District Base Hospital and 11 years in general practice (Cambourne Clinic) he has worked in a number of specialist alcohol and drug treatment services including Pleasant View Centre (Melb 1984), St Vincent's Hospital Department of Drug and Alcohol Studies (Melb), Warinilla Clinic (Adelaide), and the WRAD Centre, Warrnambool (1988–2007). Since 2007, he has been involved in the Mental Health Curriculum Working Party and since the School of Medicine opened in 2008 has played a role as Senior Clinical Lecturer (conjoint appointment) in AOD across the medical school curriculum. His principal interests are in the management of drug withdrawal, medical alcohol and other drugs education and rural AOD issues.

Judith Brown

Judith Brown is a Rural and Isolated Practise Endorsed Registered Nurse and Child Health Nurse with over 20 years of experience working in Rural Queensland. She is currently working as a Clinical Nurse in the acute area 0.8FTE and 0.2FTE as a Child Health Nurse at the Richmond Health Centre in North West Queensland. She enjoys working in rural environments as she feels part of the community and is able to establish rewarding relationships with her clients. When not working, Judith resides on a cattle station 100km from Richmond. On the station Judith enjoys helping her husband and working in her large vegetable patch. She was also heavily involved and passionate about educating her two children through Mt Isa School of the Air.

Leanne Brown

Dr Leanne Brown is a Senior Lecturer and Academic Team Leader at the University of Newcastle, Department of Rural Health where she has been based since 2003. She is an Advanced Accredited Practising Dietitian with 20 years' experience in the dietetics profession. Dr Brown graduated from the University of Newcastle in 1994 with an undergraduate degree in Nutrition and Dietetics and worked as a clinical dietitian for 8 years in a number of metropolitan hospitals gaining a broad range of dietetic and management experience. Dr Brown completed her PhD (Nutrition and Dietetics) at The University of Newcastle 2009. Her doctoral research investigated the barriers to the provision of a best practice dietetics service in rural areas. Ongoing research interests include dietetic

workforce, rural dietetic services, sports nutrition, body composition and best practice dietetic services for rural areas.

Susan Brumby

Susan Brumby is a registered nurse and midwife and has held executive positions in rural services. She has been actively involved in agriculture, running the family beef and wool property for twelve years. Combining these two passions, (health and agriculture) Sue led an innovative and award-winning program called Sustainable Farm Families (SFF), which has been taken across Australia and more recently Alberta, Canada. In 2008 Sue commenced as founding Director of the National Centre for Farmer Health—a partnership between Western District Health Service and Deakin University. She is the course leader for the Graduate Certificate in Agricultural Health and Medicine, PI of the award winning SFF™ project, CI on a NHMRC grant and previously CI on ARC, Rural Industries Research Development Corporation and beyondblue grants. She has been recognised for her contribution to rural health, awarded a Victorian travelling fellowship in 2006 and an overseas study program in 2013 to examine farmer health. In 2014 her team was awarded the Vice-Chancellors award for Excellence in Teaching. Sue has presented and published nationally and internationally.

Lesley Brydon

Lesley Brydon is a pharmacist and has an extensive background in health care communications and advocacy. She was Executive Director of the National Pain Summit in 2010 and coordinated the development of the National Pain Strategy, working closely with the Chair, Professor Michael Cousins and members of the working groups. She was responsible for setting up Painaustralia in 2011 as a not for profit body, to facilitate the implementation of the National Pain Strategy. This work is well underway with all state governments and ACT Health adopting recommendations of the strategy and working with health care professionals and consumers to implement recommendations. Painaustralia's priority now is to achieve a strategic national approach to ensure access to evidence-based, multidisciplinary pain management and treatment for all Australians, irrespective of where they live. Lesley's previous roles include: Executive Director of the Advertising Federation of Australia, General Manager, Corporate Communications for Austrade and CEO of communications consultancy Turnbull Fox Phillips, now part of an international communications network. She is an experienced consumer advocate and lives with chronic pain.

Jane Burford

Jane Burford worked as a clinical nurse specialist in the department of neurophysiology RPAH for 10 years, performing, analysing and reporting on diagnostic tests on the brain and nervous system. Jane played a large role in the epilepsy program for the surgical treatment of epilepsy and frequently worked on the neurology ward with these patients. Jane then took on the role as epilepsy educator for Epilepsy Action Australia (EAA) in the Northern

Territory, established and opened an office for Epilepsy Action NT. Jane worked in the community, including rural and remote regions in NT and top end of WA, to provide training, education, information and counselling to people about epilepsy and seizures. After moving to South Australia, Jane then took on a role as a research and development specialist for EAA in 2009. Jane plays a key role in the development and monitoring of services, resources and products including several eLearning courses.

Sally Butler

Sally Butler works as a radiation nurse at Central West Cancer Service in Orange, NSW. The idea for the project was formed after a number of patients told her they would not have had radiotherapy if the new service at Orange did not exist. Sally is currently completing a Master of Biostatistics and plans to continue her research in rural oncology services.

David Butt

David Butt was appointed CEO of the National Mental Health Commission in January 2014. David has 30 years of experience in the health system, much of it at CEO and Executive level. Prior to his appointment to the Commission, David was Deputy Secretary of the Australian Department of Health from August 2011, head of Rural and Regional Health Australia, and the Commonwealth's first Chief Allied Health Officer. This followed 15 years as CEO of three major health system organisations: Chief Executive of Australian Capital Territory (ACT) Health and Community Care, National CEO of Little Company of Mary Health Care (the Calvary group—one of Australia's largest not for profit hospitals and health services providers) and CEO of the Australian General Practice Network. Prior to this David worked as an executive in a number of positions in Queensland Health, including as Executive Director of Policy and Planning and for a brief time as Regional Director of Peninsula and Torres Strait health region.

Tom Calma

Dr Tom Calma AO is an Aboriginal elder from the Kungarakana tribal group and a member of the Iwaidja tribal group whose traditional lands are south west of Darwin and on the Coburg Peninsula in the Northern Territory. He has been involved in Indigenous affairs at a local, community, state, national and international level and worked in the public sector for 40 years and is currently on a number of boards and committees focusing on rural and remote Australia, health, education, justice reinvestment, reconciliation and economic development. Dr Calma was Aboriginal and Torres Strait Islander Social Justice Commissioner at the Australian Human Rights Commission 2004-2010 and Race Discrimination Commissioner 2004-2009. He was the inaugural Chair of the Close the Gap Steering Committee for Indigenous Health Equality, helped establish the National Congress of Australia's First Peoples, developed the inaugural National Aboriginal and Torres Strait Islander Suicide Prevention Strategy, and lead the way in promotion of Justice Reinvestment. Dr Calma is currently National

Coordinator, Tackling Indigenous Smoking, and Chancellor of the University of Canberra (the first Indigenous male Chancellor of an Australian university). In 2012 Dr Calma was awarded an Order of Australia; Officer of the General Division (AO), and in 2013 was ACT Senior Australian of the Year; both awarded for service to the Indigenous community and as an advocate for human rights and social justice. In November 2014 Dr Calma was awarded the Indigenous Allied Health Australia Lifetime Achievement Award in recognition of his lifelong dedication to improving the lives of Indigenous Australians.

Narelle Campbell

Narelle Campbell holds a Masters in Education and is a PhD candidate with University of Queensland undertaking research investigating personality and motivation in the rural and remote allied health workforce. She has previously published research investigating the rural and remote allied health workforce particularly in regard to capacity and motivation for student supervision. Other research interests are in longitudinal student placements, quality teaching and supervision, and peer review as a quality mechanism for the clinical workforce. She holds an academic role with Flinders University Northern Territory Medical Program with responsibility for the two final years of the MD. The MD program is delivered at multiple sites across the Northern Territory so Narelle has developed keen insight into the nature of the health workforce and supervision issues in rural and remote areas. Her professional background is speech pathology.

Karen Carlisle

Dr Karen Carlisle holds an adjunct senior research fellow position at the College of Medicine and Dentistry at James Cook University and is a research coordinator at Townsville Mackay Medicare Local. She has research experience within health, education and psychology settings with particular skills and experience in collaboration to improve health access and outcomes for the underserved and at risk. Karen is currently working on an NHMRC partnership grant on community engagement in oral health within rural communities.

Melanie Carter

Melanie Carter is currently the Senior Manager Training and Education of the Australian Breastfeeding Association. Melanie qualified and worked as a high school teacher before moving to adult education in the VET sector. Melanie was originally involved with ABA as a trained volunteer breastfeeding counsellor. Since 2005 she has been responsible for the management of ABA as a Registered Training Organisation and for the development of accredited courses in breastfeeding education, community mentoring, counselling and management offered by ABA.

Colleen Cartwright

Professor Colleen Cartwright was Foundation Professor of Aged Services and Director of the ASLaRC Aged Services Unit at Southern Cross University from 2005 until April

2014. She now is Principal Director of Cartwright Consulting Aust Pty Ltd. Professor Cartwright has extensive teaching and research experience in ageing, ethics and medical decisions at the end of life, at national and international levels, with publications in major journals and a number of book chapters. Much of her research and teaching over 22 years has been aimed at improving end of life care, including adequate pain relief, and ensuring that patients' wishes are respected. She has conducted a number of studies on improving the health and wellbeing of older Aboriginal people. Professor Cartwright regularly runs information and training sessions for community and health professional groups on ethical and legal issues relating to care at the end of life, including advance care planning, informed consent and capacity, issues for carers and the special challenges of caring for people with dementia.

Sarah Chalmers

Sarah Chalmers grew up in the Territory, and has practised in the NT since 2003. She is a GP at Endeavour Health Service and Senior Lecturer in Remote Medicine with the Flinders NT Medical Program. She supervises registrars and medical students in the practice, is the academic coordinator for final-year students in the NTMP and manages the long-term remote medical students based in Nhulunbuy. Combined, Sarah and Colin Smith have over 20 years' experience in East Arnhem. They have both worked at the district hospital, for local community controlled health services in remote communities and homelands, and in the general practice.

Theodore Chamberlain

Dr Theodore Chamberlain is an overseas born Australian trained rural practitioner of over thirty years standing. Dr Chamberlain currently works as a senior medical superintendent at the Maleny Soldiers Memorial Hospital which is a rural hospital servicing the township of Maleny in the hinterlands of the sunshine coast north of Brisbane in Queensland. Dr Chamberlain completed his medical education at the University of Queensland and has practice continually in rural medicine since then including over thirteen years with Dr Col Owen in Inglewood. He is a fellow of ACCRM and has contributed to the rural health movement through involvement with ACCRM and RDAQ. He has a long interest in telehealth having presented at the first National rural health conference at Toowoomba on this subject in the late eighties. Currently he is interested in expanding the role of rural hospitals to fill the needs of their communities and to this end has integrated a rehabilitation unit, palliative care unit and a movement disorders clinic specialising in end stage parkinsonism into a rural hospital to reverse the flow from tertiary centres and to provide a service the community.

Dashlyn Chee

Dashlyn Chee decided to become a health worker when she was just 15 years old because she wanted to help her people. Born in Papua New Guinea's Morobe Province, Dash obtained her Diploma of Health Extension Training in Madang and has since worked with hospitals and remote health centres across East New Britain and New

Ireland. In her current role as Clinical HEO at Namatanai Rural Hospital, she oversees the operating theatre, conducts tubal ligation operations and supports clinical staff in everything from patient diagnoses, to emergency treatment and reporting. She is a tireless advocate for hospital infrastructure and much-needed medical supplies. Prior to this, Dash was employed as Health Project Officer at Namatanai Hospital with non-profit organisation Australian Doctors International. Described as 'a powerhouse of energy and enthusiasm' by her colleagues, Dash set up the hospital's operating theatre, provided clinical training, emergency assistance, advocacy and support for volunteer doctors visiting from Australia. Dash has also held positions as Clinical HEO at the Lihir mining Medical Centre, Nonga Base Hospital and Kavieng General Hospital. She says the challenges of working in a rural setting in PNG are many: At Namatanai there's often no power or water supply; medical supplies, hospital equipment and services are limited, and there hasn't been a permanent Medical Officer onsite for six years. It's those same challenges which Dash says motivates her to continue her work advocating for, in her words, 'the desperately needed, quality care and services my people deserve.'

Antony Chenhall

Dr Antony Chenhall is an emergency physician based at Hospital Nacional Guido Valadares (HNGV) in Dili, Timor Leste. He is the team leader for the ATCLASS II program, a health workforce development program that is implemented by the Royal Australasian College of Surgeons and funded by the Australian Government through its overseas aid program. The program's focus is on postgraduate medical education and hospital quality improvement in Timor Leste and is implementing a Family Medicine Program, a two-year junior doctor training program designed to prepare recent Timorese graduates of Cuban medical schools for work in Timor's Community Health Centres. He is interested in postgraduate medical education and the interplay between workforce development and health systems development. He has worked in emergency medicine and postgraduate medical education roles in Timor Leste, Myanmar and Papua New Guinea.

Glenn Clarke

Glenn Clarke is an Arrente man from Alice Springs with wide ranging experience in youth work. He is currently team leader for the Tackling Smoking and Healthy Lifestyle team at the Mount Isa Aboriginal Community Controlled Health Service (MIACCHS). Although relatively new to the health industry, Glenn is looking forward to expanding his knowledge in this area and is passionate about helping others make healthy choices.

Richard Colbran

Richard Colbran is an experienced not-for-profit organisation manager in health and social services and is currently Business Director at Royal Far West—an independent, non-government charitable organisation which has been providing health services for rural and remote children across NSW since 1924. An advocate for

social leadership, Richard's interests include discovery and innovation, building the capacity of individuals and organisations in order to create change for the community's health, safety and wellbeing, and the commercialisation of services and products to support NGO sustainability. Richard has experience in the design and implementation of organisational business strategies and approaches. At Royal Far West he has overseen the development of the organisation's Child Health and Wellbeing Strategy, the implementation of which was noted in Royal Far West's award citation when it won the 2013 NSW Premier's Award for Excellence in Public Service Delivery. From a program management perspective Richard has participated in, and also led, national and state community development programs. Highlights include the Australian Defence Force (2010-12) and National Rugby League Alcohol (2009-12) Management Strategy projects, Good Sports (2004-12) and Australia's national DrugInfo Network (2010-12). He has also participated in multi-partner ARC, NHMRC and other competitive grant research projects, co-authored peer review journal articles and presented at international and national conferences.

Caz Coleman

Caz Coleman has worked in policy, advocacy and management in the asylum and refugee field for 15 years. For the past six years Caz has been a member of the Ministerial Council for Asylum Seekers and Detention (MCASD) providing independent advice to various Ministers for Immigration in both a Labor and Coalition government. She has also been the MCASD representative on the national Immigration Health Advisory Council (IHAG) and was appointed to the Independent Health Advisor (IHA) Panel advising the Department of Immigration in 2014. Caz is currently the Director of the Melaleuca Refugee Centre in Darwin after managing the transitional welfare services on Nauru in 2013. Caz is also studying a Masters in Refugee Protection and Forced Migration through the London University of Advanced Studies.

Marnie Connolly

Marnie Connolly is a Senior Lecturer at Monash University, School of Rural Health—Bairnsdale. In this role Marnie supervises the implementation of the Years 2–5 academic MBBS curriculum and clinical placements at the Bairnsdale campus. Her interests in longitudinal integrated clinical placements lead her to complete a Masters thesis on the impact of students undertaking longitudinal placements on their clinical supervisors. Marnie is also a registered nurse with an interest in developing educational opportunities for primary care nurses in rural and remote areas of East Gippsland—Victoria. Her commitment to providing ongoing education for primary care nurses has resulted in being awarded (twice) the June Allen Practice Enhancement grant to continue primary care nursing education.

Sara Coombes

Sara Coombes was born in Canada in 1957. She was Medical Laboratory Scientist before doing a Diploma in

Chiropody at the Chelsea School of Chiropody London UK. After two years in Public health employment in southern England Sara migrated to Australia in 1981. Sara first job was in Dubbo NSW providing services to multiple centres including Bourke and Cobar introducing her to Indigenous remote health issues early in her career. Sara moved permanently to Wauchope in 1983 working in both public and private practices. She developed a keen interest in preventative foot care and diabetes and is currently studying for Graduate Certificate in Diabetes Education at Curtin University WA. From 2009 Sara has been working for various fund holders in NT providing podiatry services to remote communities north of Alice Springs while maintaining a limited private practice at home. Sara continues to study both formally and informally. In 2010 she gained her Masters of Health Sciences (Podiatry) and is an Affiliated Member of the College of Podiatric Surgeons and is an accredited Member of the Australian Podiatry Association indicating she achieves over 40 hours of continuing professional development per year. Her goal in the next two years is to evaluate her podiatry service in NT and to continue to work towards better foot health and reducing foot amputation rates in those communities.

Samantha Coonan

Samantha Coonan is an Allied Health Assistant at Gateway Health Wangaratta. Sam has extensive experience in podiatry as an AHA and more recently has been expanding her role across the areas of physiotherapy and occupational therapy for Home And Community Care clients. Joining Annalee in the Workforce Innovation Grant project, Sam is now learning the art of goal directed care planning and care coordination with the aim of supporting the allied health team with the management of clients with complex care needs.

Simon Craig

Simon Craig is an emergency physician and Director of Emergency Medicine Training working at Monash Children's Hospital in Melbourne, while also working in West Gippsland Hospital, Warragul. His research interests include medical education, procedural pain and distress, diagnostic testing, and all other aspects of paediatric emergency medicine.

Leanne Craigie

Leanne Craigie grew up in Brisbane identifying as Gungarri through descent from her grandmother and mother. Leanne began work with Queensland Health in 1994 as a Hearing Health Worker responsible for the coordination and delivery of paediatric hearing screening services to Aboriginal and Torres Strait Islander schools in the Greater Brisbane area. The role also provided hearing health training and support to Indigenous Health Workers and Child Health Nurses. Leanne has coordinated community engagement and participation projects. The most significant achievement was leading the formation of the first Family Advisory Council for the former Royal Children's Hospital (Brisbane). In recent years Leanne has been involved with several projects relating to safe infant sleeping including the adaptation of a safe infant

sleeping e-learning course for Indigenous Health Workers. Leanne's current role is Senior Project Officer for an Aboriginal and Torres Strait Islander research project known as the "Pēpi-pod Research Study". The aim of the research is to determine the acceptability and feasibility of a novel safe sleep enabler called a "pēpi-pod" in Aboriginal and Torres Strait Islander communities in Queensland. The pepi-pod provides a safe sleeping space option for a baby for families at risk of SUDI—Sudden Unexpected Death in Infancy.

Louise Croft

Louise Croft: Radiographer Breast Screen NT, Specialist in provision of Breast screen program to remote communities. Responsible for rollout of this new program to remote areas of The Northern Territory. Previously Mammographer Warrington and Chester NHS trust UK.

Melissa Cromarty

Melissa is a university trained RN with Graduate Nursing certificates in Advanced Practice Emergency and General Practice Nursing. Melissa is a qualified educator with a Certificate IV in training and assessment who is passionate about chronic disease management and the implementation of effective systems in the primary care setting to achieve positive clinical outcomes for patients. Melissa currently works with Hunter Medicare Local playing a key role in practice nurse development, immunisation and nurse led clinics in the primary care setting. Her current focus is a unique role in alliance with the local health district to improve outcomes for diabetes.

Lisa Crouch

Lisa Crouch is Senior Project Officer of the Greater Northern Australia Regional Training Network based at James Cook University in Cairns. She has recently completed a Near Neighbours project that investigated opportunities for increasing international clinical placement capacity for health science students located in Greater Northern Australia. With a diverse background in health promotion, she has many years' experience in providing health care with a preventive health focus to rural and remote areas of Far North Queensland, Western Australia and in international settings including Vietnam, Myanmar and Cocos Islands. Lisa has always been driven to deliver unique health care projects that focus on a long term partnership approach that can enhance capacity and sustainability.

Bart Currie

Bart Currie is Head of Infectious Diseases at Royal Darwin Hospital and Professor in Medicine at the Northern Territory Medical Program, Flinders and Charles Darwin Universities. He is also Program Leader for Tropical and Emerging Infectious Diseases in the Global and Tropical Health Division of the Menzies School of Health Research and Director of RHD Australia. Areas of interest include clinical and epidemiological aspects of tropical and emerging infections, development of treatment guidelines and clinical toxicology. He initiated the Darwin Prospective

Melioidosis Study in 1989 and this remains the basis for ongoing multi-disciplinary collaborations on melioidosis.

Linda Cutler

Linda M Cutler commenced employment with the Royal Flying Doctor Service of Australia (NSW Section) in the role of General Manager Health Services in May 2012. Linda, originally from Canada began her career in Australia as a nurse in 1978 working in Tasmania and Queensland prior to moving to NSW. She has worked in rural and remote NSW since 1979 when she worked at Brewarrina Hospital as a registered nurse. Linda's previous experience as an intensive care nurse with cardiac, paediatric and neonatal experience served as a sound foundation for her many years as a rural clinician. Her career encompasses a broad range of positions in both acute and community settings, in Aboriginal health and as a front line clinician and as a senior manager both in acute services and in Rural Health Education and Training. Several innovative programs which Linda developed during her time in education and training include: the NSW Rural Research Capacity Building Program; the NSW Clinical Team Leadership Program and Video-conferenced Nursing Grand Rounds initiative.

Stephanie Dale

Stephanie Dale is an award-winning regional journalist and author, with wide-ranging experience in media, politics and publishing. Throughout 20 years in the newspaper industry she was a passionate advocate for the visibility and voices of everyday Australians. She now works to encourage people and communities to identify their story and speak for themselves. In 2014, she founded *The Write Road*, a creative initiative that takes writing and communications workshops and training to the bush and beyond. What began as an arts program quickly evolved into a proactive mental health strategy that is achieving positive results for individuals and remote communities. Stephanie's work was acclaimed at the 2014 Women Out West Awards.

Genevieve Dally

Genevieve Dally is a decade long champion of the sexual and reproductive health sector. Cutting her teeth in a busy urban general practice, Genevieve developed a nurse-led sexual health clinic to address gaps in access to services for young people. Recognising early on the limitations of a diversified workforce Genevieve then moved into sexual and reproductive health education to strengthen the skill base and build the capacity of doctors, nurses and allied health professionals. Genevieve is a registered nurse with a Masters in Public Health and is currently employed by Family Planning and Welfare NT in the role of Manager for Education and Workforce Development. Genevieve is passionate about sexual rights being human rights and works tirelessly to promote safe, happy healthy and enjoyable sexual lives for all people.

Susan Daly

Susan Daly is the Director of Mental Health and Drug & Alcohol in Far West Local Health District, NSW. Far West

Local Health District falls between the borders of Queensland, South Australia and Victoria and incorporates the Silver City of Broken Hill and most of outback NSW. Susan is a registered nurse and is proud to have been providing service to mental health consumers, carers and staff since the early 80s. She has experience in inpatient and community mental health care, management, research, policy development and education.

Angelo D'Amore

Dr Angelo D'Amore is a Senior Lecturer in the School of Rural Health at Monash University. Angelo is the Education Leader for the Department of Rural and Indigenous Health and collaborates on research with the School of Rural Health—East Gippsland.

Jill Davidson

Jill Davidson is the Chief Executive Officer of SHine SA, is a multi-site a state-wide sexual and reproductive health service providing clinical services, workforce development, community education and support services. Jill has been the CEO of small and large integrated hospital and health services in Victoria and New South Wales. With a breadth of knowledge across acute, primary, aged and community Jill is able to bring to the service delivery landscape an integrated approach to service development. Jill was responsible for establishing a multi-purpose service pilot in an isolated rural area of Victoria and it was through the challenges and this experience that she developed the innovation and passion to deliver services to rural communities. Jill is on the national Board of Family Planning Alliance Australia, has held senior roles and been a national Board member for ACHSM, state Board member for VAADA and counsellor for AHHA and a member for the National Aged Care Alliance.

Margaret Dawson

Margaret Dawson is a registered nurse and midwife with qualifications in Community Health, Child & Family Health, Endorsed Nurse Immuniser (Qld) and Health Promotion and Education. She also holds Certificates IV in Training and Assessment and Project Management. Margaret's main focus of her professional career has been providing primary health clinical services in Community Child & Family Health in urban, rural and remote areas of Victoria, New South Wales and Queensland. She brings a broad range of skills and knowledge to her current role with the Royal Flying Doctor Service (Queensland Section). As the Nurse Manager Primary Health Care Training, she provides training and support to the state-wide Primary Health Care Programs, including child and family health and chronic disease, delivered from Cairns, Charleville and Mount Isa Bases to rural and remote communities in Queensland. She is an active member of the Northern Child & Youth and Maternity & Neonatal Clinical Networks, State-wide Maternity & Neonatal Clinical Network and Queensland Immunisation Program Partnership Group. Margaret is a wife, a mother of 2 adult children and Nan to three beautiful grandchildren.

Melissa Deacon-Crouch

Melissa Deacon-Crouch is a registered nurse and midwife and Senior Lecturer/BN Co-Coordinator in the La Trobe Rural Health School at La Trobe University, Bendigo, Australia. Melissa has a varied background as a Graduate Research Assistant, Research Nurse, Nurse Educator, Nursing and Midwifery Clinician and more recently, Nurse Academic. Her past research work mainly focused on colorectal cancer. Some of her current research interests include Indigenous health issues regarding the professional and self-management of chronic illness focusing on lifestyle factors and medication therapy. Melissa is also actively involved in the development of Nursing Curricula and the use of simulation in nursing education as well as innovation in teaching and learning through E-Learning.

Lisa Deeth

Lisa Deeth has been the A/Telehealth Business Coordinator in the Darling Downs Hospital and Health Service for Queensland Health (QH). She has held this role for the last 9 months and been with Darling Downs Hospital and Health Service for the last 20 years in a number of roles including PACS administrator and Quality Officer. Lisa recently presented an abstract on "The Business of Telehealth" at the 2014 Australasian Telehealth Society Conference. Experience in engaging with rural workforce has allowed Lisa to streamline business processes which in turn has seen an increase in the uptake of services across the Darling Downs Hospital and Health Service and now the DDHHS is leading Queensland in the number of occasions of service and new models of care in Telehealth. Lisa is passionate about new initiatives and always looks at ways to streamline business processes which will in turn lead to better patient outcome. Her current Telehealth projects include TeleDentistry in Aged Care facilities, Inpatient Telehealth and developing a number of research papers.

David Dennis

David Dennis has enjoyed a wide range of roles over the course of his career, prior to his appointment as Branch Manager, Policy Evidence Branch of the Policy Office of DSS. Most recently he was responsible for the Economic and Statistical and Analysis Branch within the Department Health and Ageing. Also within the Health portfolio, he was responsible for managing Health Workforce, Mental Health and Primary Care areas. Prior to his entering government, he was Chief Executive Officer of a large hospital and health service in South Australia. He also held senior executive management positions in ACT Mental Health and was formally the Senior Forensic Psychologist for the ACT. David has clinical qualifications in physical and mental health fields. He has postgraduate qualifications in psychology and business management and has studied at the doctoral level in Epidemiology.

Pascale Dettwiller

Pascale Dettwiller is Associate Professor and Director at the Katherine Campus of the Rural Clinical School Campus of the Flinders University NT Medical Program,

Katherine, Northern Territory. She holds a Doctor of Pharmacy from the School of Pharmacy, Joseph Fourier University, Grenoble (France) and several Bachelor and Diploma awards in Teaching, Business, Nutrition and Herbal Medicine. She has held Senior Clinical Pharmacist positions at governmental and non-governmental health organisations in New Caledonia, Tasmania and Victoria. Pascale has vast experience in teaching and mentoring of pharmacy, medical and nursing students in Tasmania, Victoria and Northern Territory, especially in rural medical schools. She is a member of 12 professional societies and has contributed to many practice manuals and to the development of advanced professional practice for pharmacists. Her major area of research is in medication management and safety, drug usage evaluation and education around medication and adherence and interdisciplinary education. Pascale Dettwiller's current role is to develop these community-campus partnerships and ensure appropriate feedback from the projects' outcomes is provided to the partners. She implemented the student-led clinics for allied health discipline starting with speech pathology in primary school. She is a relentless advocate for rural and regional integrated model and partnerships.

Gina Dillon

Gina Dillon has recently completed her PhD through the School of Rural Medicine at the University of New England, Armidale. Her PhD research investigated the influence of rural, remote and metropolitan settings on the experiences of intimate partner violence (IPV) for young Australian women. Using data from the Australian Longitudinal Study on Women's Health, Gina has published a number of peer reviewed journal articles investigating geographical differences in prevalence and type of IPV, as well as the influence of IPV on self-reported health, health service use, and domestic relocation in young women from major cities, regional and more remote areas. Gina has a diverse career background spanning research in agricultural entomology, wildlife population monitoring and education in the field of adult literacy and numeracy. Outside of academia, Gina is the Director of Armidale Yoga, and has a particular interest in applying the benefits of yoga and meditation to aid the physical and mental wellbeing of people experiencing anxiety and depression, or in recovery programs for drug and alcohol addiction.

Frances Doran

Dr Frances Doran is a Senior Lecturer at Southern Cross University, Lismore, NSW with the School of Health and Human Sciences. Frances has a background in social sciences, public health, nursing and health promotion. Frances has worked predominately in the higher education sector and has simultaneously maintained a strong connection with community based women's services through research and management roles. Her research and publications have encompassed a range of women's health areas including gestational diabetes, women's access to health care including abortion, evaluative research on community based model of women's health and partnerships between community

based women's health, Aboriginal health centres and the University. Her research, professional and personal life is driven by a strong commitment to feminism, social justice and health.

Rosie Downing

Rosie Downing is passionate about and committed to the provision of accessible and appropriate maternity services for families living in rural and remote communities. Trained as a nurse and then a midwife, she has worked in public, private, community controlled, urban and remote health services around Australia, including as a Remote Area Midwife in two remote communities of Central Australia. Her interests in the social determinants of health in Australia lead her to complete a Masters of Social Health (Aboriginal Health), University of Melbourne. In 2014, with the assistance of a sponsored Churchill Fellowship (the Peter Mitchell award) she travelled through Scotland, Canada and Aotearoa/New Zealand to observe and learn from successful birthing services located in geographically remote communities. She currently works with the Alice Springs Midwifery Group Practice; a continuity of care service where 40% of clients come from rural or remote communities in Central Australia.

David Doyle

David Doyle is Executive Director of Perth-based DADAA, a leading arts organisation at the forefront of the Arts and Health movement over the past 16 years. David has worked across Australia, Hong Kong, Kenya and Ireland to extend cultural participation for people with disability and mental illness. David holds a Bachelor of Visual Arts (ANU), Graduate Diploma of Education (ECU) and is an accredited Partnership Broker through PBAS UK. David is Editor of *Proving the Practice: Evidencing the effects of community arts on mental health*. In addition, he has written widely on Arts and Health practice in Australia, has been an advocate for arts and health for more than two decades, and is active in policy discussions at the state and federal levels. He is regularly invited to speak at conferences and symposia, both in Australia and internationally. David was awarded the National Arts and Health Leadership Award in 2009 for his work in the Australian Arts and Health sectors and the Western Australian State Arts Business Leadership Award for his work in sustainable partnerships, between communities, the business and Arts sectors. He is currently a Board Member of Creating Australia, an Australia Council for the Arts initiative that provides support and leadership to the CACD sector.

Tracey Drabsch

Tracey Drabsch is a senior physiotherapist in subacute care for the Western New South Wales Local Health District as well as an Adjunct Associate Lecturer at Charles Sturt University in Orange, New South Wales. She has extensive experience in the provision of evidence based sub-acute care for people in rural communities. Her most recently published original research, supported by the Health Education and Training Institute, provides insight into a hub and spoke model of care for

orthogeriatric rural inpatients. With the challenge of reduced funding and resources Tracey has been required to consider "what matters most" to keep the delivery of inpatient sub-acute care happening in rural facilities.

Mithilesh Dronavalli

Dr Mithilesh Dronavalli is a public health medicine registrar with the Australian Faculty of Public Health Medicine. He is currently based as a researcher at The Western Australian Centre for Rural Health (UWA) in Geraldton. Alongside a medical degree he has also obtained extensive training and qualifications in biostatistics and epidemiology. He holds a first class honours in biostatistics, a Master of Biostatistics and an MPhil in Epidemiology. Mithilesh has consulted on many projects involving the analysis of clinical data. He has experience in teaching scientists and clinicians research methods. He is a published author who has carried out many presentations on clinical research. He has also had some experience in mental health as a psychiatry registrar. Mithilesh was born in India, carried out schooling in Sydney and has lived in Australia for the last 24 years. He is currently enjoying his stay in Geraldton and is loving the experience of a regional town. He aims to be a public health physician specialising in the field of biostatistics and epidemiology. He will start his PhD in biostatistics next year at The University of Western Australia.

Dubbo Aboriginal Research Team

The Dubbo Aboriginal Research Team is a group of five researchers working together to study Aboriginal people's stories of diabetes care in Dubbo as part of a larger Integrated Care trial. The team bring experience and qualifications in Aboriginal health, nursing, social services, diabetes education and research. Between them they have over 60 years' experience in health. They represent Dubbo Regional Aboriginal Health Service, Western NSW Medicare Local and Western NSW Local Health District. Val Smith is a Wiradjuri woman. Dubbo is on Wiradjuri country in western NSW. Bernie Kemp was born in Wilcannia and is a part of the Barkindji people, he has spent most of his life working in Aboriginal health in far western NSW providing health checks, preventing and treating chronic disease. Bernie recently relocated to Dubbo. Craig Johnson and Monica Johnson are from the Ngiyampaa tribe in western NSW. The Ngiyampaa were located at Carowa Tank in 1926, and later moved to Menindee Court station in 1933. In 1949 the inhabitants of the Menindee Court station were moved once again by train and truck to Murrin Bridge near Lake Cargelligo. Emma Webster is a non-Aboriginal woman who has lived in Dubbo for the past 22 years.

Vivienne Duggin

Vivienne Duggin is the General Manager, Rural Health West where she has been employed since 2006 in various roles across the broad range of programs. In 1994 she established the first rural Division of General Practice in Western Australia (located in Kalgoorlie-Boulder) where she worked as Chief Executive Officer until 2005. During those years she developed an understanding of the complexities of both living and working in a rural and

remote community. Whilst employed at the Division she was involved in the establishment of the Rural Clinical School in Western Australia and various other programs working in partnership with State and Commonwealth Governments, Universities, and numerous community and state based organisations. In her current role as General Manager, Business Development and Strategy she established the Forward to Fellowship program based in Kalgoorlie-Boulder to support International Medical Graduates obtain their Fellowship.

Darren Edwards

Darren Edwards 23, born and bred in Darwin, started his career with Gary Lang NT Dance Company at the 2005 Dreaming Festival. Darren has performed all over Australia including Deadly Awards (2006), Dreaming Festival (2007), Darwin Festival (2007), Strut Festival Perth (2007). His performance credits include: I-moves (2007), The Dream (2008), Munuk GApu Freshwater Saltwater (2008), Goose Lagoon (2010), Allure of Paradise (2010), Pineapple Woman Crocodile Man (2011), 8-80 The Architecture of Age (2012), Future Age (2013), I AM MAN (2013), Pulse (2013) and Mokuy (2014). Darren also participated in the workshop and development of Quinkan (2008) with esteemed Indigenous choreographer Marilyn Miller. Darren recently made his acting debut as Tee in Sarah Hopes production of The Hoist (2014) at Browns Mart Theatre, Darwin.

Anna Elias

Anna Elias is a third-year medical student at Flinders University. Previously a primary school teacher, she also holds a Master's Degree in Education. Anna developed an interest in rural medicine over several years volunteering with children and their families at Ronald McDonald House in a small town. During her time at Flinders University Anna has become passionate about health care equality and hopes to work to close the health care gap. Anna is motivated by the belief that we need to innovate solutions if we are going to improve health and education outcomes for our rural population.

Breanna Ellis

Breanna Ellis is the Chronic Disease Network Coordinator with the Northern Territory Department of Health, Chronic Conditions Strategy Unit. Ms Ellis' work is to coordinate a network of health professional and those with an interest in Chronic Disease Prevention and Management across the Territory. Ms Ellis is currently involved with projects around the delivery of cardiac rehabilitation across the Territory and the development of a communication package for the Social Determinants of Health.

Gretchen Ennis

Gretchen Ennis is a social researcher, musician and community development worker. She completed her PhD on network approaches to community development in 2012, and works at as a research fellow at The Research Centre for Health and Wellbeing, Charles Darwin University. Her research interests include: developmental

evaluation, the wellbeing impacts of participation in arts activity, and intercultural community work.

Janet Eyre

Professor Janet Eyre is Professor of Paediatric Neuroscience at Newcastle University in the UK. A previous Rhodes Scholar and Wellcome Senior Fellow in Clinical Science, she is an internationally recognised expert in brain plasticity following brain injury across the life span and its implications for rehabilitation. She currently leads a research program of £2.7 million into the clinical application of video games for online physiotherapy, enabling home-based-delivery of therapy with expert remote monitoring and management by therapists. She has been awarded the following for her work in Online Physiotherapy: The NHS Innovations North Bright Ideas in Health Award 2009; CELS Business for Life Awards—Partnership with the NHS 2010; The UnLtd and Higher Education Funding Council for England Entrepreneur Award 2010; Medical Futures Best Innovation to Improve Patient Care—Cardiovascular Innovation Award 2011; Medical Futures National Health Service Innovation of the Year Award 2012 presented by Professor Sir Bruce Keogh, NHS Medical Director for England.

Donna Fahie

Donna Fahie is currently the Manager, Specialist Training Program for the Australian and New Zealand College of Anaesthetists. Within this program, for the past three years, Donna has worked to address the maldistribution of and lack of access to specialists across regional, rural and remote Australia by increasing the capacity of the health sector to train anaesthetists, pain medicine and intensive care medicine specialists across Australia. Prior to this position, Donna worked for the Royal Flying Doctor Service (Western Operations), where she managed the Rural Women's GP Program and developed a passion for improving the quality of life of people living in rural, regional and remote areas. Donna has over 16 years work experience in the health and community care sector including the role of State Manager for the National Stroke Foundation responsible for managing service delivery across WA. She has also held a number of high level committee positions focused on stroke, rural and women's health. Donna holds a Bachelors degree in Human Services and has completed postgraduate studies in Health Services Management.

Heather Ferguson

Heather Ferguson is the Child Health Nutritionist in the Child Youth Health Strategy Unit of the Northern Territory Department of Health. Her focus is on improving the identification and management of childhood anaemia and growth faltering and is developing a systematic approach for monitoring and treatment of these problems in children under 2 in the remote NT. She has also begun work on identifying the determinants of anaemia and growth faltering which go beyond the accepted issues of nutrition and infection in childhood, to early determinants in pregnancy. Originally graduating as a dietitian with a Bachelor of Science and Postgraduate Diploma of

Dietetics from Deakin University, Heather has worked in industry and now in public health in the government sector. Her qualifications include a Master of Public Health from the University of Melbourne and the Master of Business Marketing from the University of Technology Sydney.

Stacy Field

Stacy Field's career has included a range of roles within the community services sector, taking in community and sector development, youth work and disability services in both rural and metropolitan areas. Since starting employment with the Health and Community Services Workforce Council in 2006, Stacy has worked in a range of sector and place based workforce planning initiatives encompassing both community service and primary health care sectors. Currently, Stacy leads the development and implementation of the Workforce Council's workforce planning services, including consultancy, training and resource development. She is passionate about the community services sector and those working in it and is motivated by developing creative and innovative approaches to growing, sustaining and developing our workforce. Stacy has a Bachelor of Social Work, a Bachelor of Arts (Political Science) and a Master of Social Work in the fields of Community Development and Social Research in Human Services. She is also a trained Partnership Broker and Technology of Participation (ToP) facilitator and holds a Cert IV in Training and Assessment and a Diploma of Project Management.

Kelly Foran

Kelly Foran, the CEO of charity Friendly Faces Helping Hands Foundation (FFHHF), knows first-hand the difficulties that country people face in accessing health care. Kelly has a degree in life and hard knocks she has taken a terrifying situation and turned it into a positive, helping over 45,000 people from all over Australia. Her unique foundation was borne 4 years ago to make health care more accessible for all Australians and ease the stress on those seeking such care, no matter what kind of medical service they need. This presentation seeks to raise awareness of the support this foundation can offer to all communities. Easing the struggle and stress reducing the onset of another disease Mental Health. The foundation offers information to people seeking medical treatment away from home. It does this primarily through a comprehensive website and a 24-hour phone service. There are basic details about specific hospitals and services around the country, but the focus is the extra services located around the country and near hospitals.

Lauren Ford

Lauren Ford is an experienced statistician, having worked at the Australian Bureau of Statistics for 10 years in a wide range of roles covering social statistics, economic statistics and the Census. Her most recent role has been project manager of the Patient Experience Survey, which collects annual data on access and barriers to a range of health care services, including general practitioners, medical specialists, dental professionals, hospital admissions and emergency department visits. Lauren has

also worked on key outputs from the 2011–12 Australian Health Survey, which is the largest and most comprehensive health survey ever run in Australia.

Susan Forrester

Susan Forrester has been working as a project manager in the community sector for over 20 years and gained much of her experience and expertise in cultural and community engagement, whilst working on various projects, for a diverse range of mainstream and Community based organisations. Susan is committed to Aboriginal health, Culture and the principles and practice of Aboriginal Community Control. Susan is currently working with ACCHOs and eye sector stakeholders across Victoria to close the gap for vision, alongside eye health project Officers in 4 of the 8 Victorian Health regions, supported by the Koolin Balit Victorian Government's strategic direction for Aboriginal Health.

Rene Forsyth

Rene Forsyth is a PhD candidate from Curtin University in WA, with a primary goal of highlighting any disparities in rural and remote patient outcomes following an acute myocardial infarction, compared to metropolitan counterparts. Rene has a background in Radiography (Bachelor of Science) and continues to work part-time in this field. She was awarded the APA Scholarship in 2012 to commence this study. Having grown up in rural areas, Rene has a passion for rural health which has sparked her interest in research benefiting such communities.

Josh Francis

Joshua Francis is a paediatrician and paediatric infectious diseases specialist, based at Royal Darwin Hospital in the Northern Territory. He is based at Royal Darwin Hospital. Josh is a member of the Medical Advisory Committee for Bairo Pite Clinic—an NGO health care facility in Dili, Timor-Leste. Bairo Pite Clinic provides care for hundreds of Timorese people each day, many of whom travel great distances to seek medical treatment. Through regular visits and remote support, Josh provides clinical input, teaching, and leadership in program development, with particular focus on the clinic's large TB and malnutrition programs.

Karen Francis

Karen Francis has over 20 years' experience teaching undergraduate and postgraduate level courses in nursing, and to a lesser extent in allied health and medical programs at a number of Australian and international universities. The latter teaching was in the capacity of an adjunct and visiting academic. She is an experienced higher degree research supervisor and nurse researcher. Her research program targets rural health and health workforce. Professor Francis is acknowledged within her profession for her expertise in rural nursing and midwifery. She has significant publications and research reflecting this expertise.

Ekala French

Ekala French is a Wiradjuri girl from Orange NSW, who is an Aboriginal health worker at the Orange Aboriginal Medical Service. She commenced studies in April 2013 at the Yarradamurrah Centre in Dubbo, and later completed the course in August 2014. Ekala has been employed at the Orange Aboriginal Medical Service as a trainee Aboriginal health worker from March 2013 to March 2015, and has since successfully completed the traineeship. Throughout the course through TAFE Western she has learnt an immense amount of information that has provided a rewarding job and remarkable life skills. Having the role as an Aboriginal health worker is so rewarding for Ekala because it gives her the opportunity every day to help people who are in need, not only to address their health needs but to address their holistic needs as well, which makes it that little extra rewarding. Ekala has set some goals for 2015 to continue doing more studies to expand her clinical skills through nursing, then to eventually become a midwife, which is her passion.

Peter Frendin

Peter Frendin started his professional life by training as a general Nurse at Sydney Hospital in the mid 70s and has had a varied career in health ever since. Peter has worked as a remote area nurse in SA and WA, managed hospitals and regional health services in NSW, WA and the NT and worked in Dubai and India as a health management consultant. More recently he headed remote health services for the NT Department of Health in Central Australia overseeing some 33 remote health centres and prison health facilities. Having qualifications in Nursing and midwifery he holds a postgraduate qualification in Health Services Management and is a graduate of the Australian Institute of Company Directors and a Consumer and Community Advisor with the Cancer Institute of NSW. Peter is married to his long suffering wife Jenn (24 moves in 35 years would try anyone's patience!) and they have two (nearing) middle aged boys. Both Peter and Jenn are passionate about Indigenous and rural/remote health, with Jenn currently overseeing the remote AOD Workforce program here in the NT. Peter meanwhile has taken on a new challenge as the NSW/ACT General Manager for the AGPAL Group of companies, Australia's most comprehensive quality and accreditation agency in the health and human services sector.

Rhonda Garad

Rhonda Garad has a background in health service delivery and has worked in the area of public health and health promotion for the last decade. She works at Jean Hailes for Women's Health as a health educator and project manager with expertise in research translation and dissemination. She has a particular interest in health equity with a focus on the health needs of minority groups. Rhonda holds a Masters of Public Health and is currently completing her PhD in health literacy at Deakin University.

Annalee Gardam

Annalee Gardam is an occupational therapist who has worked in rural health for the majority of her career.

Annalee has experience across acute, rehabilitation and community practice. Having moved on from leadership roles, Annalee enjoyed her time in the case management of home care packages for clients across Northeast Victoria. Currently Annalee is in a project management role at Gateway Health Wangaratta exploring the opportunities of Allied Health Assistants performing care coordination with complex clients.

Lynore Geia

Dr Lynore Geia is a Bwgcolman (Palm Island) woman and a senior lecturer in the College of Healthcare Sciences at James Cook University. Lynore is passionate about her community; her PhD research takes a strengths-based approach to exploring the intergenerational strengths of child rearing practices of Palm Island families. Lynore's vision is to see community development arising from the community informing government/non-government organisations out of genuine partnerships and social investment into people, more than programs.

Jacqueline Gibbs

Jacqueline Gibbs is 24-year-old Gamilarra/Yuwalaraay woman from Goodooga, a community located in north-western NSW. Better known as 'Jack' to her clients, she has been running the Kelso Indigenous Chronic Disease Clinic for four years, since its inception. With Jack at the helm, the clinic has evolved from a primarily diabetes-centred clinic into a wider chronic disease clinic. In 2014, Jack completed the Indigenous Youth Leadership Program challenging her to 'step out of her comfort zone' with a highlight being completing the Kokoda Track walk.

Stephanie Godrich

Stephanie Godrich has worked across various public health areas including research and evaluation, community based nutrition education, corporate health and project management. Her focus over the last five years has been in regional and remote WA communities, where she developed an award winning food literacy program and decided the best way to advocate for equitable food opportunities would be with evidence. Her current PhD research aims to investigate the relationship between food security determinants and fruit and vegetable intake amongst children across regional and remote WA, resulting in a recommendations document for both policy and practice.

The Grey Panthers

Tracks Dance has a long term relationship with this unique Northern Territory Seniors' Dance Troupe, begun in 1988 and continuing to the present. They explore what it means to part of the Aging Australian population and the role of the elder in contemporary Northern Territory Life. With participants predominantly over the age of 60. The Grey Panthers are 'successful', 'productive', 'healthy' and 'positive' role models for active ageing and life long learning. The group sets high expectations for themselves and constantly rise above them, enjoying their lives and living them to the fullest. This amazing group show us what happens when you commit to long term extended

relationships and links into your community. They perform regularly for special one-off events, usually charitable, and especially for older adult, and health specific organisations such as the Arthritis Foundation, University of the Third Age, and Rotary and Lions Clubs, and the Anti-Cancer Foundation, and Darwin Hospital. They were guest performers at the 2014 National Rehabilitation Nurses conference. They are regular performers on Darwin's arts and cultural calendar, including the very popular Portrait of a Senior Territorian Art Award. They are also regularly used to act as seniors in television advertising.

Heather Grieve

Heather Grieve (BSc MND MPH) is a public health nutritionist currently working as the Senior Nutrition Specialist to the Australian Embassy and Aid Program Dili, Timor-Leste and as a Nutrition Advisor to his Excellency the President of the Republic of Timor-Leste.

She is actively engaged in providing evidence based policy and programmatic advice to government's and development partners in the Asia-Pacific region and previously held the position of Nutrition Team Leader for the Women's and Children's Knowledge Hub for Health at Menzies School of Health Research in Darwin.

She commenced her career as a Public Health Nutritionist in Central Australia, supporting nutrition capacity building and the development of nutrition programs in remote Indigenous communities for 13 years.

Heather has worked closely over several years with high level decision makers and programmatic stakeholders on nutrition and food security policy development and programming in Timor-Leste, Lao PDR, Cambodia, Samoa, Fiji, Thailand and the Thai Myanmar border and Nepal.

Bridie Groenen

Bridie Groenen is an accredited exercise physiologist currently working at Bodyfit NT. She received her Graduate Diploma in Clinical Exercise Physiology from University of Ballarat (now Federation University) before commencing employment as a Graduate Exercise Physiologist at Bodyfit NT in 2013. After one and a half years as a practising exercise physiologist Bridie was elevated to a position as Remote Programs Manager, which she has now been in for the past year. Throughout her time at Bodyfit NT Bridie has primarily worked in delivering Exercise Physiology to remote communities within the Northern Territory, with particular focus on those in the Top End. Through the MOICD program and in working with Northern Territory Medicare Local, Bridie and a number of other Bodyfit NT exercise physiologists and physiotherapists are able to share their passion for healthy lifestyle and exercise with remote populations in working as part of multidisciplinary teams aiming to close the gap in ATSI health.

Isabel Gundani

Isabel Gundani is newly registered Clinical Pharmacist currently working at the Port Pirie Regional Health

Service, a regional hospital located 223km north of Adelaide. Isabel graduated with a Bachelor of Pharmacy from Charles Darwin University and completed her internship at her current workplace. As a young pharmacist, Isabel wishes to broaden and expand her experience in pharmacy with particular interest in medicines management. She has a strong passion for working and serving rural and remote communities.

Jane Hager

Jane Hager works the NSW Rural Doctors Network (RDN) as a Senior Project Officer for the Western NSW Eye Health Project. The Fred Hollows Foundation has funded the NSW Rural Doctors Network (RDN) to manage a project to improve and better coordinate eye health access and services in western NSW, particularly for Aboriginal people. Jane originally trained and worked as an optometrist. After studying public health she moved into project work for the NSW Optometrists Association, before working for the Commonwealth Department of Health in their Rural Health division. Just prior to joining the RDN Jane worked in interprofessional health education research.

Catherine Halkon

Catherine Halkon is Projects Manager at RHD Australia where she works across a number of education and training projects and is involved in operational and strategic management of the organisation. Catherine has a Masters of International Management with a focus on community engagement and not-for-profit management. She has a background in research and business management. Before joining RHD Australia in 2012, Catherine worked on a number of Indigenous education and training research projects at Charles Darwin University, including the management of a large scale literacy intervention project.

Lynne Halliday

Lynne Halliday recently commenced as the Director Mental Health, Royal Flying Doctor's Service Queensland (RFDS). Prior to this position Lynne was the Nursing Director, Mental Health Services, Sunshine Coast Hospital and Health Service from 2010–2015. Lynne's role supports the coordination, strategic development and implementation of mental health care within the RFDS Queensland. The position also supports the development of workforce capacity of mental health staff through the provision of expert strategic advice, development of local policies, principles, partnerships and tools to enhance the organisations capacity to respond to mental health need and challenges, particularly within a rural and remote context. Lynne has an extensive background in health over the past thirty years. Lynne initially undertook General Nursing training at the Royal Brisbane Hospital and followed this by undertaking Mental Health nursing training at Wolston Park (now known as 'The Park—Centre for Mental Health'). Lynne has also undertaken postgraduate nursing qualifications. Lynne has worked extensively as a policy developer, workforce planner, clinician, educator and manager in both general and

mental health contexts and commenced her current role in 2015.

Ralph Hampson

Dr Ralph Hampson is the Head, Research and Evaluation at the Starlight Children's Foundation. He has more than 30 years' experience in health and community services and is an experienced clinician, supervisor, manager, policy maker, evaluator, researcher and academic. In his role at Starlight he is responsible for undertaking and developing evaluations and research projects in partnership with the National Starlight team.

Garry Hansford

Garry Hansford is the Service Planning Manager at Goondir Health Services, an Aboriginal Community Controlled Health Service (ACCHS) providing primary health care to the local Aboriginal and Torres Strait Islander (ATSI) communities from Oakey in the south-east of Queensland to St George in the south-west of Queensland. Goondir has five full-time doctors working from three full-time clinics and a mobile outreach facility, over 30 clinical staff and a client base of almost 2,000 ATSI patients. As the Service Planning Manager, Garry has developed and implemented a reporting system that provides clinicians, managers and the executive with up-to-date data that allow quick evaluations and informed clinical and management decisions to be made. Where once the organisation relied on multiple data sources and anecdotal advice to guide service planning, the reporting system, called The Dashboard now provides clear evidence which can be accessed by staff, managers and the executive to inform decision-making that can lead to effective service delivery and improved health outcomes. Garry's background lies in community engagement and project management, and while he is not a clinician, he has worked in the health sector at both strategic and operational levels since 2009 and on the Darling Downs since 1995. His passion, sadly, is data, and his previous achievements include the publication of the first Darling Downs and South West Queensland Health Atlas, a project undertaken while he was the data and Planning Manager for the Darling Downs South West Queensland Medicare Local.

Laura Harnett

Laura Harnett is currently the President of the West Australian Committee of the Australian Association of Practice Management, and is employed as the Practice and Workforce Support Coordinator at Rural Health West, the rural workforce agency for Western Australia. Starting out as a trainee medical receptionist in a general practice located in the South West of Western Australia, Laura has gained varied experience and training in frontline management, quality improvement, finance and human resources. In 2005 Laura relocated to Perth and launched into medical recruitment, spending six years recruiting rural medical workforce, firstly with Gemini Medical Services and then Rural Health West as Recruitment and Locum Management Team Leader. Laura has also spent significant time assisting international medical graduates with orientation to Australian general practice, navigating

pathways to general and specialist medical board registration and completing Health Insurance Act (Medicare Provider Number) restrictions. Since 2011 Laura has been providing practice management and business support services to rural general practice principals and managers by providing template policies and procedures to meet accreditation standards, implementing webinar training sessions, carrying out mock accreditation surveys, providing education on the Medicare Benefits Schedule, Practice Incentives Program, Telehealth and varied other practice education needs on request.

Zoe Harris

Zoe Harris is the Manager of Health Service Planning for Southern NSW Local Health District. Working in Health Service Planning for over 14 years, Zoe has facilitated numerous Health Services Plans including the Clinical Service Plan for Bega Valley leading to a major \$170M redevelopment on a greenfield site. In rural areas, the location, level, size and models of care of services are critical decisions for future generations. Zoe considers it a Health Planner's key responsibility to provide the platform to facilitate the development of clinical service models for implementation, along with ensuring staff and community members are engaged in the decision making process. To plan services effectively and lead discussions on options for the future, it is critical to provide in-depth analysis of data and communicate this effectively to all stakeholders. When not 'planning', Zoe enjoys exploring the world and indulging in her crafts of pottery and warm glass.

Emma Haynes

Emma Haynes is a health sociologist with a commitment to addressing health inequity. She has applied and developed her approach in a wide range of positions in academia, community health, and State government. She has a particular interest in the processes involved in translating knowledge into practice in the context of addressing health inequities, with a particular focus on Aboriginal health. Currently Emma contributes to the knowledge exchange and translation component of the NHMRC funded Bettering Aboriginal Heart Health WA project; and the Healthway funded More Than Talk project—a collaboration with MAOA [Midwest Aboriginal Organisations Alliance] to develop and evaluate Aboriginal and non-Aboriginal partnerships.

Sarah Haythornthwaite

Sarah Haythornthwaite grew up in Fremantle, WA, on Noongar land and completed her training as a Clinical Psychologist in the West Kimberley 15 years ago. She first moved to the NT in 2008, working with Wurlu Wurlinjang Health Service and started working with AMSANT 3½ years ago. Her role at AMSANT involves providing clinical supervision and support to those working in alcohol and other drug, social and emotional wellbeing and mental health programs throughout Aboriginal community controlled health services. Sarah's role involves working closely with members of the Remote AOD Workforce and Remote AOD Workforce Support Program. Sarah and her AMSANT colleagues recognise

trauma, both historic and present day, as a significant underlying issue to many of the most complex issues being faced throughout communities, this recognition led to AMSANT's work exploring the principles and relevance of trauma informed care to Aboriginal Community Controlled Health Services.

Ray Heffernan

Ray Heffernan established Aston House Consulting Services to provide strategic advice to government and industry on the digital economy and on telecommunications matters. This followed a career in Telstra spanning technical, administrative marketing and sales roles. When the Commercial Manager with CYDN he undertook the development of managed internet and IT service to Indigenous communities in Cape York. Ray also has served as a Board member of a vocational education institution guiding its commercialisation framework and practices. Ray is a Director of ESU (QLD) and is a member of the GoDigitalQld business collaboration group that is working to the government's vision for a most digitally-interactive state and to be a digital innovative hub.

Marie Herd

Marie Herd is a recent graduate of the University of Notre Dame, Fremantle, and is currently an Intern at Sir Charles Gairdner Hospital in Perth, WA. During her final year of medical studies, she completed Honours research evaluating factors that influence medical graduates' preferences and work rotations in rural areas. Although being brought up in major urban centres, Marie has an interest in rural health and lifestyle, having spent a year of her medical studies in Narrogin as part of the Rural Clinical School of WA program. She has also completed two First Wave Scholarship placements in rural Western Australia and has thoroughly enjoyed the experience. Prior to medicine, Marie completed a Bachelor of Science degree and worked at a Fertility Clinic in Perth as an Embryologist and Medical Scientist.

Cindy Hinterholz

Cindy Hinterholz is the Early Years Coordinator at Robinvale District Health Services. Passionate about the early years and its importance as the foundation in a child's life Cindy previously worked in Melbourne as a preschool teacher. Cindy moved to Robinvale in 2009 and here, her passion for the early years, was magnified by the wonderful complexity of the Robinvale community. The multi-cultural and diverse nature of Robinvale offers many challenges but far more rewards. Her aim is to ensure every family has the opportunity to engage in a range of early years services that best meet their needs and that these services support families in health, education and wellbeing. She wants parents to recognise and enjoy their role as their child's most influential teacher.

Tanja Hirvonen

Tanja Hirvonen is a proud Aboriginal Australian woman who grew up in Mount Isa, QLD, and is from the Djaru people of Halls Creek WA, Bunuba people of Fitzroy

Crossing WA and connections from the Barkly Tablelands NT. Tanja is a Psychologist who has just completed Clinical Masters in Psychology. Tanja has lived and worked in rural/remote settings for the past 15 years. Tanja commenced work at the Aboriginal Medical Services Alliance of the NT (AMSANT) in late 2014. Since this time, Tanja has been involved in the work that AMSANT is doing examining the relevance of trauma informed care to the delivery of Aboriginal primary health care services and providing training and support on this topic to Aboriginal community controlled health services throughout the NT. Tanja and her AMSANT colleagues recognise trauma, both historic and present day, as a significant underlying issue to many of the most complex issues being faced throughout communities, this recognition led to AMSANT's work exploring the principles and relevance of trauma informed care to Aboriginal Community Controlled Health Services.

Heidi Hodge

Heidi Hodge is Partnership Manager of the Mid North Knowledge Partnership (MNKP), a rural and remote university research hub based in Burra, South Australia. Hosted by the Flinders University Rural Clinical School, the MNKP collaborates with rural communities, researchers, universities, industry, government and non-government organisations to ensure ready access to locally-relevant research. Heidi is developing a community engagement framework for the Rural Clinical School, to explore how rural universities can meaningfully partner with their local communities in sustainable ways, and in an academic context. Heidi assists researchers with undertaking local rural and remote research, contributes to grant and ethics applications, hosts local community seminars with visiting academics, presents research findings, and provides support to visiting students and academics. Recent and current research she has assisted with includes rural health professional mobility, tourism innovation systems in rural communities, digital participation of older people in rural communities, and the Mid North Youth Wellbeing Observatory. Heidi has extensive experience with rural communities, community engagement, facilitation, primary industries and natural resources, and has lived and worked in the Mid North of SA for over 15 years. She volunteers with several local, State, and national committees, and has recently completed a Graduate Diploma in Professional Communications.

Carol Holden

Dr Carol Holden is currently CEO of Andrology Australia (The Australian Centre of Excellence in Male Reproductive Health) www.andrologyaustralia.org. She is responsible for initiating and managing the first national men's health research project, as well as directing the development of evidence-based community education resources, clinical guidelines, national awareness campaigns and programs in Indigenous men's health. Carol gained her PhD in reproductive biology from Monash University in 1994, and was Monash IVF's operations manager until joining Andrology Australia at its inception in 1999. She has received a number of awards

for her innovative work in men's health, including the Monash Faculty of Medicine Dean's Award for Excellence, which recognises contributions that exceed the normal requirements of the position. Published internationally, Carol has more than 15 years experience in male reproductive health education and research.

Michelle Holloway

Michele Holloway qualified as a general nurse and midwife in South Africa in 1983. She worked in a number of different roles in nursing and travel medicine before taking up the position of National Operations Manager of Netcare Travel Clinics, South Africa in 2001. This was a division of the larger Netcare Hospital Group and included 11 South African Travel clinics as well as 5 remote site clinics in Africa. In 2006 she moved to Australia where she took up a position as a remote area nurse in the Northern Territory specialising the area of chronic disease. In 2010 she moved to Darwin where she worked as a Nursing Coordinator for Top End Remote Health division before commencing as the Continuous Quality Improvement Facilitator for the East Arnhem Health Area. She later relocated to Karratha where she worked in the area of chronic disease under the Closing the Gap funding program. After completing a Master of Public Health and Tropical Medicine from James Cook University at the end of 2012, she commenced working at WACRH's Geraldton office where she took up the position of Research Associate on the national research project, Discovering Indigenous Strategies to Improve Cancer Outcomes Via Engagement, Research, Translation and Training (DISCOVER-TT). Michele has worked on a number of projects in the field of Indigenous cancer and palliative and in 2014 was part of the team that evaluated the Indigenous component of the Program of Experience in the Palliative Approach.

David Horman

David Horman is an orthopaedic registrar at Royal Darwin Hospital. In his last year as a medical student at Flinders he spent time in South Africa and on Groote Eylandt in East Arnhem Land. He did his intern years at Ballarat and in 1997 won awards from the AMA and the Diners/AMSA Rural Scholarship for promoting medicine in rural and remote Australia.

Julie Hornibrook

Julie Hornibrook is an Adjunct Senior Research Fellow at Mount Isa Centre for Rural & Remote Health, James Cook University. She is a consultant to the health and community services sector in rural and remote Australia, as Principal of Hornet Consulting. Julie is based on the north coast of NSW and has collaborated with Frances Doran in research and publications in women's health, Aboriginal health and community engagement. She has actively supported women through governance roles at community based women's services. Julie has a background as an experienced health manager in rural and remote jurisdictions of NSW, Northern Territory and Queensland. She has worked in the NT as a senior policy analyst and oral health program manager and on the north coast NSW in key program areas of oral health,

mental health, sexual assault, aged care and women's health. Julie has experience in working with Indigenous programs and communities in service delivery and evaluation. She has a Master of Public Administration, a Graduate Certificate in Organisational Change and a Bachelor of Social Work.

Noeleen Howe

Noelene Howe is a senior radiographer at BreastScreen NT. Prior to this she was Senior Sonographer/Mammographer at Wesley Breast Clinic in Brisbane.

Melissa Hull

Melissa Hull is a PhD candidate with the Alliance for Research in Exercise, Nutrition and Activity (ARENA) group within the University of South Australia's School of Health Sciences. She completed Honours and undergraduate studies in Human Movement and Health Sciences majoring in exercise and sports science and health promotion. She has worked in a variety of community and university organisations across rural and metropolitan areas of South Australia. Before beginning her PhD studies Melissa worked as a Research Assistant within the School of Health Sciences, where she contributed to diverse projects including anthropometric measurements of defence personnel, several activity monitoring and lifestyle interventions, a systematic review on childhood energy expenditure and use of time phone calls. Melissa grew up in rural South Australia before moving to Adelaide to complete her university studies. The experience of rural living is now a driving force behind her current PhD research, where she is exploring the health literacy, health attitudes and health-related behaviours of South Australian farmers.

Vanessa Hutchins

Vanessa Hutchins has been working in the arts and community sector for over 20 years. She has been a senior project worker for Artback NT (www.artbacknt.com.au) since 2007 and managed both the performing arts and music programs. Vanessa is inspired to offer opportunities to artists and audiences of our remote and regional areas and has enabled many remote tours of music dance and theatre to Northern Territory communities. In 2014 she created The Road Safety All Stars as an extension of her work collaborating with the Northern Territory Government, Roads and Transport Road Safety Branch, on creating localised road safety ambassadors. Using music, song writing, video and music clips, Vanessa and the All Stars produced 11 culturally relevant informative and catchy tunes regarding safer driving on the road. Using social media platforms we have kept the project alive, and have just returned from touring regional West Australia. The project is available for touring, and is responsive to the communities it visits, offering education and workshops on road safety issues. In 2010 Vanessa was shortlisted in the NTG Research and Innovation awards for the project Muttacar Sorry Business, a remote touring theatre show created by Indigenous people for Indigenous people, on road safety issues.

Rebecca Irwin

Rebecca Irwin is a third year medical student at ANU and is the current Vice Chair of the National Rural Health Student Network (NRHSN). She is extremely passionate about promoting rural and Indigenous health. Rebecca was the President of ANU Rural Medical Society (ARMS) for the last two years. As president she was instrumental in development of the inaugural Inter-professional Health Student Networking and Skills event and has played a major role in organising the annual ARMS Close the Gap event, which she has further expanded into a two day conference. Her research includes rural high school visit program and multidisciplinary workshop evaluations. Rebecca hopes to undertake further research to improve current student programs and promotion of rural health practice.

Vivian Isaac

Vivian Isaac is currently a PhD fellow at the Rural Clinical School, UNSW. His PhD research focuses on social-cognitive models in evaluation and outcome studies in rural health and health systems. Prior to this he was a Research & Evaluation Manager with Health Promotion Board, Ministry of Health, Singapore, where he managed health policy research for tobacco control in Singapore. His previous research experience includes epidemiological and cohort studies in the areas of cognitive aging, depression and quality of life issues. Vivian Isaac was a Wellcome Trust Masters Research Fellow and completed MSc Research Methods at the Institute of Psychiatry, King's College, London in 2005. He also completed his MPhil in Social Work at Loyola College, India in 2007. Presently, he works part-time as a Project officer for Population Health Research at Sydney Children's Hospital Network.

Christian James

Christian James is the Program Manager at RHD Australia with over a ten years' experience in national and domestic rural/remote/disaster health projects with a desire to use anthropological principles to develop innovative solutions to complex health problems. Christian graduated with a B.Sc (Nursing) in 2005, after which he pursued a career in remote health in the Gibson Desert, before undertaking clinical and program management roles in Papua New Guinea, Sri Lanka. He then moved to the Middle East where he worked to redesign and manage a large remote area health service. In 2012 Christian relocated to London where he completed his MPH at Kings College London, later working with the Extreme Events Department at Public Health England and the on STEPS program at the World Health Organization.

Wendy James

Wendy James has been a registered nurse for 34 years, and during her career she has worked for a variety of health services throughout Victoria, including metropolitan, regional and rural hospitals. Wendy trained as midwife and worked in that field for many years before making the transition to management. She has held a variety of roles including clinical nurse specialist, ANUM.

NUM. Quality and Risk Manager, Out of Hours Coordinator, HR manager and Deputy Director of Clinical Services. 11 months ago she accepted the role as Warracknabeal Campus Manager—Rural Northwest Health and has had the privilege to see firsthand the success of the Nurse Practitioner role at a rural health setting. Wendy is passionate about rural health care having worked the majority of her career in rural areas and in particular she is excited about innovation to improve quality of care and accessibility of services to the local community.

Lucy John

Dr Lucy Ninmango John has been Manager, Disease Control and Surveillance Branch, Public Health Division, National Department of Health, Papua New Guinea since 2014. Prior to this promotion, she was coordinator STI/HIV Care and Treatment, responsible for two regions (highlands/Momase) for three years. Dr John is a fully fledged internal medicine physician with a subspecialty in sexual health and HIV medicine. Besides program management and coordination, she provides clinical mentoring, training and supervision to other cadres of health workers in the fields of infectious and non-infectious diseases throughout PNG health systems that comes directly under disease control and surveillance branch. She is an integral member of the oversight committee that provides acute monitoring of Global Fund grants for TB, HIV and malaria grants. Dr John is one of the representatives of NDOH to the Country Coordinating Mechanism of Global Fund as member. Her other professional roles include secretary for Medical Society of PNG since 2013 and secretary for PNG Physicians Association since 2012. She is also an active member of the National Doctors Association of PNG. Dr John comes from Simbu Province and is based in Port Moresby since 2012.

Meredith Johnson

Meredith Johnson has worked in health management for 10 years, as a practice manager for a rural GP clinic and in the Medicare Local environment. Prior to this her experience was in general management and information technology. Her experience in rural General Practice has given her insight to the issues involved in providing afterhours services to rural communities. This knowledge has been useful in the successful implementation of the Grampians Medicare Local After Hours System.

Hannah Johnston

Hannah Johnston graduated from La Trobe University in 2006 with a Bachelor of Physiotherapy (Honours). She spent her graduate years working in acute paediatrics and paediatric rehabilitation. In 2008 she moved to Malawi as an AVI volunteer and spent the next two years working in community based rehabilitation. Hannah relocated to Darwin in 2011 and joined the Top End Remote Disability team. She currently works as a specialist paediatric physiotherapist in this team and provides support to colleagues, as well as clients, families and schools across the Top End Remote Region. Hannah is currently completing a Masters in Public Health through Flinders

University. Hannah is passionate about service delivery for children and families in remote areas and tailoring services to meet the diverse needs of communities across the Top End.

Jennifer Johnston

Dr Jennifer Johnston has worked in the drug and alcohol field for 15 years. During this time she has been involved in a wide range of studies—examining illicit drug markets, the social and cultural contexts of drug use, the management of GHB overdoses on Emergency Departments, and the treatment-seeking behaviour of injecting drug users. Upon moving to the Far North Coast of NSW five years ago, the focus of Jennifer's research turned to cannabis-related issues including the health outcomes associated with long-term use and interventions to reduce withdrawal symptoms following the cessation of use. Jennifer is currently a Research Fellow at the University Centre for Rural Health in Lismore, and is working on a range of health research projects including an examination of the barriers and enablers to the implementation of smoking cessation guidelines in antenatal care, the Diagnosing Potentially Preventable Hospitalisations (DaPPHne) study and a study exploring the use and impact of synthetic cannabinoids across NSW.

Sally Josh

Sally Josh uses participant drawings as a data source along with interviews in Interpretive phenomenological research. She works as the research support/research governance officer in rural NSW, with improving patient experience and safety being a major clinical governance goal. Sally's research is into patient/professional engagement as part of medical record documentation in rural hospitals. Given that the aim of the work is to inform more useful and respectful engagement in health care, she considers the project meaningful as a health professional, as a sometime patient, and as a human. Sally has over 20 years' experience in nursing, has taught health professionals, worked as a rural health service planner, gained a public health masters by course work, and worked with a human research ethics committee. Having become interested in research methods, Sally is now enrolled in the NSW Health Education and Training Institute (HETI) Rural Research Capacity Building Program for novice researchers.

Liz Kasteel

Liz Kasteel is the A/Program Leader of the Chronic Conditions Strategy Unit of the NT Department of Health. Ms Kasteel holds a Master of Public Health and has been working in the health industry for approximately 21 years. For the last 14 years, she has been working in health policy and program development. The health policies and programs developed span across primary health care, acute care, aged care, youth and women's health. Currently she is leading the team to develop cardiac rehabilitation service model for urban and remote settings, self-management model to support Aboriginal clients and chronic conditions program for the NT.

Tim Keane

Tim Keane has worked at Northern Territory Medicare Local (NTML) since 2013 in the Mental Health Services Rural Remote Areas Program, of which he is now Principal Program Officer. The program funds allied mental health professionals through various agencies to provide mental health services to remote NT locations. He has working experience in North American Metropolitan homeless shelters and with International NGOs in South Asia and South America addressing Indigenous community development and Self-Help Mental Health Groups. Tim has spent the last 10 years mainly across Northern Australia and NSW working for progress in remote Aboriginal education, social and emotional wellbeing and mental health with various organisations. They have included Aboriginal Legal Service WA (ALSWA), Kimberley Stolen Generation Alliance (KSGAC), Aboriginal Health and Medical Research Council NSW (AH&MRC NSW), and Australian Red Cross Aboriginal Community Youth MH Programs in the Top End. Tim has a strong interest in Australian public health issues relative to Aboriginal population health. He lives by the Sea in Darwin.

Angela Kelly

Angela Kelly has a Bachelor of Health Science (Nursing), and a Master of International and Community Development. Angela has lived in the Northern Territory for 25 years. As a registered nurse, Angela worked for 20 years in the health sector including clinical, program and health research roles primarily with Indigenous people. Via a strange and wonderful pathway, Angela now finds herself working at Skinnyfish Music as the project manager of the annual Barunga Festival; putting her health skills, development knowledge and long-term experience of working in the bush to good use.

Alison Kennedy

Alison Kennedy grew up in Melbourne, but has lived in southwest Victoria's rural farming community for the past 12 years, with the most recent eight years spent living on a farming property. She has experience working in a number of areas with direct impact on the health of farm men and women including horticulture and sleep medicine. Her five-year role at the National Centre for Farmer Health has seen her involvement in research responding to alcohol misuse in farming communities, the coordination of the international photography competition 'Celebrating Rural Life', and the publication of 'Sowing the Seeds of Farmer Health'—a compilation of peer-reviewed papers from the 2012 NCFH conference. Alison is currently in the final stages of completing her PhD at the University of New England—supported by a Collaborative Research Network Scholarship and the National Centre for Farmer Health—exploring the impact that suicide and accidental death have on members of Australian farming families. This project has demonstrated significant engagement with male farmers and stimulated plans for further research to support farming men with a lived experience of suicide.

Emma Kennedy

Dr Emma Kennedy is Senior Lecturer in General Practice, NT Medical Program at Flinders University. Emma is a general practitioner with a commitment to education in health through her work as a GP and with her role teaching in the clinical years of the Flinders program. She is particularly interested in the importance of the context to learning and the importance of managing uncertainty to competence. These issues are important to successful health professional training for rural and remote areas. Emma is a Director on the Board of Northern Territory General Practice Education and practices as a GP in the Northlakes and Vanderlin Drive Surgery in Darwin.

Kathryn Kent

Kathryn Kent's academic qualifications include Bachelor of Social Science Psychology (CSU). Kathryn is currently furthering her education in Psychology through Charles Sturt University. Kathryn is currently working for CentaCare Wilcannia-Forbes in the Family and Care Mental Health Program, as the Family and Carer Mental Health Support Worker/Education Officer, providing mental health information, education, social and emotional support to carers. In this capacity Kathryn enjoys working with those who are caring for someone living with a mental illness. Working with Carers of those who are living with a mental illness has contributed to Kathryn's interest in involving carers in undergraduate nursing and paramedic students education and examining possible approaches for preparing undergraduate students to work with those experiencing mental health issues.

Sue Kirby

Sue Kirby is currently Senior Research Fellow at the UDRH in Broken Hill a role which includes rural health services research, research leadership and research capacity building. She has publications in chronic disease management, service-learning and health service research and evaluation. Her PhD, awarded in 2012 was entitled "An exploration of the reasons for frequent re-admissions in patients with chronic disease" was undertaken at the CPHCE UNSW. Former career in health service management as a manager in community health in NSW and the ACT and as a hospital manager in NSW.

Jessica Kirkman

Jessica Kirkman is a PhD candidate at the University of New South Wales. In 2012 she received First Class Honours in Psychology from Macquarie University for her innovative research into teacher perceptions of cyber bullying. Her experience includes four years as an Applied Behavioural Analysis therapist, specifically working with 4 to 8 year old children with autism. Her research career has focused on the development of online treatments to increase accessibility for high-risk families with access-to-care barriers. Jessica has an interest in international research and collaboration, and has participated in the Macquarie University Global Leadership Program. In 2010 she received an International University Program scholarship that enabled her to complete a summer semester at Copenhagen Business School. For the past

two years Jessica has been working in the Child Behaviour Research Clinic, with families with a child diagnosed with a severe behavioural disorder, after receiving a prestigious Australian Postgraduate Award. She is also Project Manager on the Macquarie University Chilled Plus Project, an online treatment for adolescents suffering from Anxiety and Depression.

Apolline Kohen

Apolline Kohen is currently Senior Policy Adviser at Ninti One. Her role involves providing high level strategic advice and policy analysis to support long-term planning and inform Ninti One's response to critical issues relevant to remote Australia. She has a background in arts management, policy analysis and formulation and community development. She is Ninti One's representative on the Broadband for the Bush Alliance Committee.

Stevenson Kuartei

Stevenson Kuartei works with Pacific Family Medical Supply, Eye and Medical Clinics in Koror, in the Republic of Palau. From 2008 to 2012 he was Minister for Health for the Republic and prior to that Director of its Bureau of Public Health of Palau. Stevenson studied in the US and at Fiji School of Medicine. He is licensed to practice medicine and optometry in Palau. He has a wealth of experience in strategic health planning and public policy design. Since 1994 Stevenson has served as Chairman of the Palau Health Professional Licensure Board; Chairman of the Palau Off-Island Medical Referral Committee; been a Member of the Palau Institutional Board; President of the Palau Medical Society; a Member of the Pacific Basin Medical Association; and Chief of Medical Staff for the Belau National Hospital. In 2004 he served as Chairman of the Committee on Traditional Healing for the 9th Festival of Pacific Arts. That same year he served as Vice President of the Second Palau Constitutional Convention; as Chairman, Committee on Fundamental Rights, where 'preventive health was made a fundamental rights for Palauan citizens'; and as Chairman of the Post ConCon Education Committee to teach the public on 22 Proposed Constitutional Amendments. His hobbies are reading, writing and fishing.

Margaret Kuhne

With an extensive career in nursing, Margaret Kuhne has moved from the wards to the boardroom. In her role as Director of Community Health for South Gippsland Hospital Margaret managed all aspects of the community health service. She has extensive experience in health quality and came to Royal Flying Doctor Service Victoria as Clinical and Quality Manager. In her current role as Acting General Manager of the Primary Health department within the Royal Flying Doctor Service Victoria, Margaret is responsible for developing new health service programs and partnerships and oversees existing primary health initiatives for the organisation.

Fiona Lange

Fiona Lange has a BHSc and a Master of Public Health. Her background is in community development, health promotion and social marketing. She has worked in local Government, education, health and hospital settings developing innovative health promotion to increase access and equity with community driven, multi-media and creative arts approaches. Fiona has worked in Indigenous Eye Health at the University of Melbourne for five years to support the elimination of trachoma. A 'creative commons' approach was developed to enable wider access to trachoma resources; this has enabled successful adaptations of materials including local language, music and art from Indigenous communities. Fiona has a collaborative approach across disciplines and jurisdictions including; Federal and State/Territory health and education departments, Aboriginal controlled health and family services, NGOs and supportive agencies and individuals. Being open to collaboration and using appealing strategies for trachoma elimination has been instrumental in inviting partnerships in hygiene-related health promotion. Fiona was given an Award in Excellence for Knowledge Transfer from the Melbourne School of Population and Global Health, University of Melbourne in 2013 for her work in developing health promotion and multi-media social marketing strategies for the elimination of trachoma in Australian by 2020.

Jessica Langham

Jessica Langham is a new graduate physiotherapist working in a small country town Macksville on the New South Wales coast. In her final year of university Jess undertook an honours project that was based in Tamworth, country NSW. Jess has a passion for rural health and a strong belief that health should be equal for all no matter where someone lives or their heritage. Jess would like to become a general therapist who is a jack of all trades and is able to best treat her patients no matter where she is working. Jess feels like she is truly blessed to be working in a rural town as she is working closely with other health professionals from doctors, dieticians through to exercise physiologists. Jess is thoroughly enjoying the rural lifestyle, helping those in her community and looking forward to further developing her skills to help those in her community.

Sarah Larkins

Professor Sarah Larkins is an academic general practitioner and Associate Dean, Research in the College of Medicine and Dentistry, James Cook University. Sarah has particular skills and experience in Aboriginal and Torres Strait Islander health research and health services and workforce research and is an internationally recognised expert in social accountability in health professional education. Sarah is also Co-Director of the Anton Breinl Research Centre for Health Systems Strengthening, a centre of the Australian Institute of Tropical Health and Medicine.

Lisa Lavey

Lisa Lavey has been Project Manager for the Centre of Research Excellence in Rural and Remote Primary Health Care for the past four years and has recently returned to her role as Research Administration Manager in the School of Rural Health at Monash University. Lisa has extensive administration experience working in universities, government departments and not-for-profit organisations and has managed whole-of-department research, teaching and other portfolio programs. She has extensive skills in office management, program presentation and marketing, human resources, finance and IT. Her office management achievements were recognised through an award by the Australian Institute of Office Professionals in 2007, and she was a key member of the team that received the Vice Chancellors Award for Exceptional Performance by Professional Staff in 2008. Lisa has assumed a leadership role in managing multi-site research programs, and has presented at major national conferences in Australia and New Zealand.

Nadine Lee

Nadine Lee is a Larrakia knowledge holder who is currently a member of the Larrakia Healing Group, a reference group of Larrakia community members who are passionate about assisting recovery of their local community from widespread, ongoing and inter-generational trauma. Nadine is also an artist and filmmaker.

Tony Lee

Tony Lee is a Larrakia healer, knowledge holder and the senior Larrakia employee at the Cultural Knowledge Unit. He is also a member of the Larrakia Healing group. Tony has strong cultural knowledge about ceremony, healing, music and art with extensive experience in working with children and youth in the area of healing, visual art, craft and music via a variety of health programs based in Darwin, including Balunu and Danila Dilba., Duwun is also an artist and didgeridoo player. He has worked in small business, government and with NGOs in cultural enterprise. Tony plays an important role in mentoring younger artists, community engagement and plays a leading role in our current Aboriginal Healing Centre development project.

Jo Leonard

Jo Leonard graduated as a dental therapist in Adelaide in 1975, moving to Katherine in the Northern Territory in February 1999 and then to Darwin in 2001. After decades of delivering clinical dental services from transportable dental chairs on the verandahs of remote cattle stations, single operator caravans in outback SA, health clinics in Indigenous communities, school based dental clinics and from the collaborative environments of urban poly clinics and hospitals, Jo took a professional U turn in 2012 taking on the role as the Oral Health Promotion Officer within Oral Health Services NT. Enjoying a new focus and involvement with the development and implementation of **preventive** oral health strategies after decades of confronting the traumatic repercussions of oral disease in

remote children of the NT, Jo took on the role of the Training Coordinator for the recently launched Healthy Smiles Training Program. Since September 2012 Jo has coordinated and delivered training workshops for this nationally accredited course for primary health care professionals across the Northern Territory. After the value of the training was recognised by the Royal Flying Doctor Service/Queensland, Jo was pleased to be able to provide the inaugural face-to-face training for RFDS staff in 2014.

Raymond Lewandowski

Dr Raymond Lewandowski completed his Bachelor of Science at University of Texas South Western and also his Bachelor of Medicine. He studied his post doctorate at the University of Arkansas. He is a Fellow of the American Academy of Family Practice, and a Diplomat of the American Board of Family Medicine. In 2008 and 2009 Dr Lewandowski and his family temporarily relocated to Kingaroy to work as a Senior Medical Officer at Kingaroy Hospital. In 2011, Dr Lewandowski and his family returned to Kingaroy permanently, and in 2012 he was appointed as the Medical Superintendent of the hospital. In 2012, Dr Lewandowski was awarded this Fellowship of the Australian College of Rural and Remote Medicine. Dr Lewandowski through his clinical skills has stabilised the obstetric service at the Kingaroy Hospital, and provided endoscopy services. Under his leadership, Kingaroy Hospital is consistently the busiest non-specialist birthing service in Queensland, and general surgical services recommenced with the employment of the first Rural Generalist (Surgery). Dr Lewandowski has developed and implemented a structured education program for medical officers, led successful completion of intern accreditation and provides a supported learning environment for the Griffith University students who are based at Kingaroy Hospital for one year of their study.

Andrea Lewis

Andrea Lewis is Head of Communications at DADAA in Western Australia and one of the Coordinators of the FIVE project. In this role, she is part of the team that developed the FIVE project and subsequently managed various media, communications and partnership elements of the project. Andrea is Editor of *Proving the Practice: Evidencing the effects of community arts on mental health* and of *Bridging the Gap: The Story of a Community Arts initiative in the City of Bunbury*. She also helps to coordinate DADAA's research, evaluation and publishing activities. From 2001 to 2006, Andrea worked in marketing and public relations at Curtin University, managing the publications office, and from 2006 until 2007, she was Marketing Manager for the Western Australian Community Foundation. She has also worked as a freelance writer in the health sector. Andrea received a PhD from Pennsylvania State University in 1995, and subsequently taught English literature and critical thinking at the University of Colorado at Boulder.

Tania Lieman

Tania Lieman is an actor, director and writer who has had the opportunity of working in the area of disability arts for

over 15 years. In that time she has created a number of full length productions and ran workshops classes in multi art forms with mixed ability groups.

David Lindsay

Associate Professor David Lindsay is an experienced nursing academic and researcher within the School of Nursing, Midwifery & Nutrition at James Cook University, Townsville. He has a longstanding involvement in rural health and rural nursing in Australia, and is a past national President of the Association for Australian Rural Nurses. His professional interests include Nurse Practitioner/Advanced practice nursing roles in rural areas of Australia and across the Western Pacific, the politics and practice of rural health and rural nursing, and the utilisation of evidence within nursing practice. Dr Lindsay is a Fellow of the Australian College of Nursing and a Friend of the National Rural Health Alliance.

Alfred Liu

Alfred Liu is currently a fourth-year medical student at the University of Queensland. Before entering medical school, he graduated from the University of Wisconsin – Madison in 2009 with a Bachelor's degree in Natural Sciences, majoring in Biochemistry. During his undergraduate studies, he participated in molecular biology research focusing on eukaryotic protein expression and purification with various cell lines. During his second year in medical school, he participated in paediatric leukaemia research under Dr Andrew Moore at the UQ Child Health Research Centre. The study looked at a novel therapeutic strategy of treating acute myeloid leukaemia by targeting the protein Survivin with a chemical YM155 (Sepantronium Bromide), and was recently published in the journal of Leukaemia Research. In 2014, he had the opportunity to visit the Torres Strait Islands for a clinical rotation. During his six weeks stay, he conducted a qualitative study to address chronic disease management issues in the Torres Strait region.

Deborah Loxton

Associate Professor Deborah Loxton is Deputy Director of both the Research Centre for Gender, Health and Ageing and the Australian Longitudinal Study on Women's Health at the University of Newcastle. Deborah's research has focused on the wellbeing of women with a particular focus on the impact of major life events, such as sole and young motherhood, and trauma, for example abuse and drought. Deborah also has a strong interest in the methods used to collect data over the lifespan and recently led the team that recruited a new cohort of over 17,000 women to the longitudinal study—which is the topic of the research she will address at the conference.

Fiona Mactaggart

Fiona Mactaggart is a Researcher at the Wesley-St Andrews Research Institute in Brisbane, and is working on a two-year project that assesses the health and wellbeing needs of mining communities in regional Queensland through a comprehensive Health Needs Assessment (HNA). Prior to this research, Fiona received her Master's

in the Control of Infectious Diseases from the London School of Hygiene and Tropical Medicine, England and worked in the UK and Australia on public health programs. Her interest is in international development and she has begun a PhD with the Berlin University of Technology, Germany, that explores health and wellbeing outcomes of regional and rural mining communities in low and middle income countries (LMICs). More specifically, she is exploring how governments and the mining sector interact to measure and respond to health needs of communities, and will apply lessons learnt from the Queensland-based project to the context of Mongolia—a country undergoing social, economic and environmental change as a consequence of mining. Fiona intends to assess the feasibility of conducting HNAs in rural Mongolian mining communities, and to explore the potential uptake of evidence-based recommendations at policy-level that provide long lasting improvements to community health.

Suman Majumdar

Dr Suman Majumdar is an infectious diseases physician working at Burnet Institute's Centre for International Health and a member of the Tuberculosis Working Group. He has focused skills in the clinical and programmatic management of TB/drug-resistant TB, HIV medicine, training health care workers and health system strengthening. Suman has worked in a variety of contexts, implementing TB/HIV and global health programs in Timor-Leste, China, India, Mexico, Swaziland and regions of the former Soviet Union. He has a passion for working in global health through sustainable partnerships and building local capacity. His work aims to redress health inequalities resulting from infectious diseases and enhance health service delivery in low and middle-income countries by providing technical support, training and conducting operational/implementation research.

Geri Malone

Geri Malone is currently the Director of Professional Services for CRANAP_{plus}, the peak professional body for remote health. Geri is a Registered Nurse & Midwife and her career has been very heavily based in the rural and remote health context. A significant period of time was spent with RFDS across several bases in clinical Flight Nurse role as well as management. A variety of education and professional development roles, policy position with State Government (Country Health SA) and Director of ARNM (Australian Rural Nurses & Midwives. Overseas experience included a contract with International Committee of the Red Cross in East Africa. Geri has been a member of numerous national advisory bodies related to workforce and other professional issues in the context of remote health and is a Council and Board member of the NRHA.

Catherine Maloney

Cathy Maloney is Director Allied Health at Murrumbidgee Local Health District in south western New South Wales. She is a Board Director for Murrumbidgee Medicare Local, and a member of SARRAH's Advisory Committee. Cathy is an Allied Health Professional with close to 30 years' experience as a Physiotherapist. In that time she has

enjoyed very diverse roles in both private and public sectors, including community health, private practice and workplace rehabilitation. Pursuing an interest in persistent pain states and exercise as therapy led Cathy to complete a Master of Science in Medicine (Pain Management) in 2008. Having worked the majority of her career in rural and regional settings, Cathy understands the challenge of delivering health services across large geographical areas. She is passionate about improving access to health services in rural communities by supporting organisations, clinicians and clients through the development of contemporary service delivery models.

Shaad Manchanda

Dr Shaad Manchanda graduated from the University of Adelaide in 2012 with MBBS. Following internship in 2013 at the Royal Adelaide Hospital, he became a Medical Registrar in 2014 at the Lyell McEwin Hospital. Dr Manchanda has a strong interest in teaching and research, having joined the University of Adelaide School of Medicine as a Clinical Associate Lecturer in 2014. His first abstract was published in 2011, and since then has gone on to have original research presented at several international conferences, including in Seoul, Venice, London, and Melbourne.

Hannah Mann

Hannah Mann is at the forefront of regional efforts to close the gap in health outcomes between Indigenous and non-Indigenous Australians. Hannah provides a range of services including developing to Medical Officers, reviewing chronic disease medication clients in rural and remote settings, patient counselling and supporting remote area staff in medication management. Although based in Broome, Hannah's hands-on approach means she spends most of her time travelling throughout the Kimberley region. Hannah is also a co-owner of Kimberley Pharmacy Services, and is actively engaged with and delivering educational resources for clients and clinicians in remote communities, providing clinical support numerous care providers within the region to ensure appropriate services are provided with a health outcomes focus.

Rebecca Marley

Rebecca Marley is an experienced nurse who has worked in ICU, Coronary Care and ED and remote and rural nursing. Rebecca is passionate about using simulation as a teaching tool. In her role as Clinical Skills and Simulation Coordinator at the Manning Clinical School, University of Newcastle, Taree she has provided and supported education to medicine, nursing and allied health undergraduate students and local clinicians. She is passionate about Interprofessional Learning and is currently working on interprofessional teamwork and communication in crisis situations as part of her Masters studies.

Trish Maroney

Trish Maroney is a Wardaman woman from Katherine Region. She has worked as a Speech Pathologist in

Aboriginal Medical Services in remote Communities in the Region and in Katherine Township for 7 years. She also has significant clinical, policy and governance experience within the primary health care setting in South Australia. Trish currently supervises visiting Speech Pathology students undertaking their clinical placement in Katherine in her role with Flinders University to enable increased access to clinical services, develop culturally safe practice skills in the next generation of clinicians and to develop allied health recruitment and retention at the local level.

Carmel Marshall

Carmel Marshall joined the team at CentacareCQ in August 2008. Prior to this role, Carmel worked in regional development on issues such as the impact of the resources boom on communities, attraction and retention of workers in regional Queensland and sourcing alternative workforces from among baby boomers and parents of school age children. Carmel's role as Planning and Development Manager brings together her skills and knowledge in sustainable development (emphasis on socio-economic factors), analytical and planning skills and her interest in seeing a thriving, sustainable community services sector to ensure living in regional Queensland remains viable for families and individuals.

Trevor Marshall

Trevor Marshall has qualifications in youth, childcare and social work; he currently has responsibility for the management, planning, development and delivery of primary care services including aged care in the Alpine Shire. Trevor has worked in the health and community services industry in Victoria for nearly 30 years. He has held a number of senior management positions for organisations at a state government, Community Health and local government levels. Trevor has experience in the delivery and management of youth and family services, aged and disability services and community services in North Eastern Victoria. Trevor has extensive experience working with local, state and federal governments. He has a keen interest in organisational and service development and how that relates to the community wellbeing and community engagement. Having a long working history in the management and provision of services which has included working with young people, people with a disability, older people in the community. Trevor has recently returned to Alpine Health following a twelve month work exchange in Scotland with Perth and Kinross Community Health Partnership. As a member of the Senior Management Team this involved working on a number of strategies including service planning, community engagement and service development.

Gregory Martin

Greg Martin is currently studying Honours in Psychology at the University of Sydney and holds a Bachelor of Communication and Media Studies from the University of Wollongong. Greg joined the School of Rural Health in 2014 as a Summer Research Scholar supported by a scholarship from the University of Sydney Medical School. Greg has a keen interest in population health,

international development studies and mental health and psychosocial support programs.

Lee Martinez

Lee Martinez lives and works in rural South Australia and has done so for most of her life, providing a lifelong experience and understanding of those residing in rural and remote areas. Lee currently works as the Mental Health Academic at UniSA Department of Rural Health. She enjoys working with people who have a lived experience of mental health and exploring innovative ways of providing services that are engaging and meaningful to the consumer. My focus is on rural mental health practice, partnerships between academia and industry, workforce development and consumer engagement in service design and delivery. Lee's three decades in community health have allowed her to pursue her passion of ensuring rural communities have access to services to achieve health outcomes equal to those that live in the city.

Jenny May

Dr Jenny May is Clinical Dean at the Rural Clinical School Tamworth Campus of the Joint Medical Program. Her role encompasses oversight of undergraduate teaching activities, research and evaluation in primary health care as well as support of postgraduate training and the rural workforce. Her research interests include new models of general practice in rural and remote areas, and primary health care integration. Her area of PHD study is related to regional centre medical workforce including both special sits and GPs. She works at Peel Health Care, a not for profit general practice in Tamworth. She holds fellowships of both the Royal Australian College of General Practitioners and the Australian College of Rural and Remote medicine. Jenny is the Rural Doctors Association of Australia (RDAA) representative on the National Rural Health Alliance. She has been involved in numerous committees and working parties around rural health issues and sits on the Commonwealth Governments advisory group on Alcohol and Other Drugs. Jenny has lived and worked in the New England area since 1984 with a five year sojourn in remote Western Australia's Pilbara and a year's work in a remote Indigenous community in British Columbia, Canada in 2004. She was named Telstra RDAA Rural Doctor of the Year in November 2014.

Diane Mayers

Diane Mayers is a Remote Alcohol & Other Drugs Worker in Elliott, Northern Territory with the Remote AOD Workforce. A local Tennant Creek woman (Warramungu) with extended family in Elliott, she provides a local, culturally-appropriate AOD service within the Primary Health Care Centre. She has worked in AOD for over 10 years and has witnessed the impact of substance misuse on her family, friends and township and wanted to make a difference to support the next generation of leaders in the Barkly region. Diane is passionate about her work in the community, and believes from little things, big things grow.

Lyn Mayne

Dr Lyn Mayne graduated from Adelaide University (1984), and has successfully completed Professional Certificate in Management, and Clinical Team Leadership program. After 10 years in her own private practices, Dr Mayne moved to Broken Hill to be the sole dentist for the Royal Flying Doctor Service. During her time with the RFDS South Eastern Section, Dr Mayne has been an integral part in the expansion of the dental service, which now operates from both Broken Hill and Dubbo bases, providing much needed dental services to rural and remote areas of NSW. She has mentored many dental students from Australian universities, as well as students from overseas, and is a Clinical Associate at the University of Sydney and an Honorary Lecturer at the University of Adelaide. Dr Mayne has been an active member of the Australian Dental Association, both at State and Federal level.

Peter McCormack

Peter McCormack has been involved in rural and remote nursing as a clinician and nursing manager since 1987, having worked across both Cape York and Torres Strait. He was in the first cohort to complete the Rural and Isolated Practice Registered Nurse (RIPRN) course in 1999 and maintains his Scheduled Medicines endorsement through regular periods of practice. For the last 6 years, Peter has been involved in quality, safety, clinical governance and clinical support for rural and remote areas across Queensland. Peter is currently the Director of the Rural and Remote Clinical Support Unit which produces the Primary Clinical Care Manual, the Chronic Conditions Manual and the Pathways to Rural and Remote Orientation and Training.

Maz McGann

Maz McGann has worked with communities for over 15 years, starting off in community centres developing adult community education programs that focused on skills development and social inclusion. Ten years with local government followed working in regional Victoria and South Australia developing and leading a range of community cultural development programs and community-based services from large-scale events and exhibitions to more discreet artist development and community engagement programs. From 2009 until early 2014 Maz was with the Barossa Council, managing their Regional Gallery, Library Services, Home Assist and Community Transport, Leisure Options Programs for people with disabilities, Youth Services and Volunteering. More recently, Maz has enjoyed working with a range of broader sector-based organisations in both a paid and voluntary capacity, including the Regional Galleries Association SA, the Creative Communities Network and Creating Australia, the national peak body for community arts and cultural development, where she was CEO for a period of time. Maz is now working part time for the Institute for Creative Health as their Director Special Projects and runs her own community and cultural development consultancy called Play Your Part. Her general approach is that most people want to be more

than just spectators and she strives to develop programs and initiatives which encourage people to get involved and play a part in fostering connections with their own culture and values and contributing to the broader community.

Joe McGirr

Associate Professor Joe McGirr is Associate Dean Rural of the University of Notre Dame Australia School of Medicine Sydney. He lives in Wagga Wagga with his family and is passionate about improving health services in rural and regional areas. He has worked in clinical medicine and senior health administration in south west rural and regional NSW for more than twenty years. He originally practised clinically as a specialist in Emergency Medicine before making a career in health administration, becoming Chief Executive Officer of the Greater Murray Area Health Service and then Director of Clinical Operations for the Greater Southern Area Health Service. He is a fellow of both the Australasian College for Emergency Medicine and the Royal Australasian College of Medical Administrators. He has worked closely with patients, communities and clinicians on a range of issues affecting health services. He played a critical role in the establishment one of the first rural clinical schools in Australia in Wagga Wagga. Currently his research interests include climate change, health services and rural medical workforce and he oversees medical school campuses in Wagga Wagga, Lithgow and Ballarat.

Charmaine McGowan

Charmaine McGowan has a background in health statistics and has been employed by the Australian Bureau of Statistics (ABS) for the past 4 years. Charmaine has worked on many ABS health publications and products, such as the Australian Health Survey and the Australian Aboriginal and Torres Strait Islander Health Survey. A major focus of her work has been around disseminating the biomedical health statistics for these two publications. She is passionate about health statistics and health promotion.

Alex McInnes

Alex McInnes has been a CemeNTstar from when the group was first formed in 2009. Since then he has starred in every production, including *Jules Heart Romeo*, *Safe Harbour* and *CemeNTstars Go Melodrama*. He has also appeared in the short movie *Super8*. Alex is very passionate about his acting and says 'I feel like a professional now. I've improved on speaking out louder to the audience and I want to pursue a career in acting ... You can show what your emotions are and also pretend to be other people.' When not attending drama workshops and rehearsals, Alex also plays baseball and enjoys working in the shoe and coffee shop at Down Syndrome Association NT.

Lachlan McIver

Dr Lachlan McIver is a rural generalist and public health practitioner, with special interests in remote, Indigenous and tropical health. Lachlan is an Associate Professor of

Tropical Medicine at James Cook University; a Consultant for the World Health Organization Western Pacific Regional Office in the fields of Emergency Humanitarian Action and Environmental Health; and Consultant Clinician/Academic Program Leader for the Vanuatu Ministry of Health, where he supervises the junior doctor training program for Vanuatu. Lachlan is the Chair of the ACRRM Research Committee, is involved in several research projects focused on rural health in Australia and abroad, and recently submitted his PhD via the Australian National University.

Carol McKinstry

Dr Carol McKinstry is a registered occupational therapist. She was instrumental in setting up the La Trobe Rural Health Occupational Therapy Program in Bendigo and currently coordinates the program. She teaches a range of subjects including evidence-based practice, project management and coordinates the practice education placements for occupational therapy students including the innovative service learning community placement. In 2014, Carol was awarded a La Trobe University Teaching Citation for Student Learning. Carol currently supervises 8 higher degree students and her research interests are cancer rehabilitation, rural health workforce development, community engagement and practice education models. She gained her Ph.D. in 2008 investigating workplace learning for newly graduated occupational therapists. She is a sub-editor with the Australian Occupational Therapy Journal and a reviewer for a number of national and international occupational therapy and rural health journals. She chairs the Occupational Therapy Australia National Reference Group for Continuing Professional Development and the WFOT-OTA committee to ensure Australian occupational therapy programs comply with the minimum educational standards of the World Federation of Occupational Therapy. Carol is also on a number of community boards including the Rochester & Elmore District Health Service.

David McMicken

David McMicken is the Co-Artistic Director of the multi award winning Tracks Dance Company with Tim Newth. David's initial training in dance, theatre, literature and music (in Melbourne) helped him develop an interest in multi-art form early in his career. After a successful career as a performer and artistic director in several dance and performance companies in Tasmania and Victoria, he came to the Northern Territory in 1991. Employing his skills in the arts, education, and community cultural development, David has worked as dance development officer at Browns Mart Community Arts, and he steered the formation of Tracks Dance Company as a leading community based dance and performing arts company. This company works with community members of all ages and backgrounds. The company has a twenty-five year cultural development relationship with the remote Indigenous community of Lajamanu, and has run the Grey Panthers seniors dance troupe since its inception in 1988. David was made a Member (AM) in the general division of the Order of Australia in 2014.

Antonio Mendoza Diaz

Antonio Mendoza Diaz is a PhD candidate under the supervision of Professor Mark Dadds at the University of New South Wales, where he studies the emergence of attachment in children with callous-unemotional traits. He also collaborates in a research partnership between UNSW and Royal Far West, delivering one of the first online treatments for disruptive behaviour disorders to children from rural New South Wales. Antonio is the recipient of several competitive scholarships, and hopes to effectuate significant societal change through his commitment to childhood mental health. He is extremely grateful to the organisers of the 13th National Rural Health Conference for allowing him to participate in this inspiring endeavour.

Jacqui Michalski

Jacqui Michalski is a Student Support Officer with the Greater Green Triangle University Department of Rural Health in Mt Gambier Sth Australia. Jacqui provides and assists all health science degree students undertaking clinical placement in the Greater Green Triangle region (Sth East SA and Western Victoria) with accommodation, admin support and pastoral care. She has worked for the GGT UDRH for the past 7 years and is passionate about ensuring students on rural clinical placements have a positive experience with the aim of encouraging students to consider taking up a health career in a rural location after graduation.

Bethany Miles

Bethany Miles is a public health nutritionist/dietitian with the NT Department of Health, and has been part of the outreach team servicing the Tiwi Islands and Belyuen for the last two years. This has involved working on projects such as building and implementing store nutrition policies with local boards, antenatal cooking programs, adult healthy lifestyle programs, and anaemia prevention initiatives. Prior to this she worked for two years as a dietitian in the private industry. This involved nutrition education and health coaching with chronic disease clients in fourteen Top End communities, as well as working clinically in hospital and Aged Care settings. Her upbringing was in the Kimberleys and Darwin, and she graduated from the Bachelor of Nutrition and Dietetics (Hons) at Flinders University in 2010.

David Mills

Dr David Mills grew up in Adelaide, South Australia doing medical training at Flinders University and graduating in 1994. He moved to the Northern Territory after completing his internship, and ended up staying for five years, doing three years of hospital training, particularly in obstetrics and anaesthesia. David was fortunate enough to then be employed in Katherine for the completion of his postgraduate degree in rural general practice. A six-week rotation as a student in PNG eventually led to his full-time return to Kompiam in Enga Province in 2000. He has been employed as Medical Superintendent there since that time, working at various times with up to two other doctors, but also unfortunately for long periods on my

own. That journey has been shared with his wife, Karina, and four children (Natasha, Ashleigh, Chelsea and Nicholas). The experiences in Kompiam have been key in the ideas that led to the setting up of PNG's first training program for rural doctors. David is President of the PNG Society for Rural and Remote Health.

Carmel Mitchell

Carmel Mitchell is an active, passionate community member, she has been involved in community and charity work since she was 7 years old when she joined Junior Red Cross in Monbulk. She works in voluntary and paid positions in disability, medical and community sectors. Carmel currently holds the following positions: State Vice President, Country Women's Association; Personal Support Officer and Single Incident Officer, Red Cross; Chairperson and CWA spokesperson on Travellers Aid Victoria.

Chris Mitchell

Chris Mitchell is CEO of Health Workforce Queensland (HWQ), a not-for-profit rural health workforce agency that creates sustainable health workforce solutions to meet the needs of remote, rural, regional and Aboriginal and Torres Strait Islander communities in Queensland. Chris leads HWQ in its work to understand the needs of Queensland communities, especially their health needs, so as to ensure optimal health workforce are available. Chris possesses a degree in Health Administration and a Masters of Business and has over 30 years of leadership experience in health workforce development. He has worked in a variety of communities including Griffith, Sydney, Dubbo, Brisbane and remote and rural Queensland. These roles have provided him with extensive experience in health service management and delivery across diverse geographic areas. Chris has a comprehensive understanding of health workforce development, industry trends and the impact and challenges of health workforce shortages in remote and rural communities. A particular interest is in collaborative solution creation activities with communities and stakeholders to optimise health service delivery and improve health outcomes. Chris has facilitated a number of action research projects in remote and rural Queensland that focused on health service redesign to ensure that communities had access to viable health services.

Nerrida Mitchell

Nerrida Mitchell is an active community member and social worker in the sexual assault and family violence field. Currently working at the Victorian South Eastern Centre Against Sexual Assault and Family Violence (SECASA) as a senior counsellor, team leader and sometimes Acting Manager. Has worked in the family violence and child abuse field in the United Kingdom; Vietnam and Australia in training/development and direct service work.

Renae Moore

Renae Moore has a professional background as a speech pathologist with experience across remote, rural and urban settings in health, education and community services. In 1995, Renae moved to the NT as the Principal Speech Pathologist and Manager of the Community Health Paediatric Team for the Department of Health. Renae's return to the Top End from her professional beginnings as a sole speech pathologist in remote north-west Queensland saw her professional journey come full circle. Renae has been actively involved in rural and remote allied health issues at a local, State/Territory and national level throughout her career. Over the last 13 years, Renae has worked in a variety of senior policy and project roles across Aboriginal health, early intervention, aged and disability and workforce strategy. As the Principal Allied Health Advisor, Renae is responsible for providing strategic allied health leadership for Northern Territory Health in the areas of professional practice standards and governance, education and training, workforce innovation and reform. Renae is also actively engaged in the development of cross jurisdictional partnerships across Greater Northern Australia to support the development of rural remote generalist allied health education and training pathways.

Mandy Morcom

Mandy Morcom has lived and worked in her rural and remote community in north-west Victoria for 30 years commencing her nursing career as an Enrolled Nurse in 1982. While being married to a local farmer and raising four children she completed an undergraduate nursing degree in 2004 which opened her mind to emergency, primary and palliative health care. Since then Mandy has obtained a postgraduate diploma in Rural Nursing, is a Rural and Isolated Practice Endorsed Registered Nurse and in 2012 completed a Master of Nursing (Nurse Practitioner) at La Trobe University. For the past eighteen months she has been employed fulltime as a Nurse Practitioner at Rural Northwest Health. In her role as Nurse practitioner Mandy also holds the Urgent Care and Standard 9 portfolios but her passion and drive is about her local and broader community being able to access timely, appropriate health care as close as possible to where they live.

Angela Morgan

Angela Morgan has worked in health care since 1990 and her background is in Nursing and Midwifery. Currently, Angela works as a Practice Development Officer for Hunter New England Local Health District, her main focus is on redesigning existing and implementing new models of care. Angela's experience and skills in project management, practice development and the formation of new and innovative approaches has driven improvements in access to health services and better health outcomes for the community. Angela has a keen interest in chronic care, technology and Aboriginal and rural health issues.

Anna Morse

Anna Morse is Project Manager for the Aboriginal Vision Program of Brien Holden Vision Institute (the Institute). Anna first worked as a clinical optometrist in Alice Springs (2005-2008), which included one day per week with the Central Australia/Barkly outreach ophthalmology clinics. Since 2009, Anna has worked as part of the Institute's Darwin-based team, running an outreach optometry program now servicing around 80 community health centres and Aboriginal Medical Services (AMS') across the NT, predominantly in very remote areas. This program continues to expand, with increasing coverage and eye examinations each year since 2009. Its success relies on strong partnerships with Regional Eye Health Coordinators (REHCs), Aboriginal Community Controlled Health Services and remote community health centres deliver eye care services that are effective, accessible and appropriate. Other work supporting eye care systems includes education programs for REHCs and primary health care teams, participating in advisory or reference groups related to rural/remote and Indigenous eye care, and researching ways to strengthen eye care systems for remote communities. The latter particularly relates to a 5-year Vision CRC research project: "Models of vision care delivery for Aboriginal and Torres Strait Islander communities" (2010-2015), a participatory research program working with Aboriginal health services and many collaborating partners to develop, implement, evaluate and refine a set of practical tools to support improved eye care outcomes.

Greg Mundy

Greg Mundy is Chief Executive Officer at Rural Health Workforce Australia, the national body for the seven-State and Territory Rural Workforce Agencies. This network of agencies provides a range of mainly government-funded workforce programs aimed at improving access to health care services in rural and remote parts of Australia. Greg has worked in government and non-government roles in the health sector and headed the peak bodies for aged care providers and public ambulance services before taking up his current position. Greg worked for the Victorian Government in a range of senior roles in the health and community services sectors, including aged care, community health and mental health. Born in England, Greg studied in New Zealand and Australia and holds a Master's Degree from the Australian National University. Greg is a Fellow of the Australasian College of Health Services Management. Greg is a Council member and Board Director at the National Rural Health Alliance.

Sue Murray

Sue Murray lectured at University and TAFE while completing a Master of Arts at COFA, Uni NSW. She has been exhibiting since the mid-1990s in both group and solo exhibitions as well as undertaking commissioned projects including National Museum, Canberra as well as Liverpool and Bankstown Hospitals. Throughout her career Sue has been commissioned by numerous public organisations to develop creative projects with a diversity of community groups. "Bordered Lives" a photographic

project with young people living in temporary accommodation was exhibited in Bus Shelters in Sydney CBD and at The Australian Museum, Sydney. The main objective of Bordered Lives was to encourage teenagers to reengage with the education system through an arts practice and to communicate issues around homelessness to a broad audience from the perspective of the homeless youth. Sue developed Imagine Me with funding from a Delineate grant, Accessible Arts in partnership with Don't DIS My ABILITY Campaign sponsored by NSW Government, FACS. Imagine Me is a series of creative skill-building photography and digital-imaging workshops where participants create self-portrait artworks using professional photographic equipment, adapted for people with spinal cord injury.

Genevieve Napper

Genevieve Napper is Lead Optometrist Aboriginal Services at the Australian College of Optometry and has been involved in providing eye care at Aboriginal community controlled health services for over 10 years. Genevieve has a long term interest in improving eye care access for communities in need and through her work at the Australian College of Optometry participates in clinical education of optometry students, mentoring of new graduate optometrists and providing specialist services in ocular diseases and low vision. The role of Lead Optometrist Aboriginal Services involves clinical service provision at Aboriginal health services and coordinating a team of optometrists providing services at 20 Aboriginal community controlled health services around Victoria. Genevieve also contributes to national and state policy and service developments in Aboriginal eye care through participation in the Vision 2020 Australia Aboriginal and Torres Strait Islander committee and the Optometry Australia Aboriginal and Torres Strait Islander Eye Health Working Group. These groups enable collaboration with a range of key local and national stakeholders.

Kia Naylor

Kia Naylor is the Managing Director of Bodyfit NT, which is in its 9th year. Born and bred in South Australia, Kia moved to Darwin in 2005 for a lifestyle and career change after graduating from the University of South Australia. Kia has grown the company from a one women enterprise to a sustainable and award winning company with a fantastic team of over 20. With a strong passion in Indigenous health programs, Kia directed the company towards an extensive footprint servicing the rural and remote Indigenous communities of the NT. The first remote program being delivered in 2009 and now expanded to include over 30 programs and communities in the Top End and Central Australia delivering both Exercise Physiology and Physiotherapy services.

Jane Newman

Jane Newman is a Clinical Nurse Consultant Women's Health, currently employed with Mid North Coast Local Health District. She has worked in a variety of health and community settings for over 30 years. Jane has worked in Women's Health in various clinical and management roles for the past 15 years and her women's health vision

focuses on health promotion, intervention, early detection and empowering women in communities to take control of their health outcomes. This is achieved by education and support programs on a range of women's health topics, across the lifespan from puberty to managing chronic illness and aging well. Jane particularly enjoys developing programs to suit the needs of clients and the community. Jane lives in a beautiful rural coastal community and participates in many community events in the region. She has a passion for fine food and wine, long lunches with friends and is always planning her next holiday.

Randal Newton-John

Randal Newton-John is the Executive General Manager of Operations at On the Line, the provider of MensLine Australia. He holds a Bachelor of Arts and a Graduate Diploma of Health Science. Randal's clinical career commenced as a group facilitator and trainer. He has worked in the area of men's health and wellbeing for over 10 years as a counsellor, group facilitator and manager. Randal has overseen the development of the MensLine Australia service for the past five years, including the introduction of online chat and video counselling. Randal leads the Operations team in the management of all On the Line's service contracts. He has overall responsibility for the operations of eight counselling services, and more than 80 clinical staff. This involves overseeing staffing levels, developing and implementing procedures and monitoring service performance. Randal and his team play a significant role as On the Line continues to pioneer new modalities of remote counselling to the Australian community. Randal has presented at numerous conferences on MensLine Australia and is a regular media spokesperson for men's issues for On the Line. He has a particular interest in highlighting men's issues and encouraging men to seek support—like contacting MensLine Australia.

Leanne Nisbet

Leanne Nisbet is a PhD student at The University of Queensland, who brings a sociological lens to the issue of stakeholder engagement with eHealth technologies. Her research interest is drawn from her background in business sociology, organisational communication and behaviour. Leanne worked as a researcher on the Smarter Safer Homes for Older Australians project, conducting interviews with participants about the Quality of Life that the project's non-invasive sensory monitoring system had worked to deliver. Anecdotal evidence suggested a cultural disconnect between the stakeholder communities of practice involved with the design and delivery of technology and the communities of older citizens for whom the technology was designed. With any technology, there are always winners and losers—and many older citizens (remote, for whatever the reason) may well become the losers unless there is an understanding of the deeply cultural factors that might prevent the technology from improving their quality of life. Leanne's PhD research will develop a series of typologies aimed to bridge that disconnect, describing the culture of older citizens in two case study towns. Her PhD topic is "Developing strategies to support the successful

implementation of technological innovations to older citizens within the Northern Inland region of New South Wales."

Amanda Norton

Amanda Norton is responsible for the Primary Health Care, Chronic Disease Clinical Nurse Service at Ayr Health Service, Townsville Hospital & Health Service, Rural Hospital Service Group, since 2007. The role involves the expansion to case manage across a broad spectrum of multidisciplinary teams of specialist and allied health to coordinate the optimum care for complex multi-chronic disease markers. This service allows emphasis on identification in adult education learning styles and apply resources at the level of knowledge base to the individual. This improves the individual education uptake on understanding health conditions, how to reduce late presentations, medication compliance through linking pharmaceutical benefits and close the gap. This results in an understanding of how to get the best from service providers and encourage self responsibility. Amanda's passion has grown for client self-empowerment to ensure they take a lead and proactive role in the disease management, particularly with diabetes, cardiac rehabilitation, heart failure and chronic kidney disease.

Shannon Nott

Shannon Nott is a passionate and enthusiastic doctor, keen to make a difference in rural and remote health. His passion for creating a improved and sustainable health system, particularly in the field of rural and remote health has seen him win numerous prestigious awards including Australian Medical Student of the Year, NSW Finalist for Young Australian of the Year, and recently runner-up for AMA's Junior Doctor of the Year. In 2014, Shannon travelled through Canada, USA and Brazil as a part of a Churchill Fellowship looking at ways in which telehealth programs can improve outcomes in rural and remote communities. Shannon's leadership within the field of health has also seen him be the youngest member appointed to the previous Minister's Men's Health Reference Group as well as the NSW Australia Day Council. He also sits on multiple advisory committees for the Clinical Excellence Commission and the Agency for Clinical Innovation. Shannon was the founding Co-Chair of Future Health Leaders, an organisation initially working alongside Health Workforce Australia to represent Australia's health professionals in-training. Future Health Leaders aims to develop both innovative and sustainable solutions to current health issues in Australia through engagement with students and early-career health professionals across professions and sectors.

NRHSN

The National Rural Health Student Network (NRHSN) is the only student body in Australia that collectively represents medical, nursing and allied health students. It has more than 9,000 members who belong to 28 university Rural Health Clubs. The NRHSN is funded by the Federal Department of Health and is managed by Rural Health Workforce Australia, the peak body for the state and territory Rural Workforce Agencies which attract,

recruit and support health professionals for rural and remote communities. The 2014 NRHSN Medical Officers: Joshua Mortimer (UNSW), David Khoo (Deakin University), Natalie Kew (University of Melbourne) and Dr Viktor Ko (Notre Dame University), surveyed health students to understand student views towards the Bonded Medical Place (BSP) and Medical Rural Bonded Scholarship (MRBS) schemes as a means of addressing rural workforce shortages.

Margaret O'Brien

Margaret O'Brien has over 12 years' experience within the Aboriginal Community Controlled Health sector. With a background as an Aboriginal Health Worker, she currently works as a Recall Support Officer at Danila Dilba Health Service covering the Yilli Rreung region of Darwin and surrounding areas. Margaret works as part of a multidisciplinary team facilitating continuity of care through a systematical and holistic approach to managing chronic conditions and following up acute conditions. She also assists other program areas such as maternity, cardiac, diabetes, renal and child health with high risk or difficult to engage clients. Margaret's role involves advocating for and assisting urban and remote clients to engage with tertiary care services and facilitating re-engagement with primary health care service after episodes of tertiary care. She has previous experience with Home Medicine Reviews undertaken with various pharmacists. Margaret is currently undertaking a Master's of Public Health through Deakin University, and has been an Aboriginal and Torres Strait Islander Consumer representative on the Northern Territory Maternity Health Network since 2008. In 2014 Margaret participated as an Aboriginal Research Fellow on the Wellbeing Study, an Australian Primary Health Care Research Institute funded study undertaken by the South Australian Health and Medical Research Institute.

Teresa O'Connor

Dr Teresa O'Connor provides academic and pastoral support to the MBBS students at James Cook University. She has a strong health background, working in clinical nursing and health management for many years and latterly in nursing and medical education. She lived and working in rural areas of Queensland and South Australia for over 25 years. Her interests are in providing appropriate support for students, particularly those who are challenged academically or personally by their chosen courses. She has a strong commitment to ensuring quality graduates who are able to maintain patient safety and professional standards. She has postgraduate qualifications in Education, Counselling and Public Health.

Maree O'Hara

Maree O'Hara has been the Barkly Regional Eye Coordinator at Anyinginyi Health Aboriginal Corporation in Tennant Creek N.T. for the last 9 years. She organises the optometrist and ophthalmologist clinics in the Barkly region, and with her assistant facilitates these clinics. Her role also involves Health Promotion and a recent collaboration with Fred Hollows Foundation has resulted in a DVD "Looking Better" now available on request. She has worked in Aboriginal health, education and

employment for the last 28 years. She has worked in these areas in not only Tennant Creek but Thursday Island, Normanton, Mount Isa, Tennant Creek, Weipa and Borroloola. She works in partnership with the Fred Hollows Foundation, Brien Holden Vision Institute, Alice Springs Hospital Eye Clinic and OPSM. She was nominated in 2012 for an Australia Day award for her work in Eye Health.

Emily O’Kearney

Emily O’Kearney is a physiotherapist who has a passion for global health. She completed a Master of International Public Health in 2012. Her Master’s research project was completed in Vietnam, investigating barriers to physical rehabilitation. Emily managed the Northern Territory Cerebral Palsy Register while she worked at Darwin’s Centre for Disease Control from 2013 to 2015 and recently published the first report for the Northern Territory Cerebral Palsy Register. Emily is currently volunteering with the Australian Red Cross as a health promotion officer for people with disabilities in Cambodia.

Yvonne O’Neill

Yvonne O’Neill is an Aboriginal woman from Goodooga NSW. Her mum is from Yuwaalaraay/Kamilaroi people and her dad a Noonghaburra man. Yvonne has worked in different industries but most recently worked in Indigenous Education. Today she works under the Federal Government funding package Helping Children with Autism as one of two Aboriginal and Torres Strait Islander liaison officers working with service providers, Indigenous communities and families giving opportunities to learn more about autism spectrum disorder and what services are available for support. Yvonne is an accomplished Aboriginal Artist and have artwork hanging in the Vatican Museums in Rome, Italy. She has also represented Australia playing Rugby League.

Rod Omond

Dr Rodney Omond currently works for Top End Primary Care (DoH) NT, and visits Pirlangimpi on the Tiwi Islands weekly. He is also reorganising the Low Acuity Evacuation system in the Top End, arranges Education and Training for Department of Health (DoH) Rural Medical Practitioners (RMPs) across the NT, participates in the Top End Duty RMP roster, and is a member of the Human Research Ethics Committee of the NT DoH and Menzies School of Health Research. Rod is also the representative for the NT on the RACGP National Rural Faculty Board. In the past I have run a small hospital in the Solomon Islands for two years, and had my own practice with a colleague in Newcastle for 7 years. I also worked for Hunter Urban Division GP and was the Chair of their Board for 3 years.

Fiona Onslow

Fiona Onslow is the Director of State Operations at The District Nurses in Tasmania. Fiona is a Registered Nurse with a Postgraduate in Family and Community Health, and is currently completing her MBA. Fiona has worked in rural, regional and metropolitan facilities in Western Australia and Tasmanian across her 18 year career. Fiona

more recently secured funding for her organisation to deliver hospice@HOME packages of care across Tasmania in a project for Better Access to Palliative Program.

Chloe Oosterbroek

Miss Chloe Oosterbroek is a Health Sciences Graduate who majored in psychology and who also successfully completed an Honours degree investigating the health status, health knowledge and health seeking behaviour of men in rural SA men’s sheds. Chloe is currently a research assistant at the UniSA, University Department of Rural Health with research focusing on male health, psychological health, health promotion and men’s sheds. She has had an active role in the development of the Whyalla Men’s Shed both as a shed member and as Secretary to the Management Committee.

Peter Orpin

Peter Orpin is a Senior Research Fellow with the Centre for Rural Health at the University of Tasmania. He has an early background in the medical laboratory sciences before moving on to the social sciences and completing a PhD in Sociology. Peter has had a long interest in how people and communities deal with change. Over the last ten years he has been part of a team conducting a series of research projects looking into issues around rural ageing. The team is presently working in partnership with Monash University on an National Health and Medical Research Council Partnership grant to look into the evidence base of policy to support ageing well in rural and regional communities.

Belinda O’Sullivan

Belinda O’Sullivan is a PhD candidate, supporting the rural health research theme with the Medicine in Australia: Balancing Employment and Life Survey (MABEL), a large longitudinal survey of Australian doctors. Her research aims to inform policy and planning of rural outreach services by specialist doctors by using information about current practice across Australia. Belinda has over ten years’ experience in health workforce capacity building and program evaluation. She has also worked in applied public health practice and research with the New South Wales Ministry of Health and is a graduate of the NSW Public Health Officer Training Program. Throughout her career, Belinda has worked in a range of rural and remote locations, to undertake clinical work as a physiotherapist as well as public health projects. She is currently located in the School of Rural Health, Bendigo, Victoria.

Marjorie Pagani

Marjorie Pagani is the Chief Executive of Angel Flight Australia. A founding volunteer pilot, Marjorie has also been the *pro bono* aviation lawyer for the charity since before its inception. She is a practising barrister, mediator, arbitrator, commercial pilot/aircraft owner (having run her own charter operation for many years) business owner and councillor in far North Queensland. Marjorie has previously been a long-serving presiding member of the Queensland Anti-Discrimination Tribunal, the Mental

Health Review Tribunal, Parole Board, a former Director of the Townsville Port Authority and a former Squadron Leader in the RAAF specialist legal corps. In her early career, she was a lecturer in history, politics, and law at Townsville's James Cook University, and was awarded the first honorary life membership of the JCU Law Society. Marjorie is married to Damon, a chief pilot based in the Northern Territory, and has three sons, and six grandchildren. In her 'down' time she breeds cattle as a hobby farmer, and spends as much time as possible boating on the reef.

Penny Paliadelis

Penny Paliadelis is the Executive Dean of the Faculty of Health, a role she has held since January 2014 at Federation University Australia, which is Australia's newest university, created in 2014 from an amalgamation of the previous University of Ballarat and the Gippsland campus of Monash University. FedUni has 3 campuses across regional/rural Victoria. Prior to this Penny was the Acting Head of School of Health at the University of New England in NSW, where she worked for 15 years. She has a broad understanding of the challenges and opportunities of living and working in rural contexts. Penny's research interests focus on collaborative interprofessional health education and practice, particularly rural health workforce experiences and capacity-building. Penny has researched and published widely in the areas of nursing management and interprofessional education and practice. Penny has attracted a number of grants and supervises doctoral students as well as mentors colleagues to gain higher degrees and build their research profiles. She has wide experience with curriculum development for a range of professional-entry (accredited) health courses, particularly in the blended and online delivery mode. Penny is currently involved in a project that explores the use of digital storytelling as a learning framework.

Didier Palmer

Didier Palmer was born in England, spent his childhood in Africa and qualified from the University of Wales School of Medicine (UK). After a few years working in various specialties and picking up a few Fellowships along the way he knew what he did not want to do. Back then the only specialty he could envisage that would still excite him when he was 50 was emergency medicine, and that has been proved true. Emergency medicine and particularly its Australasian variant developed by ACEM, has given Didier a great deal. Involvement in college bodies is a way of giving something back and hopefully being a voice for Northern Territory issues. Didier relaxes by riding horses and motorbikes—it would be fair to conclude that adrenaline is what first attracted him to emergency medicine but what has kept him there is the ability to contribute to education, system improvement and culture change—that is a more lasting buzz.

Annette Panzera

Annette Panzera (BMgt, MPH) is a project manager/senior research officer with the ABCD Case Studies project "Lessons from the best to better the rest" at the Anton Breinl Research Centre for Health Systems

Strengthening, James Cook University (JCU), north Queensland. This project is NHMRC funded research and looks at the role of continuous quality improvement (CQI) in six high performing remote primary health care centres. She has also worked with Queensland Health (QH) in north Queensland on several clinical redesign projects. Previous to coming to JCU/QH in late 2010 she spent 10 years working at the Organisation for Economic Cooperation and Development (OECD) as a statistician and policy analyst in Paris. Here she focused on producing quantitative health, education and family policy research. Some examples of OECD health publications that she contributed to include Health at a Glance (in particular Health Quality and Care Indicators), Child Health Indicators for the OECD Family database, and several case studies on the role that private health insurance plays in OECD member's health systems (including Australia).

Leonie Parker

Leonie Parker is a nurse practitioner in women's health based in Condobolin in the centre of NSW. Leonie completed both her general nurses and midwifery training in Sydney and when the Condobolin Health Service maternity unit closed its doors, Leonie turned her attention to women's health and has been specialising in women's health for 15 years. Leonie completed a postgraduate certificate in Sexual and Reproductive Health in 2000, a postgraduate certificate in Women's Health in 2004 and a Master of Nursing: Nurse Practitioner in 2006. Leonie has been an authorised nurse practitioner since 2007 and provides outreach women's health services to Lake Cargelligo, Tullamore, Trundle and Tottenham and has more recently been involved in establishing a the first Australian Nurse Led Colposcopy/Gynaecology Clinic at The Orange Aboriginal Medical Service. Leonie was a finalist in the NSW Excellence in Nursing Awards in 2014 and is the recipient of the 2015 Australia Day, Citizen of the Year for Condobolin, for her work in women's health. Leonie's passions outside work are cooking, spending time with her animals and playing the ukelele!

Penny Parker

Penny Parker spent her early career working as a Registered Nurse in both South Australia and the Northern Territory (NT) and held a number of positions including Clinical Nurse Consultant at the Royal Adelaide Hospital. Her experience covers both the public and private sectors and working with both urban and rural health services. In 1996, she was appointed as the Quality Manager for the Darwin Private Hospital until her appointment to the public sector in 2002 where she was responsible for quality improvement programs across a broad range of health and community services. Ms Parker held this position until 2003 when she was appointed as the Quality Manager for the NT Hospital Network which comprised the NT's five regional hospitals. From 2012–2014, Ms Parker was the Manager Audit and Risk Management Services for the NTG Department of Infrastructure gaining contract governance skills and assisting the department to improve the effectiveness of governance, risk management, and control processes. In

January 2014, she left the public sector and is currently the Contract and Performance Manager for CareFlight Northern Operations. Ms Parker has a key role in relation to, contract management, performance review and continuous improvement across the Operation.

Kelly Paterson

Kelly Paterson is a physiotherapist working in paediatrics at Royal Darwin Hospital, providing physiotherapy services to inpatients and outpatients from all medical and surgical areas including neonates, infants and children. Kelly has been working in Darwin for over 18 months, and has previously worked in paediatric physiotherapy in Brisbane and south-east Queensland, with an emphasis on Paediatric orthopaedic work. With the support of the RDH orthopaedic team, Kelly coordinates and provides Ponseti casting management for infants and children with clubfoot from remote as well as metropolitan areas of the Top End. Kelly is hoping to be travelling to Iowa (USA) later this year for specialised training in the Ponseti method.

Karen Paxton

Karen Paxton joined the School of Rural Health in 2007 to develop and coordinate the ARCHER Study (Adolescent rural cohort, hormones, health, education, environment and relationships). Karen has a background in rural nursing and midwifery in the public and private sectors. In the past she has also coordinated other research projects with the School of Rural Health and Division's of General Practice. She has keen interest in rural health, adolescent health and qualitative research.

Kristy Payne

Kristy Payne is a research officer with the University of Western Sydney's Rural Clinical School in Bathurst, NSW. In this role, Kristy works closely with the Orange Aboriginal Medical Service (OAMS) to support research in the area of Aboriginal health as well as contributing to the school's research in rural medicine. Kristy is involved in a broad range of research projects covering topics such as population health, health service evaluation, health service access, youth health perspectives, and health attitudes and behaviours. Kristy has a background in psychology and epidemiology with several years experience in youth mental health research. She has an interest in both qualitative and quantitative research methodologies for exploring the health of rural and regional populations and their access to health services and prevention.

Rodney Peadon

Rod Peadon is currently the Manager of the iSimCentre (interprofessional Simulation Centre) located at Coffs Harbour on the Mid North Coast of NSW. Rod has extensive experience as a health care educator and has been involved with simulation as a tool for education for most of his career. Rod is a registered nurse with acute care, emergency and critical care experience. He has 10 years' experience as a nursing officer in the Australian Regular Army and was deployed to the Rwandan

Emergency in 1994. Rod has experience in nursing in variety of rural settings including nurse management, clinical nurse consultancy and as a whole of health learning and development consultant and service manager. His achievements include the development of the Emergency Nursing Guidelines for NSW with his fellow CNC for Critical Care, the introduction of eLearning as an education tool to NSW Health and now the development of the iSimCentre and championing of Simulation as a training methodology within the Mid North Coast NSW. Rod has completed The Institute of Medical Simulation (Harvard) Instructor Training: Simulation as a teaching tool as well as the Advanced Debriefing Course. In addition Rod has also completed the Winter Institute for Simulation Education and Research (WISER)—Pittsburgh iSIM (Improving Simulation Instruction Methods).

Dianne Penberthy

Dianne Penberthy is a registered nurse, with qualifications across three disciplines in nursing. She holds an Advanced Diploma in Business Management. Dianne is currently employed by the Mid North Coast Local Health District working in Aged Care Services. She has worked in a variety of positions working across services, disciplines and health departments for over 40 years. Dianne has worked in various clinical and management roles in Mental Health, Disability Services, Women's Health, Community Health, Health Promotion Clinical Governance and Aged Care. Dianne's passion has been to develop new innovative ways to do business within our health system which focuses on empowerment and creative visionary way of working. Dianne held the position Health Promotion Coordinator working for the Rural Primary Health Service Macksville Community Health 2005-2013. In this position she worked in partnership with other services agencies and health professionals developing many new initiatives and programs including the Losing It—In the Bush Program that have been sustained and is still being run today. Dianne has lived in Port Macquarie NSW a rural coastal town for over twenty years with her husband and three children and one granddaughter. Her passion is rural country living by the beach.

David Perkins

Professor David Perkins is currently Director and Professor of Rural Health Research at the Centre for Rural and Remote Mental Health (CRRMH), The University of Newcastle. From 2008 to 2013 he was Director and Associate Professor for the Centre for Remote Health Research, Broken Hill University Department of Rural Health, University of Sydney. From 2009 to 2013, he was appointed Conjoint Associate Professor, School of Medicine and Public Health, Faculty of Health, University of Newcastle. Professor Perkins research interests have been primary health care systems in rural and remote settings with a particular interest in mental health services. He has led research focused on providing empirical evidence to inform policy and implementation of mental health service delivery for rural and remote areas. He is a member of the NSW Minister's Advisory Committee on Rural Health and a board member of the International Foundation for Integrated Care. Since

2010 Professor Perkins has been awarded nearly \$6 million in grant income. In this period his publications record includes over 30 peer reviewed papers and a similar number of editorial pieces. Professor Perkins is editor in chief of the *Australian Journal of Rural Health* and is a senior editor of the *International Journal of Integrated Care*.

Leigh Philpott

Leigh Philpott is a social worker with ten years' experience working in rural and remote mental health. Whilst working within Hunter New England Local Health District he has taken on a number of senior leadership roles, being recognised at the local and state level for innovation and success in leading positive change for rural and remote communities. He currently holds dual roles within the service as District Service Development Manager and Service Manager for Tablelands and Mehi Cluster. During this time he has overseen growth in recruitment and retention, achieving full staffing in all remote and rural sites within the area, as well as implementation of clinical and operational telehealth programs and processes aimed at increasing effectiveness of leadership and management over distance and improving access for isolated consumers to access specialist mental health services. Firmly committed to improving health services for rural and remote communities, he lives in Tamworth NSW and is currently completing his MBA. In addition to leadership, management and distance technology in health, his other interests include ethics in coercive practice, education and training, health policy and organisational change management.

Felicity Pidgeon

Felicity Pidgeon graduated from Charles Sturt University in 2002 with a Bachelor of Health Science in occupational therapy. Following graduation she worked in a small multi-purpose rural health service in Orbost, Victoria. She has been working with the Northern Territory Department of Health Service for the past nine years in the Top End Remote Disability Services Team. In this role she travels to Indigenous communities around the Top End region, working with clients across the age range. Her diverse case load covers early intervention, school aged, disability and aged care services. Felicity completed a Masters in Remote Allied Health Practice through the Flinders University in 2012. In 2013 she was awarded with a Churchill Fellowship which allowed her to visit allied health teams servicing Indigenous persons living in very remote areas in Canada and the USA to compare service provision and models and to share ideas and resources.

Claire Pilkington

Claire Pilkington graduated from the University of Newcastle in 2001 with a Bachelor of Health Science (Occupational Therapy) (Honours). Claire has experience working with paediatric and adult clients in numerous parts of Australia including country NSW, Newcastle, Kimberley Region in Western Australia and in the Northern Territory. Since moving to Darwin in 2010, Claire has been working in the Top End Remote Office of Disability team. This has involved working as an

occupational therapist and clinical leader providing specialist support in the area of paediatric disability. Claire is passionate about disability services and the provision of quality services in remote regions. Claire completed a Graduate Certificate in Social Change and Development in 2012 and Certificate IV in Frontline Management in 2014.

Michelle Pollard

Michelle Pollard is the Project Support Officer with the Brien Holden Vision Institute and has been with the Institute for the past year and a half in this position. Michelle comes from an administration background and is currently studying a Bachelor of Humanitarian and Community Studies at Charles Darwin University. Michelle's current role includes the coordination of the outreach schedule and bookings for the outreach optometry trips within the Aboriginal Vision Program in the Northern Territory. She regularly liaises with remote clinics, ACCHOs and locum optometrists to ensure the outreach trips run as smoothly as possible.

Dimity Pond

Professor Dimity Pond is head of the Discipline of General Practice at the University of Newcastle. She is a GP with a Fellowship of the RACGP, and has continued in clinical practice, including nursing home practice, throughout her academic career. She has a long track record of research on dementia in General Practice, and is currently exploring the implications of this problem in remote Indigenous communities, including some education around the issue for health workers and community members. In the past 3 years she has made a number of visits to remote communities to learn and to explore options with community members and with other workers. Professor Pond has contributed over 80 peer reviewed publications. She has worked on knowledge translation from research into general practice, including contributions to the GP "Red Book" of preventive activities around aged care and dementia, contributions to the "Check" training program for GPs around the elderly, and regular teaching sessions at postgraduate and undergraduate level. She has also served on a number of government advisory groups including most recently the Ministers Dementia Advisory Group, which advised the Commonwealth government on matters relating to dementia.

Kelli Porter

Kelli Porter holds qualifications in health promotion and health policy and management. She has over 20 years' experience working in health within the government and not-for-profit sectors and in private general practice. In her role with Rural Health West as Manager Workforce Development, Kelli contributes to primary care planning for health workforce solutions in rural Western Australia, promotes rural health careers to the future health workforce, and provides business support to rural general practices.

Rachael Purcell

Dr Rachael Purcell is a medical resident in Victoria. She is passionate about the health issues facing rural and regional Australians. She holds MBBS and BMedSc (hons) degrees from Monash University and a Masters of Public Health from the University of Queensland. She is a member of the John Flynn Placement Program National Parking Panel and has been a delegate to the United Nations Framework Convention for Climate Change 19th Conference of the Parties and the 63rd Session of World Health Organisation Regional Committee for the Western Pacific. Her research interests include the health impacts of climate change for rural communities and health services, factors influencing medical students' intentions to practice rurally, and the development of neonatal incubators for use in resource-poor settings.

Megan Purvey

Dr Megan Purvey is a medical doctor and specialist advanced trainee with the Australasian College for Emergency Medicine, having undergone basic and provisional training at the Royal Brisbane and Women's Hospital and Mackay Base Hospital. During her training in Mackay, Dr Purvey developed an interest in the challenges facing rural health, forming an interest in the health care utilisation of working men in these areas. In addition to her clinical duties, she is also studying a Master of Public Health at the University of Queensland.

Christine Putland

Christine Putland is a consultant specialising in research and evaluation of arts and cultural initiatives designed to improve public health and wellbeing. She has a background spanning community arts, public policy, and public health fields. Her qualifications include an Honours degree from the Flinders University Drama Centre, DipEd in Drama and English teaching from Sydney University, a Masters and PhD from the Flinders Institute for Public Policy and Management. Christine worked in community development and community services management in local government and non-government organisations within SA and NSW for more than a decade. She later joined the Department of Public Health at Flinders University as manager of a research consultancy for the Commonwealth Government. Having completed her PhD in 1999, Christine then taught graduate programs in Public Health and Primary Health Care, was an investigator on nationally competitive ARC and NHMRC research grants, and convened national training programs for health and arts practitioners in evaluation and research methods. Since 2007 she has focused on researching arts and health, while retaining academic status at Flinders University. She is currently involved in research and evaluation in relation to several major arts and cultural initiatives in rural and remote South Australia.

Quito Washington

Quito Washington has been promoting swing dancing in Darwin since 2000 and with Swing Dance NT has been the leading force in carving out a niche for swing dancing in Darwin on the national scene. His latest venture is to

start a full-fledged authentic New Orleans swing band called *The Mint Slices* to bring both original swing music and much-loved favourites to the streets of Darwin. In 2008, Quito made a full-length film about swing dancing called *Swing It*, starring Miss Kelly Ann Doll. You can download it online at <http://vodo.net/quitofilms/swingit/>. The film was shot in Melbourne, Australia and has been submitted to various national and international film festivals. The film is set in modern times but is shot in the style of 1940s romantic comedies.

Debbie Reid

Debbie Reid is a Grade 5/6 teacher at Bridport Primary School, in the North East of Tasmania. Debbie holds a Bachelor of Education Degree and has a heart for working extensively within her community. Prior to working in education, Debbie worked as an Interior Designer, and gradually made links through her creative skills, and her passion for student learning, by engaging classes in extra-curricular activities in Bridport. Once her degree was in hand, Debbie pursued her passion for student links within the community. With the demands of the Science area of the Australian Curriculum, Debbie found it invaluable for her classes to make links with the local farming area and health and nutrition sectors, seeking applicable opportunities and projects. This has led further to Debbie making a rural health partnership, and engaging students in learning about food supply from the ground up. As well, Debbie has ensured that students become aware of the sustainability of food in their rural area.

Fiona Reid

Fiona Reid has worked in community health and social services for 15 years and has extensive experience with a diverse range of communities and sectors across West Australian. In her current role as Special Projects manager at Womens Health and Family Services she oversees a variety of unique and innovative programs including the Rural in Reach program. A masters qualified family therapist (M.So.Sc), and Graduate of the Australian Institute of Company Directors (GAICD), Fiona has a wealth of professional, academic and community experience. She has a strong commitment to volunteer service and is a member of a number of Local Government committees, community advisory groups, consortia and boards. Fiona was elected to the City of South Perth Council (COSP) in 2011 is a West Australian Local Government Association (WALGA) State Councillor. A past sessional lecturer at Edith Cowan University and accredited clinical supervisor (counselling), she has significant experience in delivering adult education and training. She has presented at international, national and local conferences on a range of health and well being topics. Fiona is a mother of two teenagers and in her spare time she enjoys travelling, reading and when possible being still.

Deidre Rennick

Deidre Rennick is a registered nurse with experience across a range of health care sectors including public, private, acute, community and higher education sectors. She is currently the Executive Manager, Primary Care at

Grampians Medicare Local. The Grampians Medicare Local After Hours System was developed from a smaller pilot program which had been operating in Western Victoria for almost 12 years.

Shelly Reynolds

Shelly Reynolds has been in the health sector for the past 29 years. She is married to her exceptional husband, Mal, and together they have eight children. Starting in nursing, Shelly has worked in all areas of health over many years in many different environments from paediatrics to renal dialysis and pathology, and for the past decade in Indigenous health in various roles from PHC trainer, chronic disease, clinical manager roles and has also spent four months as acting CEO of an AMS in Queensland. Shelly has a passion for Aboriginal health workers and the vital role they play in the health sector. Ensuring the health workers' ever-evolving skill base is in line with the need of the community is a challenge, a privilege to share her knowledge and passion with health workers and advocate on behalf of the sector to empower health workers with knowledge and skills that supplement and drive service provision in the health sector. Shelly has been fortunate to be employed by NATSIHWA to assist the team to develop the CPD Continual Professional Development Framework and in the near future deliver this framework to the ATSIHW and health practitioners across the country. Shelly has joined the steering committee to assist in developing the National Scope of Practice for ATSIHWs and is looking forward this being completed. Shelly has been invited by AAPM again this year to showcase the value of ATSIHW in both the private and NFP health sectors. Shelly will continue to advocate for the ATSIHW population, and is very privileged and honoured to work in this sector of health, that produces outcomes that empower communities and close the gap between Indigenous and non-Indigenous people's health needs.

Janet Richards

Janet Richards is a research assistant with the Flinders University Rural Clinical School in Renmark, South Australia where she contributes to research in the field of medical education and rural community health. She has authored and co-authored peer reviewed articles and presented at conferences in Australia and New Zealand. Janet has a Bachelor of Applied Science in Medical Laboratory Science from the South Australian Institute of Technology and worked as a medical scientist before changing her career direction and joining the rural clinical school in 2009. She has recently completed an Honors Degree in Health Science which explored the role modelling of resilience to medical students. Her research interests include determinants of rural and remote health and assisting rural communities to improve their health services.

Aimee Riley

Aimee Riley has worked with Department of Health, Alcohol & Other Drug Services, as a Tobacco Education & Community Support Officer since 2011. Aimee works with remote communities across the Top End delivering QUIT

100 Program and training Aboriginal Health Workers & Youth Workers in the sets as Tobacco Cessation providers. Aimee has been instrumental with development NT specific resource targeting Smoke Free homes. Aimee has completed Certificate IV in Alcohol & Other Drugs Work and is a qualified QUIT educator. With the support of Alcohol & Other Drugs Services, Aimee is now working with Dr Lis Young to reflect the Updated Smoking Guideline in the Tobacco Service Delivery across the Remote Settings of the Northern Territory.

Kate Robertson

Kate Robertson has worked in Health Promotion and Public Health Nutrition over the last six years. She has worked for the Department of Health during this time, with four years based in Katherine as a Public Health Nutritionist/Dietitian and for the past two years has been coordinating the Healthy@Work Project in Darwin. Kate is currently the Training and Education Program Development Officer with the Health Promotion Strategy Unit for the Northern Territory Department of Health and is responsible for providing expert advice and guidance on health promotion policy and program development for health promotion education, training and workforce development. Kate holds a Bachelor of Nutrition and Dietetics and is currently studying a Masters in Public Health and Masters in Business Administration.

Sylvia Rodger

Professor Sylvia Rodger AM is Director of Research and Education at the Cooperative Research Centre for Living with Autism Spectrum Disorders (Autism CRC) and Honorary Professor, School of Health and Rehabilitation Sciences at the University of Queensland. She is an occupational therapist with more than thirty years experience as an academic and clinical researcher. She is an Australian Learning and Teaching Fellow who has conducted large national and international academic capacity building studies. Her current research relates to improving research co production for people with ASD. She has published 4 books, 25 book chapters, and more than 180 peer reviewed research papers.

Margaret Rolfe

Dr Margaret Rolfe is an experienced biostatistician who has lived and worked in the rural Northern Rivers area of NSW since 1985. Dr Rolfe currently has a full-time academic research position as a biostatistician at Sydney University, Faculty of Medicine, School of Public Health with the University Centre for Rural Health—North Coast Lismore (from April 2011). In this role, she brings high level statistical and Geographical Information System expertise to a range of health related research projects, including the NHMRC funded project that she is presenting at this meeting. These skills have been fundamental as quantitative methods advisor to the NSW HETI Rural Research Capacity Building Program, which enable rural-based NSW Health practitioners to engage and be supported in research projects. Dr Rolfe holds an adjunct position with Southern Cross University School of Health and Human Science Lismore to enable higher degree student supervision. She was awarded a PhD in

Bayesian Statistics from the Queensland University of Technology in 2010. Her thesis, titled "Bayesian Models for Longitudinal Data" includes a project using Bayesian statistical methods to identify sub-groups of women who had different trajectories of cognitive function over time following chemotherapy for early stage breast cancer. Dr Rolfe holds a BSc and Masters of Statistics, from the University of NSW. Her research interests include maternal and child health, nanotechnology attitudes, rural health issues, analysing linked hospitalisation data, longitudinal statistical modeling for health data, the analysis of spatial data using geographical information systems, designing and analysing clinical trials, survey data analysis.

Jill Romeo

Jill Romeo is the Executive Officer with ANZAHPE (Australian & New Zealand Association for Health Professional Educators). Her role supports the ANZAHPE Committee of Management and includes all aspects of the administration of the Association and includes the role of Editorial Assistant for the Association Journal (Focus on Health Professional Education). The early part of Jill's career included various roles in the optometric field, having begun her working life with a rural optometry practice servicing the Riverland region of South Australia. Her roles in the optometric field have included administration, technical advice and sales and staff and business management. Jill had a change of direction in 2010 when she joined the Flinders University Rural Clinical School in an administrative position with the PRCC Program in Renmark, SA. This saw her work closely with the medical students who undertake their entire third year of study in a rural community setting, along with the associated teaching staff and local health care providers.

Asman Rory

Asman Rory is a traditional Garawa and Gudanji man from the Gulf of Carpentaria, and a Remote Alcohol & Other Drugs Worker with the Remote AOD Workforce in Borroloola for 6 years. Asman has learnt from his Elders and lives what has been practised by his ancestors, passing onto his children and family the lore/law, ceremony, hunting his grandparents taught him. Asman uses his ancestral knowledge to help young people in Borroloola understand and learn about the effects of alcohol and other drugs and its consequences as part of his life and role as a Remote AOD Worker.

Michelle Rothwell

Michelle Rothwell is passionate about providing safe and equitable health care for rural patients. Michelle is an experienced clinical pharmacist based at Atherton District Hospital on the Cairns Hinterland in Far North Queensland. Michelle has the responsibility for medication management for two large rural hospitals and ten rural and remote sites. Michelle is also experienced in the field of patient safety and is passionate that health care services are as safe for rural patients as they are for our city counterparts. Michelle studied at Aston University in the UK and completed her Research Masters with the

Queens University, Belfast. Michelle has a strong interest in research and was awarded a Health Practitioner research grant to investigate the number of emergency readmissions due to medication. Michelle was recently successful in obtaining rural and remote revitalisation funding which is currently allowing for Michelle to implement new clinical pharmacy services into rural hospitals and remote sites in Far North Queensland. Current roles include chair of the Rural Director of Pharmacy Services Advisory Committee of Queensland and Rural Advisor to the Society of Hospital Pharmacists Queensland Branch.

Louise Roufeil

Dr Louise Roufeil is currently the Executive Manager of Professional Practice at the Australian Psychological Society (APS). This role includes developing policy and standards related to the professional practice of psychology. Louise was previously the Mental Health Academic at Mount Isa Centre for Rural and Remote Health, James Cook University, and is currently Adjunct Associate Professor in Psychology at Charles Sturt University, Bathurst. Louise resided in rural Australia for over 20 years and was formerly Clinical Program Director at the NSW Central West Division of General Practice and a consultant with Kristine Battye Consulting providing services to the primary health and community services sectors in rural and remote Australia. Louise also practiced as a health psychologist in regional NSW.

Ingrid Rowlands

Ingrid Rowlands' interests focus on young women's health, particularly the psychosocial aspects of women's reproductive health. Ingrid has a background in psychology, completing both her undergraduate and doctoral studies within The School of Psychology at The University of Queensland. In her PhD she used data from over 14,000 young women born in 1973-78 in the Australian Longitudinal Study on Women's Health (ALSWH) to examine women's adjustment to miscarriage. Following this, she worked as a postdoctoral research fellow at QIMR Berghofer Medical Research Institute on a national, Australian study of women with endometrial cancer, focusing on women's quality of life following treatment. In this role, she also led a study exploring young women's fertility concerns following a diagnosis of gynaecological cancer. In 2014, Ingrid moved back to The University of Queensland, working within The Centre for Research Excellence in Women's Health in the 21st Century (CREWH21). Ingrid's current work within CREWH21 focuses on the physical, mental and reproductive health and health service use of a new cohort of 17,000 young women, born in 1989-95, who were first surveyed in 2012 when they were aged 18-23. Ingrid is comparing the outcomes of these young women to the original cohort of young women (born in 1973-78) who were surveyed 17 years previously when they were also aged 18-23. This enables changes in women's health and wellbeing to be examined against the backdrop of policy changes over the past 17 years.

Elena Rudnik

Dr Elena Rudnik is an early career researcher (ECR) who is employed by the Discipline of Rural Health at The University of Adelaide and the Flinders University Rural Clinical School in the roles of Research Fellow and Senior Lecturer. Elena has a PhD in the field of Health Psychology. Her research interests include rural community mental health, the evaluation of rural based health services, and strategies that promote interprofessional practices of health practitioners. Elena has lived and worked for most her life in rural/regional South Australia. Past employment experiences as a research program manager, rehabilitation and grief counselor, brain injury casemanager and disability service manager have provided an eclectic skill-set and research academic career. As an ECR Elena's current focus is to increase publications, supervise HDR students and build networks to attract collaborative research grant funding.

Deborah Russell

Deborah Russell is a Research Fellow at the Monash University School of Rural Health, and with the Centre of Research Excellence in Rural and Remote Primary Health Care and the Centre of Research Excellence in Medical Workforce Dynamics. She has a PhD and Masters in Clinical Epidemiology. Prior to academia Deb was a rural GP for ten years. Deb's main research areas of interest are the rural health workforce and rural primary care health services.

Peta Rutherford

Peta Rutherford grew up in Wodonga Victoria, and commenced work for Queensland Health in 2004 after 10 years at Medicare. Peta was the original project officer on the Rural Generalist Pathway initiative back in 2005/6. After five years working in Corporate Office, focusing on Medical Workforce projects, Peta relocated her family to work in Charleville Queensland, as one of the two Chief Operations Officers for South West Health Service District. She was responsible for managing five hospitals and two primary care clinics. After three years in Charleville the family was up and moved again to Kingaroy to commence work as the Cluster Operations Manager for South Burnett Darling Downs Hospital and Health Service. Peta is committed to supporting a work environment which values education and training for the clinicians, increases the delivery of clinical services locally and developing sustainable workforce and service models.

Benjamin Ryan

Benjamin Ryan is a PhD candidate at James Cook University; Disaster Coordinator for the Cairns and Hinterland Hospital and Health Service, Queensland, Australia; and Director of Disaster Risk Reduction for the International Federation of Environmental Health (Asia-Pacific). Ben's professional interests and research are focused on mitigating the impact of disasters on the health and wellbeing of individuals and the community through public health infrastructure resilience. He has worked on responses to natural disasters and disease outbreaks

(including Ebola and Dengue), managed public health projects in Aboriginal and Torres Strait Islander communities, facilitated delivery of health services to asylum seekers and worked in public health at all levels of government in Australia and internationally. Most recently, has led engagement with international agencies and governments to operationalise Ebola Treatment Centres and Units in Liberia and Sierra Leone. He is passionate about the role public health interventions should have in the prevention, preparedness and response phases of disaster management and hopes to share his experiences, insights and research with people across the world.

Richard Sager

Richard Sager originally a Chef, he completed his Dietetics degree at Newcastle University. He completed a Masters of Science degree investigating health promotion options within General Practice. Richard is completing his Doctorate and has been working in Private Practice with Darwin Dietitians for the past 10 years. He has a mix of particular interest towards workforce in remote, food Intolerances and promoting capacity around nutrition.

Jacki Schirmer

Jacki Schirmer is a Senior Research Fellow appointed jointly between the Faculty of Health and Institute for Applied Ecology at The University of Canberra. Her research explores the relationship between the wellbeing of people and the wellbeing of the places they live and work in, and she works in a team focused on understanding how changes in rural and regional Australia affect the wellbeing of the people who live there. Her work focuses in particular on understanding the social and health impacts of changes in primary industries (agriculture, fishing and forestry), and the nexus between engaging in action to improve environmental health and human wellbeing.

Kyle Schofield

Kyle Schofield graduated from Indiana University with a BA in Chemistry and completed her Masters of Public Health through Flinders University. She began her professional career in the field of medical sales as a Specialist Representative and Manager, before pursuing her passion for work in Health Promotion. In her current role at the National Heart Foundation as National Recruitment Officer, she oversees the promotion and recruitment of Heart Foundation Walking, Australia's largest free network of community-based walking groups. She is also a member of both the Public Health Association of Australia and the Australian Health Promotion Association.

Adrian Schoo

Adrian Schoo is professor in rural allied health education at Flinders University. Before moving into clinical education Adrian was physiotherapy discipline leader at La Trobe University's Rural Health School and, prior to that, deputy director of the Greater Green Triangle University Department of Rural Health. He established a

state-wide continuing education program for allied professionals in Victoria, with online access in other Australian jurisdictions. Professor Schoo played an instrumental role in establishing a solid foundation for physiotherapy at Flinders University to underpin the musculoskeletal and inter-professional practice curriculum and clinical placement partnerships. His work informs policymakers, educators and health professionals. Research interests include continuing education, allied health workforce development and health service enhancement, particularly in the area of chronic disease.

Tarun Sen Gupta

Tarun Sen Gupta is Director of Medical Education and Professor of Health Professional Education at the James Cook University College of Medicine and Dentistry in North Queensland. He has worked in undergraduate and postgraduate medical education since 1993, with interests in rural medicine, small group teaching, community-based education and assessment. He is a co-Director of the Queensland Health Rural Generalist Pathway and has previously worked in solo remote practice. He is a director of the Postgraduate Medical Council of Queensland, a member of the Australian Medical Council Board of Examiners and the current President of the Rural Doctors Association of Queensland. He has been involved in the national assessment committees of both the RACGP and ACRRM and currently chairs the ACRRM assessment committee. He is married to Wendy; they enjoy the company of two thriving teenage children, a pair of disobedient golden retrievers and a neglected cat.

John Setchell

Dr John Setchell is the General Manager of Health Services for the Royal Flying Doctor Service Central Operations. Since commencing with the RFDS in 1999, John has been responsible for the provision of health services ranging from traditional clinics in remote areas to aero medical evacuation services, and has overseen growth in the areas of primary care and health promotion/prevention programs. John has taken an active role in the development of national RFDS health policies and programs such as the implementation of a national electronic medical record system and plays an active role in the RFDS National Health Advisory Committee. Further interests of his have been the development of education programs for medical and nursing students and the provision of an emergency medicine training program for rural GPs in South Australia. John has previously worked as a GP in Adelaide, a medical practitioner in the Ramu Valley of Papua New Guinea, and the Medical Director of the University of Adelaide Student Health and Counselling Service.

Kristylee Sharp

Kristylee Sharp is the Training and Evaluation Coordinator for Services for Younger People; Brightwater Care Group. Since graduating as an Occupational Therapist in 2002 she has worked in various fields specialising in rural and remote services, Aboriginal health and brain injury rehabilitation. Kristylee has received a number of scholarships for research and service development and

has presented at conferences including the Australian Society for the Study of Brain Injury (ASSBI) and Occupational Therapy Australia on topics including developing culturally competent services for rural and remote clients; utilising contemporary technology in rehabilitation and implementing outcome measures for service evaluation. She has been on the scientific committee and chaired sessions for ASSBI and was a co-convenor of the WA Occupational Therapy Neuroscience interest group. She is passionate about providing equitable health care to all.

Janie Smith

Janie Dade Smith has lived most of her life in rural and remote Australia. She is now Associate Professor (Medical Education) and Academic Lead, for the *Faculty of Health Science and Medicine at Bond University*. She previously ran a national company—*RhED Consulting Pty Ltd*—where she undertook consultancies for health departments, universities, professional colleges, government and not for profit organisations. Janie is the author of the very successful text *Australia's Rural and Remote Health: A social justice perspective*, which is used by many Australian universities and organisations. Janie is the President of CRANAPlus—the peak body for remote health in Australia.

Tony Smith

Tony Smith is a radiographer with over 35 years' experience. He has worked in both the public and private health care system and is an academic at the University of Newcastle. In 2003, he relocated to Tamworth as the Medical Radiation Science academic in the then newly established University of Newcastle Department of Rural Health. He is currently Associate Professor and Deputy Director (UDRH) in that Department and is based at Taree on the Mid-North Coast of NSW. Tony's research interests are in allied health workforce and interprofessional education and practice. He has a long term interest in the education and support of GPs and nurses who perform limited-licence radiography in rural and remote locations.

Tobias Speare

Tobias Speare is the pharmacy academic at the Centre for Remote Health (CRH), a joint University Department of Rural Health of Flinders University and Charles Darwin University (CDU). Toby completed his pharmacy degree at James Cook University in Townsville, North Queensland, in 2004. Since this time, he has worked in a variety of pharmacy practice, including clinical pharmacy, retail pharmacy, education and mentoring, and program development, in rural, remote and metropolitan Australia and internationally, in New Zealand and Scotland. Toby possesses a keen interest in improving health care in a holistic fashion, and completed a Master of Public Health in 2012. Toby arrived in Alice Springs to work as a clinical pharmacist at Alice Springs Hospital in August 2013, before taking up the position of pharmacy academic at CRH in November 2013 to pursue the goal of improving the Quality Use of Medicines through education and research.

Chris Speldewinde

Chris Speldewinde is a Research Fellow at the Centre of Rural and Regional Law and Justice which is part of the School of Law at Deakin University. The Centre's vision is to enhance access to improved justice systems and services for rural and regional Australian's through research, engagement and collaborations with relevant communities, professions and industry. Chris is currently in the latter stages of writing his doctoral thesis in anthropology. He has worked across numerous health and wellbeing projects under the auspices of several Deakin University Research Institutes.

Catherine Spiller

Catherine Spiller is currently project manager for Tasmania HealthPathways, at Tasmania Medicare local. HealthPathways is currently being implemented in Tasmania, funded under the Tasmanian health assistance package. Tasmanian HealthPathways is an agreed approach between primary, secondary and tertiary care providers to managing a range of health conditions, based on the Canterbury Initiative, NZ. Catherine's career started as a pharmacist in the UK, transitioning over time from clinical practice into clinical teaching, then onto senior pharmacy management roles in the NHS. As Director of Pharmacy, University Hospital Lewisham, London, she was heavily involved in the successful South East London Structured Training and Education Programme (STEP) for pharmacists and collaborated on numerous medicines management initiatives. She moved from London to Hobart in 2010, and taking up the position of clinical lecturer at the School of Pharmacy; University of Tasmania, with key responsibility for the Master of Clinical Pharmacy degree. In 2012, as Director, Medication Strategy and Reform, she led statewide safety and quality initiatives in medicines management including the development of an electronic medicines formulary. Her current interests include clinical leadership, change management and health service redesign. The work being presented focuses on the importance of clinical leadership in the development of Tasmanian HealthPathways.

Renata Spiller

Renata Spiller is Health Promotion Coordinator at Goulburn Valley Primary Care Partnership. Renata has four years' experience in health promotion working in regional Victoria across community health, primary care partnership, and women's health sectors; with skills in strategic planning, project management, evaluation and partnership building. Renata is currently completing Master Public Health with Flinders University.

Glenda Stanislaw

Glenda Stanislaw is CEO of Great South Coast Medicare Local. With postgraduate qualifications in public policy, primary health care, public health, and counselling psychology, she has extensive experience working in national, state and local government bodies, as well as multiple positions in several non-profit organisations. Her passion for community development and capacity building has led to work in three developing countries, while

gaining an appreciation of what diverse cultures can bring to Australian life. Glenda currently chairs a Victorian Primary Care Partnership, while leading an innovative and dedicated team developing and coordinating a range of primary care services in Victoria's south west. Her consulting experience includes working with government departments, NFP Boards and senior management to strategically position themselves to embrace sector and system change; to evaluate current performance and priorities and to develop internal capacity for excellence.

Ruby Stanley

Ruby Stanley is a Wakka Wakka woman from the Dawson Valley Region in Queensland. For the last 50-odd years she's lived and worked around different communities in the Top End of the Northern Territory—as an Aboriginal Liaison Officer and Aged Care Coordinator. Ruby has been involved with improving health services, including education and knowledge of nutrition among the elderly. She helped establish aged care hostels in several communities in the Top End. Ruby currently sits on the board of Wurli-Wurlinjang Health Service, and the North Australian Aboriginal Justice Agency. She continues giving back to the community by working towards improving the lives of Aboriginal people for a better future.

Evan Stanyer

Evan Stanyer is employed as a Project Officer with the Collaborative Health Education and Research Centre, CHERC, Bendigo Health. Evan has extensive experience in mental health and aged care and has worked in a wide variety of roles in this area over the last 30 years. Over the last 5 years Evan has expanded the role of, initially a Cognition Consultant, then Project Officer to support both Bendigo Health and the smaller health services across the Loddon Mallee region in improved detection and management of older people suffering from dementia, delirium and or depression.

Shane Stenhouse

Shayne Stenhouse has very recently been appointed to the role of Telehealth Business Coordinator, Darling Downs Hospital and Health Service. Shayne had previously been Telehealth Facilitator for Central and Southern Queensland for a period of four years and prior to that a Business manager for Toowoomba Health Service District. Shayne has co authored two papers: "The Practical Issues in Using Existing Digital Stethoscopes in Telehealth" and "The establishment of a Sustainable Telehealth Service for Preadmission Clinic Consultations". The latter he presented at the 2009 IARIA Telemedicine conference in Cancun Mexico. Shayne has been made an Adjunct Associate Professor Business and Law at the University of Southern Queensland, for his close working relationship with the faculty in developing a digital stethoscope that is compatible with Queensland Health's Telehealth platform, and from mentoring students doing various research papers. Some Telehealth projects that Shayne has managed are: ICU ward rounds Bundaberg To Royal Brisbane and Women's Hospital(RBWH), Preadmission Clinics from 20 Rural sites to Toowoomba Hospital, Inflammatory Bowel Disease from RBWH to

Rockhampton and Bundaberg. His current Telehealth projects include Oral Health, Interpreter Services and inpatient Telehealth within Darling Downs Hospital and Health Service.

Miranda Stephens

Miranda Stephens is a Lecturer in Clinical Psychology at the Rural Clinical School in Burnie, Tasmania and has her own private practice on the North West Coast of Tasmania where she lives. Miranda works collaboratively with rural organisations and clinicians to facilitate rural mental health education for medical students and psychology students studying with the University of Tasmania. She also participates in clinical research conducted by the Rural Clinical School and is currently the lead researcher in a partnership with the unique Autism Specific Early Learning and Care Centre located in Burnie, Tasmania. Miranda has been a Clinical Psychologist and educator for over 20 years and worked in rural Tasmania as well as rural and remote New South Wales. Miranda holds a masters degree in Clinical Psychology and a postgraduate diploma in Management Psychology.

Maida Stewart

Maida Stewart is an Aboriginal Health Practitioner who has worked with Danila Dilba Health Service for the past twelve years. She is currently involved in the coordination and care of Aboriginal and Torres Strait Islander clients with cardiac conditions (including Rheumatic Heart Disease) as part of Danila Dilba's Chronic Disease team. She has also been involved with the 'Improving secondary prophylaxis in Rheumatic Heart Disease' project in collaboration with the Menzies School of Health Research. In 2014 Maida, along with twelve other Aboriginal Research Fellows, was involved in the development of a Wellbeing Framework for Aboriginal and Torres Strait Islander people living with chronic conditions, in partnership with the South Australian Health and Medical Research Institute. This project was funded by the Australian Primary Health Care Research Institute. It focused on, developing the Wellbeing Framework in consultation with local Aboriginal and Torres Strait Islander communities, as well as developing and enhancing the research skills of Aboriginal Research Fellows across Australia. Maida is hoping to continue with implementation activities associated with the Wellbeing Framework, including an exploration of how this framework can be integrated into local Primary Health Care Services in the greater Darwin region.

Nigel Stewart

Dr Nigel Stewart was born and educated in Auckland, New Zealand. He has lived in Port Augusta, South Australia for over 20 years and has worked as a regional paediatrician with the Port Augusta Hospital since 1993, and since 1995 has been Head of the Northern Regional Paediatric Unit at Port Augusta Hospital. Dr Stewart aims to provide a high-quality child health service as close to home as possible for the children of rural and remote locations across northern South Australia. He has a strong interest in many aspects of children's health, including

rural children's health, Indigenous health, behavioural paediatrics and developmental paediatrics. As a rural practitioner he has been a strong advocate for rural health consumers and their access to health services. Teaching roles have included Honorary Clinical Lecturer at the University of Adelaide since 1995, and in 2003 as a Senior Clinical Lecturer for rural teaching in the Department of Paediatrics for the University of Adelaide.

Ruth Stewart

Dr Ruth Stewart is the Director of Rural Clinical Training and Support, Associate Professor of Rural Medicine at James Cook University School of Medicine, Australia. She worked for twenty-two years as a procedural GP in South West Victoria, Australia where she developed and implemented the Integrated Model of Medical Education in Rural Settings (Deakin IMMERS) for Deakin University. Ruth received a PhD in December 2015 from Flinders University for her thesis "Lessons from the development of a maternity managed clinical network in a low volume rural context" Ruth's research interests are rural maternity care and policy, rural medicine and rural medical education.

Melissa Stoneham

Dr Melissa Stoneham is the Deputy Director of the Public Health Advocacy Institute of WA (PHAIWA). PHAIWA is an independent public health voice based within Curtin University, that aims to raise the public profile and understanding of public health, develop local networks and create a state-wide umbrella organisation capable of influencing public health policy and political agendas. Advocating for Aboriginal health particularly in rural and remote areas is a key priority for the organisation. Melissa has over 25 years' experience in public health, working with local, state and federal government agencies, the University sector and International Aid Agencies. Melissa's career highlights include 2 years working in the Pacific on an alcohol and young people harm minimisation project and 12 months working in Mozambique on a medical waste project. She has 2 young children and enjoys travelling.

Christopher Stubbe

Chris Stubbe is a final-year medical student studying at The University of Melbourne through the rural clinical school. He has spent time at Wangaratta and Ballarat and is currently doing a research component at Austin Health in Melbourne. He has studied a Bachelor of Biomedicine previously, with a major in Human Structure and Function. His medical passions include preventative medicine, health literacy and rural and remote health. Furthermore, Chris enjoys travelling and the outdoors, through hiking, scuba diving, fishing and skiing. Chris also has significant experience with the radiology industry through a teleradiology company.

Lindy Swain

Lindy Swain is a pharmacist academic and Rural Pharmacy Liaison Officer at the University Centre for Rural Health in Lismore, NSW, where she conducts

education for pharmacy students, medical students, Aboriginal Health Workers and pharmacists. She also teaches Rural Policy, Aboriginal Health and prescribing at UTS, University of SA, UQ and UWS. Lindy's particular area of interest is working with Aboriginal people to assist with medication management, optimising treatment and outcomes. She is a PhD scholar researching "Strategies to Increase Home Medicines Review in Aboriginal communities". Other projects in which Lindy has recently been involved include the development of the PSA Guide to Providing Pharmacy Services to Aboriginal and Torres Strait Islander people and a Heart Foundation resource for Aboriginal patients with chronic heart failure, establishment of the North Coast Aboriginal pharmacy assistant traineeship program and the Australia Pharmacy Council's Remote Rural Pharmacists' project. Lindy is also the Director of Rural Policy for the Pharmaceutical Society of Australia (PSA). Lindy is an advocate and advisor for rural pharmacy issues, writes government submissions and chairs the PSA Rural Special Interest Group. Lindy is passionate about changing rural service models to include clinical pharmacists, as she believes greater pharmacist involvement in team care arrangements could reduce medication mismanagement and hospitalisations. Lindy also works as a clinical pharmacist at Bullinah Aboriginal health service and is a tireless advocate for more pharmacists to be working in Aboriginal health. She is a National Rural Health Alliance board member and was announced the 2014 PSA Pharmacist of the Year.

Julie Sykes

Julie Sykes is the Director of Health and Education Programs at the Prostate Cancer Foundation of Australia. Julie is a registered nurse with a special interest in prostate cancer and has worked in both the UK and Australia in senior nursing positions in cancer care service development and delivery. Julie is responsible for the strategic development and implementation of PCFA's education programs and services. Julie was the project manager for PCFA Rural Education Roadshow, a program which took prostate cancer experts to regional and rural Australia to deliver structured education to health professionals and those affected by prostate cancer. Julie is also responsible for the production of PCFA consumer information materials in both online and print format and PCFA advocacy programs in partnership with key stakeholders. Julie has an extensive publication and presentation profile on prostate cancer nursing and was responsible for the development and implementation of the PCFA Prostate Cancer Specialist Nursing Service. This national structured program currently funds 27 Prostate Cancer Specialist Nurses hosted in hospitals in all States and Territories across Australia providing care to men and families affected by prostate cancer. Julie is also President of the Australia and New Zealand Urological Nursing Society.

Lyn Talbot

Dr Lyn Talbot had an extensive career in tertiary education in the fields of Nursing and Public Health at La Trobe University, Bendigo. She was a Senior Lecturer in Public Health, Health Education, Health Promotion,

Program Planning and Evaluation and Environmental Health. She is the co-author, with Dr Glenda Verrinder, of *Promoting Health. The Primary Health Care Approach*. Dr Talbot is now the Corporate and Community Planner at the City of Greater Bendigo. Her role includes assisting the small towns and communities in the municipality to develop a local community plan that can assist them to adapt to changing social and environmental circumstances and to achieve their local goals.

Lauren Taylor

Lauren Taylor is a clinical psychologist (registrar) and research associate at the Autism Association of Western Australia and the University of Western Australia. She has 10 years' experience working with children, adolescents and adults with autism spectrum disorder, across early intervention, school and residential settings. Lauren is currently a project leader for a national project that is investigating diagnostic practices for autism spectrum disorder. She is also working to establish a graduate certificate in assessment and diagnosis of autism spectrum disorder. Both of these projects are initiatives of the Cooperative Research Centre for Living with Autism Spectrum Disorders (Autism CRC). The overarching aim of these projects is to establish a national baseline for diagnostic practices and to improve national diagnostic standards for ASD.

Lena Taylor

Lena Taylor is a senior Anangu Pitjantjatjara woman who grew up in South Australia and lived much of her life in the remote community of Oak Valley. She currently lives in Alice Springs with her grandchildren. Lena is a qualified interpreter and worked in Aboriginal health and child wellbeing with Congress in Alice Springs for 17 years. Lena speaks four languages and has worked as a Ninti One Aboriginal Community Researcher on alcohol, mobility, eating and cooking habits, and art centre projects.

Selina Taylor

Selina Taylor's role at the Mount Isa Centre Rural and Remote Health (MICRRH) has opened up multiple opportunities for her. She has developed the MICRRH Intern program to provide rural Intern pharmacists a supported year of learning and immersing themselves in the community. She also coordinates pharmacy student placements in and around the region to remote areas such as Karumba, Normanton, Longreach, Winton, Camooweal, Boulia and Cloncurry. The student placements generally involve an experience of a few facets of pharmacy including a Community Pharmacy, Hospital Pharmacy, and Outreach/Remote Pharmacy as well as HMR/MMR experience. This allows the students to see first-hand the opportunities and challenges rural pharmacy can present. Student support is also high on the agenda for Selina. She is currently mentoring 2 young Mount Isa women who are studying pharmacy at JCU. Providing mentorship for local students whilst they are studying helps students remain connected to their home town and keeps them involved in what happening with local health and pharmacy issues while they're studying at university.

Selina's passion for rural and remote health shines through in her enthusiasm, and in her encouragement for students and pharmacists to enjoy the vast opportunities that North West Queensland has on offer.

Karen Thomas

Karen Thomas is a Senior Project Officer in Prevention Projects at the Northern Territory Medicare Local (formally General Practice Network NT). Since moving to Darwin in 2011 Karen has worked at the NTML in programs including workforce and eHealth. She is currently undertaking a Graduate Diploma in Public Health through the Menzies School of Health Research and Charles Darwin University. Karen has a keen interest in the social determinants of Indigenous health and the importance of addressing these challenges through preventative health initiatives to facilitate community empowerment and sustainable capacity building.

Bianca Todd

Bianca Todd has worked at National Centre for Farmer Health for five years as Website Content Coordinator and in 2013, became Web Administrator of Western District Health Service in southwest Victoria. Bianca has spent most of her life in rural communities of South Australia and Victoria, understanding the issues surrounding health care access. Her particular expertise is in helping rural people (health professionals, consumers, farm men and women) to engage across a variety of web based platforms, providing improved access to farmer health related resources. She is also aware of the importance of quality information and works closely developing relationships with Deakin University, Better Health Channel and HON code accreditation. In 2014, Bianca was part of the National Centre for Farmer Health team to be awarded the Deakin University Award for Teaching Excellence for Australia's only Agricultural Health and Medicine course in Australia. Bianca has also been actively involved in developing a video with farm men and women to encourage exercise on farm and make use of the resources available to them in their own farming environments.

John Togno

Dr John Togno has been an active general practitioner for 30 years. His main interests are assessing the appropriate use of technologies, including information and communication technologies (telehealth), in primary care; rural health and medical education. Dr Togno has been actively involved in telehealth since 1992. Dr Togno has worked as a consulting medical educator to the ACRRM pilot of workplace based assessment of OTDs working towards attaining the AMC certificate. Working in this capacity lead him to refine effective store and forward technologies for remote formative assessment of health practitioners. In addition, he has provided medical educator services to NTGPE and is an Associate Professor in the School of Medicine at Bond University. Dr Togno lives in a semi-rural area near Bendigo with his partner and two teenage daughters; he also has a 27-year-old son who works in Melbourne as an app developer. At his home Dr Togno enjoys cooking fresh

meals from a wide range of cuisines, often using fresh vegetables and herbs from his extensive vegetable garden.

Jane Tomnay

Jane Tomnay is Director of the Centre of Excellence in Rural Sexual Health in Victoria. This Centre has supported the development of rural sexual health services, the skills and coordination of rural health professionals, and improved access to and awareness of sexual health care for young people, GLBTIQ people and Aboriginal people across rural Victoria. Jane is passionate about improving access to sexual health services in confidential and appropriate ways for their users. Her research has focused on improving the sexual health of Victorians and access to services for those living in rural areas.

Mike Toole

Professor Michael Toole is the Deputy Director of the Burnet Institute. Until March 2013 he was Head of the Institute's Centre for International Health since 1995 and also has a Professorial appointment in the School of Public Health at Melbourne's Monash University. He is a medical epidemiologist and public health physician with special interests in communicable disease control, including HIV prevention and care, women and children's health, nutrition, refugees and humanitarian emergencies. Between 1986 and 1995, he worked at the US Centers for Disease Control and Prevention where he coordinated the US Government's public health response to complex humanitarian emergencies. He was a founding board member of MSF Australia and is currently a member of the International Monitoring Board of the Global Polio Eradication Initiative and the assessment panel of the Fund for Research for Health in Humanitarian Crises. He was awarded a Member of the Order of Australia in 2013.

Jane Tonkin

Jane Tonkin has 25 years' experience in the arts in the areas of festival development, project management, venue management and event producing. Jane has a BA and a Grad.Dip. in Arts and Entertainment Management and specialises in developing projects (including assembling creative teams and seeking appropriate resources), and providing support to artists. After extensive involvement with Corrugated Iron in previous years at board level, Jane took up the position of Executive Producer at Corrugated Iron in 2006.

Meaghan Trovato

Meaghan Trovato was the initial Rural Transfer Coordinator for the Townsville Hospital and Health Service. Based in Ingham Hospital at the time, Meaghan was able to successfully implement the program, which resulted in a permanent position being created and increased utilisation of rural facilities. Most importantly it provided the opportunity for patients to continue their episode of care close to home, in their local facility. Meaghan holds a Bachelor of Nursing Science and Masters of Advanced Nursing Practice from James Cook

University. While her initial clinical focus was cardiac and intensive care nursing, circumstances lead to embarking on a rural nursing career at Ingham Hospital. Meaghan also enjoys education of nurses, teaching advanced life support with both the Australian College of Critical Care Nurses (ACCCN) and CRANA. The Rural Transfer Coordinator role has sparked interest in patient flow, and she is now Nurse Manager for Patient Flow Support Unit at The Townsville Hospital.

Avinna Trzesinski

Avinna Trzesinski is a research officer at the Australian Indigenous Health *InfoNet*, based at Edith Cowan University in Western Australia. The Health *InfoNet* is a free to access web resource that contributes to 'closing the gap' in health between Indigenous and other Australians by developing and maintaining the evidence base to inform practice and policy. A member of the team since 2011, Avinna has research responsibilities including the Australian Indigenous Alcohol and Other Drugs Knowledge Centre resource, Indigenous eye health and CQI. Avinna has a Bachelor of Science (Health Promotion) from Curtin University and is currently undertaking a Masters of Public Health at University of Western Australia.

Karen Tully

Karen Tully resides on the banks of the Warrego River at Charleville, Queensland in South West Queensland and has experienced two major floods, which have severely impacted her home and business and have given her a personal insight into natural disasters. When not cleaning flood mud, she is the Program Manager for the National Rural Women's Coalition (NRWC), which provides a collaborative national voice for women living in rural, regional and remote Australia. Karen has a professional background in rural education, having worked in various positions at Schools of Distance Education. More recently, she has shared her passion for rural Australia through her leadership roles on a number of Boards (South-West Rural Financial Counselling Service, South-West Natural Resource Management; Red Ridge Foundation; Foundation for Australian Agricultural Women) as well as working in the rural advocacy and leadership arena for a variety of clients connected to her consulting business, Mulga Solutions. Karen has a Master of Education; Diploma of Financial Markets; Certificate IV in Business Governance and Training and Assessment and has completed the AICD Company Directors Course. Karen Tully is a proud and passionate rural woman who is energised by the big picture and future of rural and remote Australia, and who is inspired by visions of what could be.

Anna Tynan

Anna Tynan is a social scientist, with a background in occupational therapy, health services research and public health. She has worked and participated in research projects in a number of different rural, regional and international settings including Emerald, The Hunter Valley, India, Papua New Guinea and Vanuatu. Anna has just commenced as a Research Fellow with Queensland Health for the Darling Downs Hospital Health Service. She

is particularly interested in the translation of research into health policy and practice with previous research focusing on social determinants of health and people's lived experiences of health, and health system strengthening. Anna completed the research to be presented whilst working as a Post-Doctoral research fellow with the Wesley-St. Andrew's Research Institute in Brisbane on a project aimed at improving the health and wellbeing of rural and regional Queenslanders.

Colin Urquhart

Dr Colin Urquhart is currently working as a retrieval registrar for Careflight NT in Darwin. This position is part of a break in his UK based training in Anaesthetics. Dr Urquhart graduated from the University of Aberdeen in 2008 with a Bachelor of Medicine and Bachelor of Surgery, and a Bachelor of Medical Science with honors. He has worked in numerous specialties in the UK before commencing specialist training in Anaesthetics in 2011. He is actively involved with teaching, including being a certified advanced life support instructor and an involved member on the faculty of courses regarding the transfer of critical care patients. Dr Urquhart has specialist interests in pre-hospital medicine, patient transfer and emergency care.

Anne Vail

Anne Vail moved to Dubbo in 2001 from Western Queensland and has been working in primary health care for over 20 years. Anne has been managing the Rural Outreach Programs for the Western NSW Medicare Local and the Dubbo Plains Division of General Practice prior, for 6 years. Part of this role involves overseeing the clinical governance of the Kelso Indigenous Chronic Disease Clinic. She has a Masters in Nursing from Queensland University of Technology. Anne has had a long attachment to primary care nursing in rural and regional Australia through previous roles in general practice nursing and community nursing.

Elleni Vassilakoglou

Elleni Vassilakoglou is a new graduate nutritionist/dietitian working as a nutrition educator with Healthy Living NT. She is a born-and-bred local Territorian, is passionate about Aboriginal and Torres Strait Islander health and has a strong interest in cardiovascular disease. Elleni completed her training with Flinders University in 2014 and was able to undertake all her placements within the Darwin reign. This allowed her to expand her cultural awareness within Aboriginal communities and be exposed to various diseases at Royal Darwin Hospital.

Glenda Verrinder

Dr Glenda Verrinder is a Senior Lecturer in the Department of Public and Community Health in the La Trobe Rural Health School. Prior to this role she worked in community-based health agencies for 20 years. Her teaching, research and publications reflect her interest in human ecology and health, promoting health, ecological sustainability and healthy rural communities. She participates on a number of committees including the

Executive Committee of the Environment and Ecology Health Special Interest Group of the Public Health Association of Australia. Glenda is the author, co-author and editor of several texts and other publications.

Fiona Wake

Fiona Wake is a registered nurse with over 25 years' experience in critical care and primary health nursing. She has been based in the NT since 2007 and initially worked coordinating hearing and ear, nose and throat services in Central Australia and Top End remote communities. Since 2009, Fiona has been the Clinical Manager for Remote Area Health Corps (RAHC). Fiona works to attract a new clinical workforce to the NT and providing these new health professionals with comprehensive support to prepare and assist them to make a successful transition to remote practice. RAHC delivers a tailored pathway that includes comprehensive Cultural and Clinical Orientation and a suite of eLearning modules covering various clinical issues relevant to the remote setting. Nurses and GPs also have access to the support of a Remote Educator for their first placement. In collaboration with the NT health services, Fiona believes RAHC is contributing significantly to a competent new remote workforce. Fiona keeps her hand in as a clinician by completing short-term contracts each year through RAHC with the Hearing Health Program. Aside from enjoying the work, these placements enable her to retain her clinical skills and remain in touch with the current remote environment.

Nerida Walker

Nerida Walker is a graduate in psychology and has worked in health promotion, health communication, QI and integration in both the tertiary and primary care sectors. Nerida currently works in the Primary Care Support Team at Hunter Medicare Local and is working towards her Masters in Health Sciences (Primary Care). With an interest in advancing new models of care and intersectoral collaboration, Nerida is implementing quality initiatives in both urban and rural primary care settings in NSW.

Shelley Walters

Shelley Walters is the Kimberley Eye Health Coordinator based in Broome and is employed by Kimberley Aboriginal Medical Service. She has a nursing career spanning 37 years, starting as an Enrolled nurse before converting to Registered Nursing through Notre Dame University. Of the 37 years in nursing, 36 years has been the Kimberley Region of West Australia covering the areas of Remote Nursing, Accident and Emergency, Coordinator of Specialist Services, Ophthalmology, Coordinated and trained Retinal Camera operators in Diabetic Retinal Screening program and is a trained Haemodialysis nurse. Her passion is Diabetes and Renal disease especially in the area of young adolescents and what the future holds for the next generation. She loves to travel to isolated uninhabited areas in other countries with a special interest in Cultural Anthropology and has travelled the High Arctic through Nordic countries, Greenland, Canada, Alaska and Russia visiting isolated Indigenous communities, the next big adventure is Mongolia. As a mother of 3 daughters who have been

raised in isolated areas of the Kimberley and being a part of the Indigenous culture, she has witnessed the discrepancy between Indigenous and Non Indigenous quality of health.

Bonnie Ward

After completing a Bachelor of Nursing at Deakin University (Melbourne) Bonnie Ward gained experience in a variety of roles including malignant haematology, intensive care at The Alfred Hospital and in emergency medicine at Mildura Base Hospital. She expanded her scope of clinical practice as a community health nurse and clinical nurse specialist in London, United Kingdom between 2012 and 2013. On returning to Australia she has completed post-graduate studies in clinical teaching (University of Melbourne) and worked as a clinical teacher at Alfred Health. She has recently undertaken a Masters of Public Health and Tropical Medicine at James Cook University. Bonnie brings this experience to her role as Operations Manager of the ROCKET-SHIP primary health care initiative in the Pacific with Dr Lachlan McIvor.

Kate Warren

Kate Warren is a descendant of the Wiradjuri people of NSW, and is employed as Research Associate at the Department of Rural Health, University of South Australia. Kate has a nursing background and been involved in several population health and chronic disease prevention studies in rural SA. Kate is a certified trainer of Flinders Chronic Condition Management programs including Close the Gap and Tobacco Cessation; and a T-Trainer in several Stanford Chronic Disease Self-Management Programs including Diabetes and Chronic Pain. Kate co-lead the cultural adaptation of the generic Stanford program for Indigenous Australians and also co-developed a lifestyle modification program based on self-management principles named Shape Up For Life. Kate has modified Shape Up For Life to be peer education based and has been piloting the peer led model in a small research project for the past two years for the Indigenous and non-Indigenous local community. Kate is also involved in interprofessional practice learning in rural centres as well as activities that encourage Aboriginal and/or Torres Strait Islander youth to enter the tertiary education sector in pursuit of a health career.

Ella Watson Russell

Ella Watson Russell trained as an actor at the Victorian College of the Arts, graduating with a Bachelor of Dramatic Arts in 2005. She has worked in the Northern Territory, Queensland, Victoria and New Zealand as an actor, theatre maker, producer and drama tutor. Her acting credits include work for Darwin Theatre Company (A Midsummer Night's Dream, The Beauty Queen of Leenane, Jerusalem), Festival of Darwin (Andante, Fixer, The Sound of Waiting), ArtBackNT (Gift of Life), JUTE (Bastard Territory, At Sea Staring Up, Night, Constance Drinkwater and the Final Days of Somerset), Optic Nerve Performance Group (YES, Five Kinds of Silence), Melbourne Fringe Festival (Bash), National Gallery of Victoria (Dora Dolorosa), La Mama (Shhhhhh!), Corrugated Iron Youth Arts (Pirates of the

Arafura Sea, Shakespeare's Fools), as well as work in film, TV, voiceovers and for the corporate sector. Ella has trained in a number of different physical theatre disciplines and is particularly interested in the development of new theatre works in a collaborative context.

Lauren Waycott

Lauren Waycott has a background in public health and health promotion and has extensive experience in healthy literacy research and the delivery of health promotion activities. Lauren works at Jean Hailes for Women's Health as a project officer in the translation department, as well as at Deakin University in academia. She is interested in reducing health inequalities; and the provision of equitable interventions to improve health outcomes in marginalised populations.

Loretta Weatherall

Loretta Weatherall is a Kamilaroi woman. Her father is from Goooodoo and Loretta lived there until she was eight years old. After that she moved to Walgett where her mother is from. This is where Loretta finished her primary school years and then high school until Year 9. Her parents decided to send her off to boarding school in Sydney, where she attended Mackellar Girls High whilst staying at an Aboriginal hostel (Biala) to complete her HSC. Later, Loretta returned to Walgett met her partner John Sands and had two beautiful girls Zoe 16 and Georgia 13. Loretta worked for Attorneys General in the local court system for five years. She decided to move to Tamworth so that her daughters could have a better education and enjoyable lifestyle. Loretta has worked for the University of Newcastle and completed her administration traineeship. Through the research opportunities offered under the Gomeroi gaaynggal program she has significantly changed her role and has now completed her Indigenous Research Capacity Building Certificate IV and Pathology sample collection certificate. In 2015 Loretta is undertaking further study towards her PhD. She is currently working as an Indigenous researcher with the Gomeroi gaaynggal team exploring ArtsHealth as a mechanism to improve Indigenous health outcomes in pregnancy. Loretta is using all of her skills to become a role model for Indigenous women.

Louise Weber

Louise Weber came to Larrakia Nation in mid-2013 and is responsible for LNAC's five outreach programs focused on the safety and wellbeing of people living in the long grass and broader Aboriginal community and run from 5.30am-12midnight 7 nights a week. Louise brings 25 years of experience in the sector with a background in Aboriginal adult education, social policy in housing and homelessness, and leading community development programs at a specialist Trauma Survivors Service. Louise has introduced an integrated service delivery model across our outreach programs and a workforce development plan to build capacity and support her teams working in high risk environment.

Nicole White

Nicole White is the director of nursing at the Maleny Soldiers Memorial hospital on the hinterland of the Sunshine coast in Queensland. Nicole White originally trained at the Royal Brisbane Hospital and did her advanced Midwife training at the Mater Hospital in Brisbane. She continued a career of rural nursing in western Queensland. She has been the Director of Nursing of Surat hospital which was the first hospital to introduce Studer group management principles under her leadership. She has continued to demonstrate Strong leadership skills in her role as director of nursing at the Maleny Soldiers Memorial hospital during a time of great change. She enjoys the challenges of running rural facilities and enjoys the ability to solve problems directly. She has contributed broadly to the nursing profession sitting as a committee member of the Association of Queensland Nurse Leaders in 2006 to 2008. Her leadership potential has been recognised by the hospital and health service whose encouragement has allowed her to advance her professional development through the top 500 Executive leadership program Queensland health, the Public Service Management program through Mathews Flinders University and Health Management Diploma through Queensland Institute of Technology.

Kieran Wicks

Kieran Wicks is a Patron Musician for the Shout a Mate cause, which aims to bring social and mental respite to drought-affected communities across Australia while simultaneously raising awareness throughout our broader community of the plight that many on the land face day to day. Shout a Mate shows are booked in every corner of the nation, with more and more people asking how they can get involved with the cause every day. After spending his professional life in the depths of the wider industry, Wicks has decided that there is no better time than now to concentrate on his own music career, while conversely contributing to a cause that appeals to his broad social conscience. The Novocastrian musician captures the sound of his city in song and taps its cultural bedrock. Wearing his heart on his sleeve, Wicks' music is a melting pot of western influence forged in a Steel City, with an air of familiarity you can never quite put your finger on. It's all here; the elements of raw emotion, driving, tribal, caveman rhythms, soaring lead guitar, impassioned melody, rich harmonies, animating perennial tales served up on tasty, tasty hooks.

Florence Williams

Florence Williams is a Gungurri, Kamilaroi descendant and has been involved in Aboriginal and Torres Strait Islander health since the early 1970s. Florence commenced with the Dental team with ATSICHS Brisbane based in Red Hill. While some time spent living in New Zealand and working in the Department of Housing and Education, she returned home to take up the position as CEO of Kambu Medical Centre in Ipswich for 10 years. While in that role Florence held numerous positions on state and national Boards. In the past 10 years she has worked on workforce development with Queensland

Health and the Health and Community Services Workforce Council, and the Closing the Gap program with the Greater Metro South Brisbane Medicare Local.

Robyn Williams

Robyn Williams has nursing and education qualifications and has thirty-five years of experience of working with Indigenous people from urban, rural and remote communities, throughout Australia but primarily in the NT. Her fields of expertise include cross-cultural curriculum development and program implementation; evaluation of community based programs, Continuous Quality Improvement programs, and qualitative research in Indigenous health issues and working cross-culturally. She is currently coordinating the Bachelor of Health Science at CDU where she is working with colleagues to develop a cultural competency framework and a remote health pathway in the Bachelor of Nursing. She works closely with the Chronic Conditions and other health programs in the NT Department of Health and works collaboratively with AMSANT, IAHA, Centre for Remote Health, Lowitja Institute of Indigenous Health Research, CRANApus, LIME and of course the NRHA. Finally, she is undertaking PhD studies where her thesis is on exploring preparation for health professionals to be culturally safe and effective practitioners in Indigenous primary health care settings.

Stephen Winn

Professor Stephen Winn is currently Head, School of Teacher Education and Early Childhood Studies at the University of Southern Queensland. He also retains close connections to the University of New England as an Adjunct Professor within the School of Rural Medicine, and with the University of California Irvine School of Medicine where he is a Visiting Professor. Professor Winn holds strong professional connections to a range of industry leaders and Government departments including the Queensland Department of Education, Training and Employment and the New South Wales Department of Education; New South Wales Department of Ageing, Disability and Home Care; CSIRO Australian Centre for Broadband Innovation; and Regional Development Australia. He works extensively upon the application of technology to deliver innovative solutions to issues associated with public health, agriculture and education. He is also a member of the National Centre for Vocational and Educational Research (NCVER) and has undertaken research for Department of Communities, Disability Services Queensland evaluating Intensive Behaviour Support Teams. Professor Winn is one of Australia's leading researchers and academics, with published scholarly works providing insight into public health issues associated with disability, social inclusion, and post-school outcomes as well as quality assurance in teaching and learning.

Brooke Winzer

Dr Brooke Winzer is a Grade 2 Physiotherapist at Northeast Health Wangaratta, a 228-bed acute hospital in the Hume region of Victoria. Brooke's role includes treating respiratory patients on the general wards and in

the Critical Care Unit. She is a clinical supervisor for Physiotherapy undergraduate students and a mentor for junior Physiotherapy staff. Brooke also educates Allied Health, Nursing and Medical Staff on topics including Physical Activity and Cancer; Oxygen Therapy; Non-Invasive Ventilation; Chest Physiotherapy and Spirometry. In addition to her role at Northeast Health Wangaratta, Brooke is a Senior Research Assistant at The University of Melbourne. She is currently an Interventionist on a NHMRC funded RCT investigating the effect of a rehabilitation program on lung cancer patients. Previously, Brooke has been a casual Lecturer at The University of Queensland (Brisbane) and Charles Sturt University (Albury). Brooke completed a full time PhD at The University of Queensland (School of Medicine) in 2012. Her thesis, titled "The Effect of Exercise on Cancer Risk Factors in Males with Barrett's Oesophagus" included three publications in international journals (Cancer, Causes & Control, BMC Cancer and PLOS ONE). She was also successful in obtaining \$85,436 in competitive grant funding for the project.

Danielle Withers

Danielle Withers has been with the Eye Health Program for five months as the Eye Health Assistant. She comes from Townsville and this is her first position in eye health. She has worked in Aboriginal education and retail. Her last place she worked was at Maningrida. She is enjoying working in eye health and learning more about Aboriginal culture.

Aryati Yashadhana

Aryati Yashadhana is a PhD candidate at the University of New South Wales through the Vision CRC, and a Research Assistant with the Brien Holden Vision Institute, Public Health Division. Her PhD study is exploring how Aboriginal patients experience eye health care in the Northern Territory (Katherine & South East Arnhem Land) and New South Wales (Western), and how this is linked to clinical outcomes, social determinants and health equity. Aryati has a background in international development studies, with experience working in cross-cultural, participatory and qualitative research with marginalised communities in Australia and abroad.

Rachel Yates

Rachel Yates is currently the Primary Health Care Director at the Mount Isa Aboriginal Community Controlled Health Service (MIACCHS). Prior to that she held national policy roles with Medicare Locals and Divisions of General Practice. Rachel has qualifications in psychology, management, medical laboratory and human bioscience.

Ashley Young

Mr Ashley Young is a Senior Clinical Business Analyst with Hunter New England Health in NSW, leading the implementation and mainstreaming of telehealth as a standard mode of service delivery across all specialities and disciplines in the district. A pathology scientist by background, Ashley moved into redesign project management roles in 2005, and into IT system design and

implementation in 2010. Hunter New England Health is successfully delivering clinical telehealth services to patients in their homes, at their GP practices, Aboriginal Medical Services and Aged Care Facilities, and lobbying hard to mainstream the service delivery for the benefit of all patients when clinically appropriate.

Lis Young

Dr Lis Young has a background in Public Health and Health Services Research and Evaluation. Her key interests are community based interventions and community development. In late 2008 she relocated from Sydney to the Top End, N.T.; she spent her first year as a resident medical officer in a large Remote Community in Arnhem Land. In early 2010 she took up the position of Senior Rural Medical Practitioner, the Maternal and Child Health Program, the Primary Care Branch, Top End Health Services. Since early 2013, as part of her portfolio, she has worked collaboratively with residents in Remote Communities, service providers, policy makers, senior managers and NGOs in the development of a Smoking Cessation Support Program targeting all Remote Communities in the Top End.

Michael Zhang

Dr Michael Zhang is an emergency physician/paediatrician working in the Emergency Department of John Hunter Hospital, Newcastle. Part of his portfolio is to chair the Paediatric Interest Group meetings in this mixed Emergency Department. He has been helping to build and contributing to the GP Outreach Support Program to support the continued professional development of rural GPs in the local health district. Dr Zhang graduated from the medical school at the University of Melbourne. He undertook his postgraduate medicine training in Victoria and New South Wales, and has been granted Dual Fellowships in Paediatrics and Emergency Medicine. Michael also has a Master degree in Medical Statistics. He is an executive member of the Paediatric Research in Emergency Departments International Collaborative, PREDICT. He has a broad interest in a variety of clinical researches, especially in the areas of infectious diseases, quality improvement, and occupational health. He is actively involved in several research projects such as clinical predictors, observational studies and randomised controlled trials.

ABSTRACTS

Keynote abstracts

NDIS history, design, progress, adaptation, challenges and opportunities

Bruce Bonyhady

National Disability Insurance Agency Board

The National Disability Insurance Scheme (NDIS) is the most significant economic and social policy reform for 30 years. The NDIS was first discussed at the 2020 Summit held in 2008, when it was identified as a 'big idea'. It then ran the gauntlet of reviews by the Productivity Commission and Commonwealth and State governments, as the evidence for disability reform was carefully analysed and reviewed, before winning the unanimous support of all governments, all political parties and the broader Australian community. It involves a transformation of disability services from welfare to insurance, and is now being trialled in seven sites, including in the Barkly Shire in the NT (for people with disabilities of all ages), and in the APY Lands (for children). The Scheme is on time, on budget and participant satisfaction is very high. When the NDIS is fully implemented it is expected that in excess of 400,000 people with severe disabilities will be participants and will receive supports based on their individual needs. Total disability spending will more than double in the next five years to around \$22 billion in 2019–20. The implementation of the Scheme in rural and remote areas is particularly challenging, because choice and control of supports by participants and, hence, a contestable market for disability services is a key element of its design. However, this also implies new and very significant opportunities to develop local workforces and for business in allied sectors, such as health.



Art for arts' sake

Kathy Burns

Barkly Regional Arts, NT

We are the dirt road travellers, quite literally sweating for the arts in the dry and dusty heat, enabling the transfer of the cultural practice and knowledge of a living culture. Knowledge that is held within the artwork, the music, the dances, the

storytelling, and the making of artefacts. Indigenous culture is rich and unique and if it is diminished or lost so too will be the heart of Indigenous peoples: a sense of purpose lost, disconnection and obvious repercussions to their health. Our stories of creating art amidst areas of dysfunction and chaos show how arts for arts' sake is invaluable towards creating healthy people and societies.

Connecting places: a best-practice rural health service based in the city

Lindsay Cane

Royal Far West

From post-war Sydney in the 1920s to post-modern Australia in 2015, Royal Far West remains steadfast in its mission to connect country children with specialist health care services, despite their isolation. Rooted strongly in the belief that country kids deserve the same right to access health services as city kids, Royal Far West is a provider of specialist child health assessment, treatment, teletherapy and education programs, with a special emphasis on early intervention for children and young people in rural and remote communities.

By no accident, our Child and Family Health Centre sits by the sea at iconic Manly Beach, with our heart resting firmly in rural Australia. Connecting the bush and the beach is fundamental to our wellness model. Connections to people and places are the cornerstone of our service model. Technology-enabled care allows us to work closely with local service providers to build capacity and resilience in rural communities and help families find solutions to seemingly intractable issues.

Under one roof, 130 RFW clinicians, guest house staff, teachers, researchers, volunteers and fundraisers work together to connect and engage with country families, GPs, nurses, teachers, allied health professionals, mayors, NGOs, Rotary Clubs and others to offer the very best of our service to people who deserve the same—'country kids'.

Research in remote Australia: doing work that really matters

Alan Cass

Menzies School of Health Research, NT

In 1993, I was working as a junior doctor at Royal Prince Alfred Hospital in Sydney. One Friday the medical superintendent indicated that on Monday I needed to be in Alice Springs, where I would be working as the medical registrar at the hospital for the next three months. I arrived totally unprepared for a crash course in remote Aboriginal health. Those three months sparked a passion to contribute meaningfully to address the complex health problems faced by Aboriginal and Torres Strait Islander communities across remote Australia.

Aboriginal and Torres Strait Islander people in remote areas are more than 50 times more likely than other Australians, of the same age and sex, to be hospitalised for dialysis for end-stage kidney disease. The impact of kidney disease on patients, families and communities is devastating, especially when people must relocate hundreds of kilometres away to access dialysis. In my work, I have sought to understand what drives this heavy burden of disease, to generate evidence regarding how to prevent and better treat disease, to listen to and empower patients to tell their stories and to engage with policy makers to improve patients' access to health care that better meets their health, social and cultural needs. In this talk, I will reflect on my journey, what I have learned and why I have found my research career so rewarding.



Health security—strategic priorities of the Department of Foreign Affairs and Trade in health in developing nations

Geoff Clark

Health Programs and Performance, Australian Aid

Investing in health is a positive investment in our partner countries' and our region's economic growth. Between 2000 and 2011, approximately 24 per cent of the growth in income in low-income and middle-income countries resulted from health improvements. Poor population health, emerging and existing diseases and weak public health systems pose major threats to Australia's economic, trade and political interests. Our region is not well prepared to manage health threats. Risk factors such as rapid urbanisation, population movement and disasters are increasing. A recent World Health Organization (WHO) assessment of Ebola

preparedness in the Asia Pacific showed that most low and middle-income countries do not have the capacity to respond adequately to contain a disease outbreak. Prioritising regional health security and health systems strengthening will protect Australia and Australians against the impact of diseases and health threats, promote economic growth, and decrease the risk of economic shocks arising from suspension of trade and people movement.

An international and domestic law perspective on the health and wellbeing of Australia's Aboriginal and Torres Strait Islander people

Megan Davis

Indigenous Law Centre, University of NSW

Megan's address will be based around an international and domestic law perspective on the health and wellbeing of Australia's Aboriginal and Torres Strait Islander people. It will draw on her experience as a UN expert member of the United Nations Permanent Forum on Indigenous Peoples, in which she holds portfolios, including Administration of Justice and Gender and Women. She will draw on international work with which she has been closely associated combating violence against indigenous women and girls. Megan has expert views on the Recognition of Aboriginal and Torres Strait Islander Peoples in the Constitution and continues to be involved in legal discussions on the constitutional issues relating to the referendum model. She has a particular interest in the sentencing of Indigenous offenders of sexual abuse in the Northern Territory.

The big smoke and distorting mirrors

Julian Disney

Social Justice Project, University of NSW

The geographical distribution of population in Australia is more centralised in metropolitan areas than applies in many comparable countries. It is greater than can be attributed to factors such as climate, topography, and availability of natural resources.

The distribution has been made less fair and efficient by distortions in the tax system which disadvantage people living or investing outside major metropolitan areas. This applies especially to taxation of property and other assets.

For these and other reasons, reform of some key distortions has been recommended by several

official inquiries. It is a much higher national priority than, for example, changing the rates of GST, personal income tax or company tax.

Geographical distribution is also adversely affected by basing choices between competing needs for infrastructure investment on narrow and short-sighted methods of cost-benefit analysis. The same applies to analyses of the long-term impacts of key forms of privatisation.



When disaster strikes: the health impacts of Cyclone Pam in Vanuatu

Hensley Garae

Hospital and Curative Services, Ministry of Health, Vanuatu

Dr Hensley Garae, Director of Hospital and Curative Services in the Vanuatu Ministry of Health, describes the devastation caused by one of the worst disasters in the Pacific in living memory, the contemporary health challenges of the post-disaster phase in Vanuatu, and the health sector's response and recovery efforts.

Overcoming medicine shortages, adverse events and clinical variation

Tony Hobbs

Therapeutic Goods Administration, ACT

Dr Tony Hobbs, Principal Medical Adviser at the Therapeutic Goods Administration (TGA), is providing an update on current TGA initiatives and discussing how the TGA can support health professionals in making timely and well-informed decisions on health care for their patients.

The TGA has partnered with industry groups to develop a number of initiatives including the Medicines Shortages Initiative (MSI). Dr Hobbs will give an overview of this initiative, as well as adverse event reporting, the Special Access Scheme and the importance of clinical variation across the health system, while looking at ways for health professionals to utilise tools from the TGA to avoid individual patient care being compromised.

Labor's approach to regional and remote health

Stephen Jones

Shadow Assistant Minister for Health

Stephen Jones, Labor's spokesperson for regional health, will outline his party's continuing approach to health care for the people who live in more remote areas. Drawing on the federal budget, which will have been recently announced, Stephen will draw distinction between the two major parties. Central to Labor's approach is a continuing commitment to fairness for people irrespective of their location or income. As the creator and long-time supporter of Medicare, the Labor Party continues to be concerned about attacks on it, especially given that such measures particularly have adverse implications for regional, rural and remote Australians who already experience poorer access to health care, greater out-of-pocket expenses for health services, poorer health outcomes and a shorter life expectancy than metropolitan residents.

How well is our current health system supporting people in rural, regional and remote Australia?

Rob Knowles

National Mental Health Commission

Australians living in rural, regional and remote areas generally live with poorer health than those living in major cities. People in these areas live shorter lives, experience higher rates of illness (including mental illness) and death from suicide. The health system in rural, regional and remote areas is affected by workforce issues (the transience of professionals), and is at the whim of state and federal funding cycles.

Traditional health service provision appears to decline with distance away from major cities. This is true also of access to mental health professionals as outlined in the Mental Health Commission's recent review of national mental health services and programs.

To improve the health of those living in rural and remote areas, a one-size-fits-all approach will not work. There are vast differences in the specific needs of communities in various parts of rural and remote Australia. Communities can experience more exposure to environmental factors such as flood and drought. They may have lower rates of employment, limited access to education and people are more likely to experience social isolation. The

Commission has seen some innovative work through the non-government sector in this area, providing a huge range of services in rural communities which are flexible to local needs.

The advances in the use of technology in particular can play a huge role in supporting the health and mental health of people in rural and remote Australia.

Sovereignty in health—towards a new paradigm in the Pacific

Stevenson Kuartei

Palau Health Foundation

The presentation is about sovereignty in health, not health sovereignty. Sovereignty in health alludes to the ability of people to live in a society where health—ultimately wellness—is attainable through informed health choices. Wellness as a public good must be pursued relentlessly by governments, communities, clans, families and individuals because traditional cultures of the Pacific have limited options and poor health outcomes in ‘health’ systems dominated by disease.

This presentation will review several issues:

- health versus disease
- wellness as a public good
- an ecological model for the pursuit of wellness
- Palau Health Foundation as an example of a possible Pacific solution to achieving sovereignty in health.

The goal is to present a platform for debate about disease versus health-focused strategic approaches in trying to achieve wellness in the Pacific. Health focused approaches and systems must be relentlessly pursued by the Pacific Island countries, if they are to address their disease burden, vulnerabilities, resiliencies and survivability. Even more so the pursuit of wellness must be at the epicentre of developments in small and isolated island countries of the Pacific—especially in a world dominated by hugeness, borderless commerce and globalisation.

Treating the patient is only half the solution: seeking sustainable solutions—Australian Doctors International in PNG

Peter Macdonald

Australian Doctors International

Australian Doctors International (ADI) is a not-for-profit organisation with 12 years’ experience providing health services in remote and rural regions of Papua New Guinea. Initially ADI viewed its role as treating patients and saving lives. However, we’ve since moved away from this medical ‘welfare’ approach and instead adopted a health ‘development’ approach that addresses the underlying systemic problems and structural reforms needed to achieve sustainable community-based change.

Treating the patient is only half of the equation. Finding sustainable solutions is paramount, whether through building the capacity of local health staff, introducing family planning programs, rolling out public health initiatives or ensuring access to basic resources.

Help us decide—is ADI making a difference and is progress possible?

Papua New Guinea's National Health Plan: a case study in health system development

Clement Malau

Divine Word University, Madang, PNG

Health system development is a major topic for discussion in international contemporary health developments. Global funds have been created acknowledging global threats and most work through individual vertical systems of operations for accountability purposes. The “3 Ones” principle approved by donor partners in 2004 for UNAIDS was an excellent initiative. The Paris Declaration for Aid Effectiveness and the Accra Agenda for Action 2005/2008 had laid out important principles; ownership, harmonisation, alignment, results and mutual accountability.

Through the World Health Assembly, countries also sign on to commitments to meet global targets and objectives such as the Millennium Development Goals. Have these global principles worked and how can they be translated to the local level?

Noting the global commitments and the enormous challenges in service delivery to the rural majority in PNG, the presentation will describe the experience of the development of the Papua New Guinea National Health Plan 2011–2020 and the challenges being faced in its implementation. The National Health Plan focuses on service delivery to the rural majority and the urban disadvantaged.

AUSMAT: challenges and experiences in the development of an acute care disaster workforce

Bronte Martin

Royal Darwin Hospital, NT

The Australian Medical Assistance Team (AUSMAT) program is funded by Australia's Department of Health through the National Critical Care and Trauma Response Centre (NCCTRC) to maintain and deploy an acute care medical capability to sudden onset disasters and medical emergencies. In the past 10 years AUSMATs have deployed in response across a diverse range of disaster settings, demonstrating a distinctly unique and adaptable capability throughout the region.

The austere disaster environment creates many unique health care challenges. In the context of overwhelming demand, resource limitation and a low-tech environment, the clinical workforce must be adaptable and multiskilled in order to adequately meet the needs of the population at risk. In addition, the absence of high-tech modern diagnostic tools in the disaster setting necessitates a return to the core clinical assessment skills as foundation principles of care. Many parallels and comparisons can be drawn from those experiences of clinicians in the remote and rural health care settings.

The impact of current funding policies on the provision of Aboriginal primary health care

John Paterson

AMSANT

In 2005, Tom Calma, the then Aboriginal and Torres Strait Islander Social Justice Commissioner, released the Social Justice Report 2005 calling for the governments of Australia to commit to achieving equality for Aboriginal people in the areas of health and life expectancy within 25 years. From this point on a considerable amount of work has been undertaken to close the gap in life expectancy between Aboriginal and non-Aboriginal Australians.

Despite some successes, there is still considerable work needed. In the current environment of short-term funding cycles, an open market approach to tendering, restricted funding opportunities and policies that negatively affect the social and emotional wellbeing of Aboriginal peoples are having negative impacts on the ability to close the gap. John will briefly describe the impacts of a selection of policies, their actual or potential negative effect, and what can be done to address concerns.

Brilliantly connected health

Bronwyn Pike

Western Health

Telstra is uniquely placed to bring health into the digital age. From the early days of the Post Master General and Telecom we've been connecting Australians for more than 100 years and are well versed working in complex enterprises and bringing together fragmented solution providers.

Increasing demand, rising costs and more people with chronic illness are among the challenges Australia's health care industry is facing. Working harder can only go so far—we need to reimagine what the future could look like.

Looking at other industries, the promise of transformation through technology and connection becomes real very quickly, and you can see what a digital revolution for health might deliver.

Helping users to do more for themselves has been a key feature of almost every other industry change of the last decade. Banking is a perfect example—where once every single interaction required your physical presence in front of a teller, now you can manage almost every aspect of your banking needs securely online.

Health is caught in a model that is inconvenient for patients and labour intensive for health care providers. We need to tailor the model to suit the health industry and capitalise on the benefits connection can provide. Those living in rural and remote communities without regular access to all levels of care stand to benefit enormously if we can unlock the potential of ehealth.

We believe that ehealth solutions are a game changer that lays the foundation for the health system we need. TelstraHealth is quickly acquiring the capability, investing and partnering with health technology leaders to build innovative connected

solutions to complex health challenges. An early acquisition which is addressing rural health needs is Communicare.

Communicare is a fully integrated electronic health and practice management system. It is designed with a focus on community and population health, making it ideal for health services and social services whose primary concern is the health of the individual and of the community as a whole.

To date, ehealth has remained largely a promise for the future, but never has there been a better time to bring that promise to life.

The challenge of providing fair care

Carole Reeve

Centre for Remote Health, NT

To set the scene for the theme of the conference I will describe some of the people and places in rural and remote areas. If we look at three of the biggest risk factors for poor health: joblessness, families with children living in poverty and school leavers not in higher education—they increase dramatically for the 30% of Australians who don't live in major cities. The result is decreasing life expectancy and increasing avoidable mortality outside of the main centres.

Rural practitioners are the key to improving health outcomes for people in rural and remote areas. Growing multimorbidity and complexity of care are increasing the demands on patients and practitioners in ways not addressed by traditional health care models and training.

The presentation will illustrate some of the principles and strategies that are making a difference and the possibilities for us as health professionals and community members to improve health outcomes.

Creating healthy rural places

Jacki Schirmer, Helen Berry

The University of Canberra, ACT

People, place and wellbeing are intrinsically interwoven, with many complex relationships linking the place a person lives and that person's wellbeing. These linkages are diverse: the place you live may influence your wellbeing via your social interactions with others in the community, the physical landscape, availability of key services, and overall liveability, to name just a few. A community with poor leadership, few facilities, a lack of green space,

poor housing, and high levels of social conflict is less likely to support wellbeing compared to a community with good, accessible facilities and services, attractive landscapes, and strong community cohesion. Despite a rapidly growing body of work in this area, designing wellbeing interventions that focus on the place a person lives in, rather than on the individual, is not easy. In this paper we examine both expected and unexpected connections between place and wellbeing. To do this, we use the findings of the Regional Wellbeing Survey, an annual survey of more than 10,000 rural and regional Australians that measures both the wellbeing of individuals, and how they experience the community they live in. We draw on this rich dataset to examine the nexus between people and place in rural Australia, and identify place-focused interventions with promise for supporting wellbeing.

The serious challenge of delivering health care in rural and remote areas that is high quality and reflective of need

Stephanie Trust

Kimberley Aboriginal Medical Services Council, WA

Delivering health care in rural and remote areas that is high quality and reflective of need is challenging. Dr Stephanie Trust's—a Kidja Woman, Director of the Australian Indigenous Doctors' Association and general practitioner based in Kununurra—keynote presentation will provide an overview of some of these challenges.

Dr Trust will explore the realities of delivering health care, especially to Aboriginal and Torres Strait Islander people, in rural and remote settings through a focus on her personal experiences as a health professional in the Kimberly. As a general practitioner, immediate past Medical Director of the Kimberly Aboriginal Medical Service Council, former Enrolled Nurse and Aboriginal Health Worker, Dr Trust's keynote presentation will provide a multifaceted regional level view on health inequalities in the Kimberly.

Different places, different voices: same goal of better outcomes

Amanda Vanstone

Royal Flying Doctor Service

Country and city people are different. They live different lives, and face different challenges. One difference needn't exist. Flying Doctor research

shows country people see doctors half as often as city people, specialists a third as often, and mental health services a fifth as often. The research links low primary care access to death rates in remote areas being thirty-five per cent higher than in cities, and life expectancy of country people two years shorter than for city people. Is it because we come from different geographic places, is it because we value our different voices that rapid improvements in rural health outcomes are so hard to achieve? Royal Flying Doctor Federation Board Chair Amanda Vanstone, a former Howard Government Cabinet Minister, will talk about how an argument for better health outcomes for country Australians can be made, and the need for a single voice when talking to governments.

Research excellence, knowledge exchange and policy development

John Wakerman

Flinders University

Research evidence can be a powerful tool for effecting change. Hefty research reports can also completely miss the mark and be used as doorstops. The science of knowledge exchange and translation is young. This paper explores how we—as researchers, service providers, policy makers and health service planners—can maximise benefit to the population and to health outcomes through the process of research translation or knowledge exchange.

The paper addresses the questions: Why does an idea's time come when it does? How can high quality research make a difference in the real world? It briefly describes the policy process. The paper then draws on the work of the Centre of Research Excellence in Rural and Remote Primary Health Care (CRERRPHC) to examine the key features of an effective knowledge exchange process.

The rural and remote Aboriginal and Torres Strait Islander health narrative

Mark Wenitong

Apunipima Cape York Health Council, QLD

Although we have seen some improvements in Indigenous health and chronic disease in remote Aboriginal communities, we still have significant ground to cover in order to see sustained changes. What could be described as a failure of both policy and practice can be partly explained by the emphasis on health strategies such as the SNAP

framework (Smoking, Nutrition, Alcohol and Physical Activity). While the SNAP approach is important in many respects, the emerging evidence around a number of likely key drivers of indigenous health and social issues may be much broader than the individual approach. As the health system came to understand the relevance of social determinants on ill health, other evidence has emerged that can help to explain the lack of real improvement, especially in terms of remote Aboriginal health. The new evidence includes issues relating to epigenetics, early childhood adverse events, and poverty trap thinking. This new evidence can lead us to some valuable new interventions that may support generational changes in chronic disease status. This presentation will adopt a solutions focus and discuss some of these emerging issues.

The future for health workforce in rural Australia

Ian Wronski

Division of Tropical Health and Medicine, James Cook University, QLD

Governments worldwide are working towards implementing the goal of universal health coverage—the goal that all people obtain the health services they need without risking financial hardship. The availability of qualified personnel is critical to access and quality of care. Rural and remote Australians have for many years contended with geographic maldistribution of Australia's health workforce (meaning shortages in non-metropolitan areas), and the unbalanced distribution of health workforce between and within countries is a significant and longstanding problem worldwide. Epidemiological and demographic transitions (ageing populations, higher rates of chronic disease), as well as new technologies and changing patterns of demand for health care, are putting pressures on old structures—and health systems both here and abroad are being required to develop their sub-acute, chronic and rehabilitative capacity. New workforce models (including medical and allied health generalism), funding structures, cross-country mobility of health professionals and other policy levers will have a role to play in shaping our rural health workforce over the next two decades.

Concurrent abstracts

Aboriginal community researchers: promoting meaningful research outcomes in remote Aboriginal communities

Lyn Allen, Tammy Abbott, Lena Taylor

Ninti One, NT

Over the past 3 years, Ninti One Ltd has employed more than 120 people as Aboriginal Community Researchers in remote communities across Australia.

Local people are trained and engaged to join our research teams, contributing their deep cultural knowledge at all stages of the research cycle: setting priorities and research questions; obtaining community approvals and participant informed consent; creating survey and other research instruments and supporting material; working with project leaders from academic, industry and government organisations; collecting and analysing data; presenting results and feeding back research findings to community members and organisations.

The ongoing and enduring benefits of community control over priority setting and service delivery are well known, especially in relation to Aboriginal health services. Our network of Aboriginal Community Researchers provides a practical way for Aboriginal communities to have much greater influence and control over research and the findings. So-called “mainstream” researchers also gain a greater understanding of the community and cultural context in which they are working, and the research project inevitably benefits from more meaningful and deeper engagement with participants. For the individual, working as an Aboriginal Community Researcher is a source of meaningful work as people are valued for their local and cultural knowledge, it pays well, and commonly leads to other employment opportunities.

In a team presentation, Aboriginal Community Researchers will give a firsthand description of their work and the benefits of the approach for their communities, research projects and to them as individuals. The implications for research funding and improved service delivery to remote communities will be articulated for the benefit of policy advisors and program managers. The approach is scalable and can be implemented

across a range of locations and to service a raft of different roles and requirements.

Frontier stories: nursing and midwifery politics, policy and practice over time

Robyn Aitken, Kay Farquharson

Department of Health, NT

The provision of health care in the Northern Territory is characterised by geographical, climatic and cultural diversity. The goal of improving the health and wellbeing of Aboriginal people is core business for nurses and midwives. However, the work of nurses and midwives does not occur in isolation. The interaction between politics, policy and practice both encourages and stifles innovation; influencing health service models, health outcomes, and recruitment and retention of the health care workforce. There is also a sense of history repeating itself, the same mistakes being made over and over, old models resurrected, and successful models having only short lifespans.

This paper presents research based on the oral histories of Northern Territory nurses and midwives. The oral histories are unique in that they contribute data from health professionals who have spent the majority of their working lives in the Northern Territory. The stories have been analysed to identify recurring themes that are relevant to the current context of health care delivery for remote and Aboriginal populations.

The new knowledge generated from analysing these stories provides an insight into how professional practice is influenced by the politics and policy of remote and Indigenous health. The findings are heartening: they demonstrate that individual health professionals can use their influence to improve decision making, or make good of poor decisions at the political and policy level. The lessons learnt from the reported experiences of nurses and midwives translate more broadly across professions and are relevant both today and for the future.

Illicit use of fentanyl patches in rural Australia: challenges of harm reduction

Julaine Allan¹, Nicole Herridge¹, Michele Campbell¹, Alan Fisher², Innes Clarke³, Pat Griffiths⁴

¹Lyndon Community, NSW, ²Wodonga Health Service, ³Murrumbidgee Local Health Network, ⁴Penington Institute

Background: Fentanyl is a synthetic opiate with powerful pain-killing and tranquillising properties. Fentanyl transdermal patches are used for the management of chronic pain. Australia has seen a steady increase in the prescribing and non-medical use of prescription opioids (Rintoul, Dobbin, Drummer & Ozanne-Smith 2010), most recently fentanyl in the form of long-acting patches. From 2000 onwards, the deaths in Australia associated with fentanyl have increased (Roxburgh et al. 2013). Additionally, these deaths appear to be over-represented in rural areas (Roxburgh et al. 2013).

Non-medical use of fentanyl can involve high risk preparation and administration methods. Further, no rural Australian drug user-focused research has been published to date, and the drug and alcohol workforce is without adequate resources to assist them to discuss risk reduction options with fentanyl-injecting clients. There is an urgent need to increase the capacity of frontline workers and policy makers to understand fentanyl and its use by illicit drug users so that they can more effectively reduce associated harms.

Aim: The study aimed to investigate how and why people use fentanyl for non-medical reasons in rural NSW, Australia and; to identify strategies that may mitigate risks and associated harms.

Method: Semi-structured interviews exploring rural fentanyl users' (n = 14) experiences of obtaining, preparing and using fentanyl were conducted. A narrative analysis identified key points around participant's harm reduction practices, perceptions and experiences with using fentanyl.

Results: Themes relating to participants' accounts of learning to use fentanyl, experiences of harms and benefits, sources of information about harm reduction and strategies for controlling or stopping use are described. Peer networks were identified as key channels of information but rarely included internet user groups or sharing of formal information.

Conclusion: In rural communities, beliefs and practices about obtaining and using fentanyl are transmitted and reproduced across groups of illicit

drug users, amplifying and distorting information about methods and harms of fentanyl use. Peer networks are critical sites of harm reduction action that are challenging to infiltrate in the rural context where dispersed populations, distance and risks associated with disclosing illicit drug use are significant barriers to disseminating harm reduction information.

NT and Darwin by dance

Owen Allen¹, David McMicken²

¹Atherton Family Physiotherapy, QLD; ²Tracks Dance Company, NT

This is not a discussion about the habitual embodiment that drives our organisations, professions, and communities down the highways that bypass the burden of disease and disability. This is restructuring. This is taking the exits off that highway. This is dance.

Although none of the original members are still in the group, the Grey Panthers of the Darwin TRACKS Company have been performing since 1988. They have often challenged the role of the senior in society, working with playwrights, choreographers, filmmakers, and other artists. As individuals, the Grey Panthers are driven by constant volunteerism; extra care for others; and making activities that are relevant and fun. Dance is seen as a tool in their arsenal of health, fitness, mental dexterity, socialisation, care and support, entertainment, and visibility.

TRACKS Company has also worked for 25 years with the Lajamanu elders near the Tanami Desert, south west of Katherine, observing the value of dance in the empowerment of elders in the community. Other dance companies with mature dancer programs have alluded to the empowerment that comes from 'creating a future for the older person' (Glen Murray, MADE in Tasmania, Inaugural DANscienCE Festival, Canberra, 2013).

The Grey Panthers will perform a 20 minute enquiry into their experience of Darwin and Northern Territory life. Given the health burden of remote Australians, and in the spirit of 'the message is in the media', the performance comes with an invitation to look at the development of dance and movement arts in rural Australia as having a significant contribution to the cultural change required for healthy community: physical and cognitive adaptability; emotional and social resilience; and social discourse.

And maybe something else will show up for you.

***headspace*—geospatial analysis of mental health service provision for Indigenous young adults**

Sophie Alpen¹, Reuben Bolt², Zachary Steel³

¹University of NSW, ²Nura Gili, University of NSW,

³St John of God Health Care; School of Psychiatry, University of NSW

Background: ‘Are we in the right place?’ It is a question we constantly face in discussions about health service provision. *headspace* is a growing network of youth specific mental health centres that provide a service to the youth community. This cohort includes Indigenous young adults who are highly affected by mental ill health however often do not receive mental health care.

Method: Geospatial analysis using population-to-provider ratios was used to compare the location of centres with Indigenous young adult population and proportion. Similarly, remoteness areas compared these distributions to areas of deprivation. Case studies were used to determine the impact of the population proportion and remoteness may have on the success of the clinic.

Findings: *headspace* is well situated in areas of high Indigenous young adult populations, however this is not the case for areas where Indigenous young adults are of a higher proportion of the total young adult population. A significant distribution difference is present between *headspace* centres and the Indigenous youth population by remoteness. Centres in areas of high Indigenous proportion draw closer connections to the local Indigenous health community.

Discussion: The location of new *headspace* centres is based on a consideration of the entire youth population. To better service the needs of Indigenous young people *headspace* could consider areas of high Indigenous young adult proportion, in combination with creating partnerships with the Indigenous health community and increase its reach in rural and remote areas at the individual clinic level.

Recommendations

1. Establish clinics in areas where the proportion of Indigenous young adults are a high contingent in the youth population.
2. Extend the reach of existing clinics to areas of high proportionality of Indigenous young adults

where it is not feasible to have a fully operational clinic (these may be rural or remote).

3. Create partnerships with existing Aboriginal Community Controlled Health Organisations.
4. Research further into the outcomes at the location of the centres i.e. change in the prevalence of severe mental illness for a region due to the primary care and prevention strategies deployed by *headspace*.
5. Further research into the cultural competency of the *headspace* service and its affinity to the needs of Indigenous young adults.

Keeping up with the Joneses while at home with the Smiths

Janelle Amos, Miriam Gerber

Hope Therapy

With the introduction of the Australian Health Practitioner Registration Authority many allied health disciplines have had significant changes to their registration standards, including some states and disciplines that have never had statewide registration requirements previously. This has been a significant transition for the whole workforce but one group particularly affected by the changes are ‘stay at home (SAH)’ care givers. These professionals, whilst not currently practising or in a very part-time capacity, have had a mammoth task in understanding and meeting new requirements. It has been our experience as ‘SAH’ care givers that meeting the continuing professional development requirements and recency of practice standards pose a significant threat to our ability to maintain our registration. This is made more difficult by our rural and remote locations. So how can we fulfil our desires to SAH with infants and children and yet remain registered and able to continue to play a significant role in the health field on re-entry?

It is well documented that rural and remote locations have great challenges in recruiting and retaining allied health professionals. It is also well recognised that the vast majority of allied health professionals are women and that they will leave the workforce for a period of time in order to pursue a family. In doing so we are often losing senior clinicians with years of experience out of the workforce and unless we are able to provide innovative solutions for these care givers many are unlikely to maintain their registration and re-enter the workforce with all their experience at a later date.

This paper addresses some innovative ways to complete the requirements of recency of practice and also of continuing professional development, particularly for those located in rural and remote locations. We as professionals are concerned about the lack of support for this SAH group and are passionate about finding solutions to keeping people work ready. If we are really serious about 'people' and 'places' then let's look seriously at some 'possibilities' for this group of practitioners.

Encountering the lived experience of mental health undergraduate nursing/paramedic student responses

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Consumers and carers from rural and regional New South Wales shared their accounts of their lived experience of mental health with undergraduate nursing and paramedic students at a regional university in a collaborative project with an NGO. Students responded to these in a survey immediately following presentations of these stories and a panel discussion of common experiences. They were surveyed again at the end of the session. The survey contained basic demographic data, and a combination of Likert scales and open responses. Ethics permission was obtained and 102 surveys were completed.

Emerging evidence from the literature demonstrates the importance of carer and consumer led education. This is seen to challenge dominant biomedical paradigms and specifically counter stigmatising attitudes. The lived experience provides the opportunity for consumers to speak from a position of expertise, empowering them to address issues of pertinence in interacting with health professionals and the services they provide.

Student demographics between the cohorts were reflective of gender distribution within the professions. Age groups were consistent with an undergraduate population. The differences in the courses included clinical placement specifically in mental health areas for the nursing students only during this session (between the administration of the 1st and 2nd surveys). Nursing students were also much more likely to be employed in health and welfare sectors (as AINs) at the time of the surveys. (46.4%:6.7% of respective respondents).

The findings indicated that students gained new knowledge of issues related to diagnostic difficulties. They also expressed a previous lack of knowledge about the lived experience of people with mental health issues and their carers. The paramedic cohort were more likely to identify issues related to control and management of people experiencing mental health issues, whereas the nursing students were more likely to identify issues related to caring for people experiencing mental health issues and their families, and deficits within mental health services.

Responses indicate that the structure of student courses could be informed by these findings. The imperative that paramedic students perceive of needing to establish control and manage people experiencing mental health issues during their practice may require initial acknowledgement in order to enhance engagement prior to introducing recovery principles. In contrast nursing students initially engage from a caring perspective but may need to better understand the impact of biomedical interventions.

Key lessons for closing the gap for vision

Uma Jatkar, Mitchell Anjou, Hugh Taylor
University of Melbourne, VIC

There has been progress to close the gap for vision for Indigenous Australians, with lessons to be shared between people and places. Vision loss represents 11% of the health gap, and Indigenous adults have 6 times the rates of blindness and three times as much low vision compared with non-Indigenous Australians.

The *Roadmap to Close the Gap for Vision (2012)* comprises an evidenced-based set of multidisciplinary recommendations to achieve equitable eye health outcomes. It addresses the four major eye conditions that affect Indigenous people: refractive error, cataract, diabetic retinopathy and trachoma. The *Roadmap* outlines coordinated regional, jurisdictional and national action, and has wide support from the Aboriginal health sector, federal and jurisdictional governments, and the non-government and eye care sectors.

Currently the *Roadmap* is being implemented in 12 regions that cover 35% of the Indigenous population. There have been both successes and challenges in implementation, but progress is being made on regional action to improve eye health

outcomes and services to Indigenous Australians. These regional achievements also link to broader jurisdictional and national action, such as jurisdictional eye health committees, that affect Indigenous people and places across Australia.

For example, in Victoria significant progress has been made in 2014 in implementing aspects of the *Roadmap under Koolin Balit: Victorian Government strategic directions for Aboriginal health 2012-2022*. These include a specific focus on Indigenous eye health and a statewide eye health advisory committee to coordinate eye care in Victoria, in addition to particular regional actions.

Specific regions, such as Central Australia/Barkly and the Grampians, have made progress through elements that are a model for other regional areas of Australia, including specific funding for eye health, dedicated eye health project officers and regional stakeholder advisory groups.

Progress outlined in this presentation will highlight possibilities for how the gap in vision can be reduced with effective and coordinated regional improvements, linking in with jurisdictional and national action.

Are retinal cameras essential for remote health clinics?

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Retinal cameras have been used in detecting, diagnosing and managing eye disease for several decades. Their use in primary health care clinics has steadily increased, particularly as they have become more affordable. Given their availability and usefulness for diabetic retinal screening, we sought practitioners' views on whether retinal cameras may be considered "essential equipment" for remote primary health care clinics.

We conducted in-depth, semi-structured interviews with 12 primary health care practitioners and administrators responsible for providing primary eye care services in remote clinics. Interviews were designed to understand the systemic barriers for patients trying to access screening and treatment for diabetic retinopathy, as well key barriers and enablers for diabetic retinopathy screening programs—all from the practitioners' and

administrators' perspectives. Additional insights are drawn from the literature and the primary author who has experience delivering eye care training to remote primary health care practitioners.

Practitioners' and administrators' responses focused on image quality and issues around pupil dilation as well as the administrative processes involved in getting appropriate diagnoses and assisting patients with referrals. Having primary care practitioners use a retinal camera rather than a direct ophthalmoscope to view the retina was considered highly advantageous and given broad support. Respondents also considered retinal photography a powerful opportunity to improve patient outcomes, by using the images as a patient education tool, to engage patients in their diabetic eye care.

Primary health care practitioners are required to examine retinas of patients with suspected sight-threatening disease. These practitioners often receive only limited training and practical experience in using ophthalmoscopes and may have a corresponding lack of confidence in viewing the retina. Remote practitioners face additional challenges in determining which eye problems require expensive evacuations for urgent (sight or life saving) ophthalmological care. Given the improved accessibility and useability of modern retinal cameras, and usefulness for referral decision-making regarding medical evacuations, they may be reasonably considered essential equipment for remote health clinics.

Policy recommendations: 1) All remote health clinics, particularly those requiring aerial evacuations for urgent ophthalmology care, should be equipped with a digital retinal camera and corresponding system for tele-ophthalmology to support referral decision-making 2) National diabetic retinal screening programs must consider unique and locally diverse requirements of rural and remote clinics (e.g. IT and training needs).

Community Ward: getting ahead of the game

Mark Ashcroft
Alpine Health, VIC

Conjointly configuring a service model in consultation with an available workforce around the management of long term conditions is one of the major challenges facing health and social care systems worldwide. In rural areas, access to care

supports for managing long term conditions can be particularly challenging.

A demonstration project, as part of a Health Workforce Australia grant initiative in 2012, which focused on complex care for the elderly in the community, saw the development of a Community Ward model at Alpine Health. This model, albeit with small numbers, has been able to demonstrate a range of outcomes including that:

- the prevention of unnecessary admissions to hospital is possible
- the coordination of workforce effort across service domains is possible
- predictively engaging people in an anticipatory care model facilitates earlier intervention
- the establishment of intervention success measures in long term illness interventions must consider contamination effects of the environment and other behaviours over time
- there is significant value in harnessing existing community assets for the co-production of health promotion initiatives.

The Community Ward model is based on similar international models and was designed as a combined service and workforce development model for delivering multidisciplinary case management. The model has the dual purposes of;

- using a predictive model to identify people who are at high risk of future emergency hospitalisation
- aligning these individuals with a coordinated anticipatory care focused workforce for a period of intensive, multidisciplinary preventive care in home using the systems, staffing, and daily routines of a hospital ward construct.

The ability to replicate, transfer and scale the Community Ward model concept was an important consideration of the project. Key enablers of the Community Ward model include the following points:

- 'joined up' primary and secondary care patient intelligence
- the ability to influence the MBS national policy development to encourage system behaviour in the direction of early, predictive intervention
- the establishment of a set of 'organisational readiness' metrics for those organisations that

are planning workforce and service reform, to act as a checklist so managers commissioning this type of change can reliably perform an organisational gap analysis and apportion resources strategically

- recognition of the MPS model as flexibly appropriate in the small rural setting to facilitate the re-apportionment of workforce resource from secondary to primary care with service development
- a commitment to a broader organisational improvement strategy, such as a clearly defined planning structure and or improvement framework.

Agricultural sectors and primary school students find a common ground: building a resilient local food system in rural Tasmania

Stuart Auckland², Sandy Murray², Gretchen Long¹, Alison Ward¹, Debbie Reid¹, Caitlin Saunders²

¹Tasmanian Health Organisation—North, ²Centre For Rural Health, TAS

Access to an affordable and nutritious food supply has been recognised as an important determinant of people's nutrition and health outcomes. Tasmanians across all income levels do not eat sufficient fruit and vegetables despite Tasmania having some of the most productive soils and suitable climate for fruit and vegetable production. Previous community-based investigation in two Tasmanian local government area (LGAs) revealed a wide variation in access, availability and cost of a healthy food both with and between the two municipalities. The community consultations process uncovered a level of interest from communities to work towards solutions to improve both physical and financial access to healthy food and in particular locally grown fresh fruit and vegetables.

The Healthy Food Access Tasmania (HFAT) research project seeks to *make healthy food choices easy choices* by ensuring that fresh fruit and vegetables (preferably locally grown) are readily available across Tasmania.

The HFAT study applies a range of methodologies which contribute to the building of a resilient local food system. The approach uses a variety of methods to achieve the aim of the study. This includes an initial stakeholder review with key informants from the local food industry; determining

the availability, cost and affordability of food across Tasmania; and mapping the production, distribution and supply of fresh fruit and vegetables. Findings will assist with the establishment of local community food initiatives aimed at improving access by communities to fresh fruit and vegetables as well as a process for monitoring food access in Tasmania.

Preliminary findings suggest that it is more difficult for people residing in rural and regional areas, where there is limited or no access to Major and Minor Supermarkets, to purchase healthy food. Furthermore, families living in towns serviced by a limited number of food shops may also be at a disadvantage in their ability to access healthy food if they do not have transport to a supermarket.

The findings supports a policy framework based on the true value of our food system from paddock to plate: inclusive of the natural resources and the people, on which, it—and we—depend. This would contribute to better population health outcomes and enhanced food security through supporting an increase in the sustainable and viable production of fruits and vegetables, and thus enable the progressive reduction of hunger, chronic disease, and obesity.

Fit4YAMs-2: health-related text messages preferences of overweight rural young adult males

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To maximise the effects of text messaging interventions messages need to be engaging and motivational. Striking the right balance with message content, text talk, text acronyms and emoticons, delivery frequency/time, and personalisation of messages is crucial. This is particularly important when trying to appeal to traditionally hard to engage groups such as rural young adult males (YAMs).

Fit4YAMs-1 reported the detailed method used to develop a text messaging intervention specifically designed for overweight or obese (OWOB) rural/regional YAMs. Fit4YAMs-2 reports on the preferences of OWOB rural/regional YAMs for health-related text messages.

Contrary to our hypothesis that YAMs would prefer health messages that used text talk, acronyms and emoticons, the participating Group 1 YAMs indicated a preference for correct spelling and grammar particularly for health-related text messages. Similarly, emoticons were not a preferred option as these were considered “teenage girl talk”.

However, the YAMs were unanimous in their preference for short, concise messages of 1-2 sentences. Longer messages were not engaging. Personalisation of messages was deemed important. Not “fake” personalised with just their name at the start of the message, but really targeted towards their individual goals and interests. A frequency of 3-4 messages/week delivered on weekday afternoons or weekend mornings were considered the best approach to motivate them.

The refined “yammised” messages were sent to a different group of OWOB YAMs (Group 2) for rating on a scale of 1 very poor through 5 very good. On average, 51 out of the 74 yammised messages were well received, getting above average ratings (mean 4.3 out of 5). Within the 23 messages that did not rate well, we deliberately included several messages that used emoticons and acronyms, to confirm the findings from the Group 1 participants. These types of messages were also not well received by Group 2, but were not the most disliked messages within the collection. Interestingly, the most disliked messages were regarding diet. A message relating to the consumption of frozen meals in place of takeaway food was the most disliked followed closely by another message which addressed reducing alcohol consumption to cut kilojoule intake.

The above average messages will be used in the intervention phase of the Fit4YAMs project when we perform a pilot study to ascertain the effectiveness of using specifically designed health-related text messages plus incentives to promote and maintain weight loss in 17-25 year old OWOB YAMs in rural/regional Australia.

Nurse practitioner led services in primary health care—two case studies

Frances Barraclough

University Centre for Rural Health, NSW

Aims: This study aims to describe, in detail, the roles of two nurse practitioners (NPs) in rural New South Wales in primary health care settings. One

case study focuses on the delivery of an integrated mental health service and the other on leadership in aged care.

Methods: A case study methodology was employed, using multiple data sources. Data were gathered using semi-structured interviews with 31 key stakeholders, the examination of key documentation, and observation of the NPs within these settings. In the first case study, quantitative data were also analysed. Interview data were analysed thematically.

Relevance: NPs are a relatively new advanced nursing role. It was hoped that NPs would reduce some of the challenges facing health care, address workforce shortages and improve access to services for rural populations. The most recent census of Australian NPs showed that just twelve of 208 working NPs were located in primary health care settings. It also showed the majority of NPs were employed in metropolitan areas. Few previous studies describe NP roles in detail, or in rural primary health care settings. This study highlights the significance of implementing NP roles in primary health care settings, as well as the additional scope that these roles can bring to small rural communities.

Results: The case studies offer an in-depth description of why and how these roles were established, what the NPs do and their impact within the context of small rural towns. They illustrate how NPs established intersectoral partnerships, new service delivery models and advocacy regarding the way health care was provided. The case studies also provide valuable information on how to best incorporate NPs into rural primary health care. The case studies provided evidence of how integration works to deliver better health services within rural settings.

Conclusion: This study details the complexity of two NP roles within rural primary health care settings. The two case studies show that in these settings, NPs are providing leadership, supporting other services, helping to address workforce shortages, improving access to services for rural populations, and therefore demonstrating the positive impact of NPs working in these settings. The NPs established intersectoral communication, partnerships and service delivery and used policy and advocacy to change how health care is provided in small rural towns. The NPs were able to achieve coordinated care management across providers and settings.

☆ Detecting and preventing cervical cancer: a nurse-led model for rural Aboriginal women

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¹NSW Rural Doctors Network, ²Condobolin Community Health Western NSW Local Health District, ³Royal Hospital for Women, Sydney, ⁴Orange Aboriginal Medical Service

The incidence of cervical cancer and related deaths in Aboriginal women is significantly higher than that for the wider population. In one NSW rural community, cost was a major barrier for local Aboriginal women needing to access colposcopy services. Instead of providing services locally, the Aboriginal Community Controlled Health Service (ACCHS) had been supporting women to travel to Sydney to receive the necessary investigations and treatment. Difficulty in finding a suitably trained and available medical practitioner to provide clinical services locally led to the decision to support and train a women's health nurse to perform colposcopy.

To support the service a partnership was formed between the nurse, her employer, the ACCHS, a gynaecologist from a teaching hospital and a statewide NGO. This led to the introduction, in 2012, of what is most likely to be the first nurse practitioner led colposcopy and gynaecology clinic in Australia. By nurse practitioner-led we mean the nurse practitioner is wholly responsible for the clinic from accepting referrals, triage, addressing the results, providing follow-up and pursuing a defined education plan.

Following a well-structured training program developed and overseen by the gynaecologist, the nurse practitioner commenced the clinic with on-going support and supervision provided by the teaching hospital and regular meetings between the project partners. The meetings discussed and resolved issues around referrals, clinic space, equipment and remote supervision. The clinic was marketed to general practitioners as the main referrers. A comprehensive evaluation has been undertaken of the first 125 patients seen at the clinic and the results show that high quality care has been provided with appropriate treatment, referral and follow up.

The introduction of a nurse practitioner led colposcopy and gynaecology clinic has improved access to essential health care for vulnerable and at risk patients. The model employs best practice in

terms of effective collaboration between partner organisations, training and supervision and has recently been recognised by receiving a significant statewide health award. The availability of a nurse practitioner provider number, Aboriginal Health Worker training and support to improve cultural competence and the application of suitable telehealth technology will assist to improve both efficiency and effectiveness and enhance access in a culturally safe environment. The evidence suggests that this model can be replicated in other rural and remote locations.

☆ Symbiotic partnership to grow the health workforce in rural and remote Australia

Kristine Battye, Cath Sefton
KBC Australia, NSW

Over recent years there has been increasing focus on the need to build clinical workforce training capacity in rural and remote health service settings as a mechanism to meet increasing demands for student clinical placements across health professions, and as a strategy to increase health professionals choosing a career in rural, remote and Indigenous health. At the same time, government policy at a state, territory and federal level is seeking to increase Aboriginal and Torres Strait Islander participation in the health workforce.

This paper will present a synthesis of the literature and findings of projects undertaken since 2012 that have sought to identify and/or develop clinical workforce training capacity in rural and remote settings with particular consideration of the Aboriginal Health Worker and Practitioner workforce. Projects included in this synthesis are drawn from the Northern Territory, Victoria, Western Australia and nationally.

As a result of the synthesis, a model for clinical workforce training has emerged that is underpinned by a symbiotic partnership between the:

- training organisation/provider
- trainee
- employer and workplace.

This paper will describe the key features of the partnership model, and structural shifts required to better support the education and training of Aboriginal Health Workers and Aboriginal Health Practitioners to achieve educational outcomes. The

central role of the clinical educator within primary health care services and settings will be discussed as a crucial, but often missing element that is required to support training, education and workforce development in rural and remote Australia, not only of Aboriginal Health Practitioners, but nursing, medical and allied health professions.

Having this essential human resource (**people**) working in the right **places** expands **possibilities** to build the rural, remote and Indigenous health workforce. Mechanisms for how this clinical educator role can be supported will be described.

👍 Improving nutrition and providing jobs in remote Indigenous communities

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¹Jimmy Little Foundation, NSW; ²Discipline of General Practice at the University of Newcastle, NSW

It is well understood that adoption of a Western style diet (high in fat and carbohydrates) in Indigenous communities has been associated with high rates of diabetes, hypertension and other non-communicable disease. Less well known is the prevalence of food insecurity among the elderly in these communities. As the mortality gap slowly closes, better medical care is resulting in higher numbers of over-45 year olds and there is need for increased attention to personal care and diet in this group.

For half of its ten years of operation, the Jimmy Little Foundation has been providing multi sector nutrition education to remote Indigenous communities through the Thumbs Up! program. It's message of Good Tucker = Long life is delivered across the whole of community through song writing and music workshops with school children, local store branding, cook ups of healthy food and with performances at music concerts and cultural festivals.

In partnership with the University of Newcastle, the Foundation is now exploring the possibilities and merits of delivering certificate level courses in healthy nutrition/care of the elderly to Indigenous youth. The outcomes would serve the dual purpose of providing employment for young people and addressing nutrition needs for the elderly. The project will embed the healthy eating and lifestyle message into the whole of the community in a sustainable and culturally respectful way.

This proposal is in line with current government policy around finding employment for Indigenous people in remote communities. It will also provide high school students with a pathway to a qualification that will guarantee employment in the local or wider community. The model might be considered by other organisations working in these communities.

Rheumatic heart disease in Australia—a Dickinsonian disease still prevalent in the Top End

Claire Boardman, Christian James, Catherine Halkon, Catherine Milne

Menzies School of Health, RHDAustralia, NT

Acute rheumatic fever (ARF) is an autoimmune sequelae of group A streptococcal (GAS) infection mostly affecting children 6-14 years of age. Recurrent episodes of ARF lead to cumulative heart valve damage and the development of rheumatic heart disease (RHD). RHD is a chronic, sometimes fatal disease that often requires heart valve surgery. It is estimated that RHD affects 15.6 to 19.6 million people worldwide and causes 233,000 to 492,000 deaths each year. ARF and RHD are particularly prevalent in remote Aboriginal communities.

RHDA was established to support RHD control programs in the Northern Territory, Queensland, South Australia and Western Australia by providing technical assistance, advocacy and policy development. RHDA has established a data collection and reporting system to measure the quality of local health service delivery and to provide epidemiological data across participating jurisdictions. Preliminary analysis of data will be discussed and used to determine how we can use the data to leverage better health outcomes linked to the social determinants of health.

In partnership with the National Heart Foundation and the Australian Cardiac Society the evidence based Australian Guideline for Prevention, Diagnosis and Management of ARF/RHD was developed and disseminated and, translated into an iPhone and Android app platform for use in clinical and remote settings. RHDA also works to increase community awareness and prevention of ARF/RHD with a particular focus on primordial prevention through the development of resources that have been designed specifically for use in Aboriginal and Torres Strait Islander (ATSI) communities following a process of community engagement.

ARF and RHD remain a major health problem in Indigenous people in the top end with rates remaining the highest in the world. The Australian Northern Territory has the highest rate of ARF in the world with RHD affecting approximately 25 Aboriginal people in every 1,000 of which 45% require heart valve surgery in Australia, most of whom are less than 25 years old.

Timely diagnosis of an initial ARF episode and subsequent use of antibiotic prophylaxis is the best method of preventing RHD. This paper summarises current strategies to improve health outcomes for ATSI drawing on international and Australian experience.

Disclosure of interest: The RHDA National Fever Strategy is a Commonwealth funding initiative housed at Menzies School of Health Research in Darwin.

Rural young people's perspective of sexual health

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Background: Rates of sexually transmitted infections are increasing. Rural young people are vulnerable to engaging in unprotected sex where access to sexual health services is low.

Aim: To understand perspectives of sexual health and safe sex among young people living in rural communities in northern Victoria.

Methods: A series of eight focus groups were conducted with young men and women from a rural area in northern Victoria. Young people were recruited from two football and netball clubs in small towns as well as a gay/lesbian/bisexual/transgender/intersex group in a regional centre. Young people were asked about their use of health services for sexual health and their adoption of safe sex messages. Focus groups were recorded and transcribed and then thematically analysed.

Relevance: Sexual health is important for the health and wellbeing of young people. Young, rural residents' understanding of sexual health and safe sex messages provides important insight into how these young people practice safe sex. From this, recommendations for improving sexual among rural young people can be drawn.

Findings: Young people spoke about sexual health in ways that differed between genders and among older and younger age groups. Young people were concerned about pregnancy and women used health services for contraception. Beyond this, their knowledge of sexual health was limited and their use of local health services for sexual health was rare, particularly for prevention of sexually transmissible infections. Access to youth friendly health services was key to the use of sexual health services. Their talk reflected a general lack of engagement with sexual health and safe sex messages.

Discussion and conclusions: Young people appeared to not want to engage with sexual health and safe sex messages. The focus on sexual relationships was focused on gendered understandings of sex and social pressure to conform to sexual behaviours. The lack of readiness to engage with these messages and adopt sexual health messages in their behaviours was concerning. The need to develop sexual health and safe sex messages in ways that rural young people will hear is overdue. This study recommends that safe sex messages to rural young people be reconsidered.



Lived experience of wellness: photovoice and learning conversations in an Aboriginal community

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A holistic approach to wellness places greater emphasis on spirituality, culture, and identity of individuals, family and community than traditional clinical models of health and illness.

The participatory action research project into the lived experience of wellness within the Aboriginal community of Condobolin NSW was supported by the Memorandum of Understanding between the Wiradjuri Condobolin Corporation and Charles Sturt University who share a vision of wellbeing for Aboriginal people of the inland communities we each serve.

The aim of the study was to conduct cooperative, culturally-appropriate, community supported research to increase knowledge and understanding of what helps create positive change that benefits the lives of Aboriginal people and their experience of living in Condobolin. Elders and community

representatives were actively engaged in developing the research project, which involved photovoice and learning conversation methods of enquiry. The questions explored were: 1) What is wellness and a good life for Aboriginal people in this community?, 2) Why do some Aboriginal people experience wellness and a good life in this community while others do not?; and 3) How could wellness and a good life be experienced by more Aboriginal people in this community?

Photographs were taken of places and objects around the town that were thought to affect the wellness of Aboriginal people. Elders and a range of community groups came together in a series of learning conversations in which the photographs were discussed and key themes identified as being associated with wellness in the community. Further photographs were suggested and discussed in an iterative manner. Key themes identified included:

- Identity—link in the young people
- Reclaiming history—returning to culture
- Education, work and skills—positive engagement.

The project was unique in that it involved the community in ethical and practical research; identified strategies that could help close the gap in Indigenous disadvantage; and has some transferability to the wider Wiradjuri Nation and the Aboriginal and Torres Strait Islander population of other regions of Australia.

From Divisions to Medicare Locals to PHNs in Tasmania

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Aims: Our collaborative project between the University of Tasmania and the Tasmanian Medicare Local aimed to track the journey from Divisions of General Practice, the State-Based Organisation (SBO) and the Rural Workforce Agency (RWA) to the Tasmanian Medicare Local (TML). The last two decades have seen remarkable changes in the health landscape in Tasmania, and the evolution of Divisions into the TML had signalled increasing primary health care integration across Government, private and NGO sectors. 'Telling the story' of the journey was imperative to ensure valuable lessons learned along the way were not lost, nor major contributions underestimated. In the

process of exploring the journey, the next iteration of Primary Care Networks (PCNs) rose over the horizon, making the chronicling of change even more significant.

Methods: Two researchers from the Centre for Rural Health worked with a steering group from the TML to identify key players in the TML, the three former Divisions, SBO and RWA to narrate their perspectives from the past and present, and identify their imperatives for the future. Twenty-seven in-depth interviews were held, including current and former Board members, rural and urban GPs, State Government stakeholders, NGOs, current and former staff and other professional bodies.

Relevance: The study is highly relevant in the face of further changes in primary health care infrastructure nationally, as well as concurrent State Government restructuring. In this rapidly evolving environment, valuable learnings and corporate memory are tapped, naming up both strengths and weaknesses of the antecedent organisations.

Results: The study has indicated improved integration in the Tasmanian primary care setting, building on some notable phases in leadership in both Divisional and TML settings. It also identified major challenges faced by the TML in both creating a new organisation from three regional structures and a small SBO and in also being required to lead and manage core aspects of the Tasmanian Health Care Package (THAP). The separation of the RWA (now Health Recruitment Plus) from the Divisional framework has not been seen as significantly disadvantageous to rural GPs, but GPs also identified a loss of collegiality with the demise of Divisions.

Conclusions: The next iteration of primary care organisations needs to use the positive building blocks of the past, and to specifically address identified shortcomings. Rural primary care services are particularly at risk if new organisations fail to build on past gains.

Rural connections, possibilities through telepractice

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Royal Institute for Deaf and Blind Children, NT

Telepractice is fast emerging as a relevant response to meeting the early intervention needs of families in rural and regional areas. A number of factors, including wider availability of technology, more affordable equipment costs, and the ongoing need

for access to appropriate services, have led to an increasing use of telepractice to meet the diverse needs of families in rural and regional communities. Technology allows practitioners to overcome the challenges associated with distance, isolation and lack of services by providing families with early intervention on-demand, whenever and wherever services are needed.

Our organisation provides educational services, audiological management, assessment and therapy supports to children with hearing and/or vision loss and their families throughout Australia. In metropolitan areas, individual and group early intervention services are delivered 'in-person' through home-based or centre-based sessions. Families in regional and remote areas are able to access similar early intervention services through home-based or centre-based 'telepractice' sessions using videoconferencing technology. Our organisation continually explores ways to improve services to families in regional and remote Australia, including developing models of 'blended service' which combine both in-person sessions and videoconference sessions in order to meet the individual needs of families. Our service allows clients to regularly access a highly qualified multidisciplinary team that includes audiologists, psychologists, occupational therapists, teachers and speech and language therapists, without geography being a barrier.

This presentation will outline how, with the effective use of telepractice, it has been possible to overcome geographical barriers in order to provide a client-centred high quality service model that enables consistency and continuity of access to specialist services throughout Australia and is tailored to meet the needs of individual families.

Through the presentation of a case study, we will demonstrate how the service delivery model of telepractice has been used to successfully support the individual needs of a family in regional Australia, from diagnosis of hearing loss to cochlear implantation and ongoing rehabilitation and support from a multidisciplinary team of specialists.

Preliminary findings in developing an e-health intervention for child conduct problems

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Aims/rationale: In Australia, less than 24% of children who require mental health treatment access evidence-based interventions (National Mental Health Survey: Sawyer et al., 2000). The percentage of rural children accessing adequate treatment is far lower. One of the main reasons for this is a lack of available local services. The present study reports pilot data from a randomised control-trial of an innovative e-health intervention designed to help bring evidence-based mental health treatments to rural families.

Method: Children (N=20) referred to a multidisciplinary child and adolescent health service were identified as having primary conduct problems and were subsequently assigned to either a week long face-to-face (n=10) or an 8-10 week e-health (n=10) intervention provided by a clinical psychologist. Clinical ratings and questionnaire data was used to assess treatment efficacy across time (Pre-treatment, Post-treatment and 3-month post-treatment).

Findings: Preliminary findings support the hypothesis that e-health interventions may provide a viable option for the treatment of child conduct problems in rural areas.

Future directions: The e-health intervention model presents a cost effective but somewhat inefficient model for the treatment of rural children. The second stage of our research project will explore the viability of training and supporting rural allied health professionals in the use of this e-treatment.

Facilitating improvements in the work-life balance of Directors of Nursing

Judith Brown

Queensland Health, QLD

The work-life balance of the Director of Nursing at our small health centre has improved dramatically in the past five years. Prior to 2010, the DON was expected to be the sole practitioner responsible for providing the ambulance service; being on-call 24 hours a day, seven days a week. This workload

often resulted in the experience of fatigue at levels well above what is acceptable and safe.

An initial proposal by a DON to management to allow two clinical nurses job description to include being on call to cover ambulance call outs was accepted. The funding was obtained due to the service delivery model being changed and this was taken into consideration, with in the budget. The model does cost more to implement than having the DON on call 24/7. The cost of having staff on call is not significant, but when an actual call out occurs and the ambulance is actually mobilised the cost of staffing can increase by 20% per month. The work/life balance that the DON has gained, far out ways the economic cost to the service.

Today all nursing staff are encouraged to complete some on-call work; with some suitably qualified staff are sharing ambulance on-call while others involved in 'on ward' call to relieve the staff member rostered on duty to attend ambulance call out. This remodelling of the on call system facilitates the operation of the ambulance service while assisting to accommodate the work/life balance of the nursing staff at our hospital. While the system takes time to implement, it has also benefited the facility by keeping nursing staff engaged in another aspect of rural nursing, pre-hospital emergency nursing while allowing the DON to have a much improved work/life balance. The service looks forward to making further adjustments to the on-call roster, in 2015, when we welcome two postgraduate registered nurses with paramedic experience.

This paper will demonstrate that it is important for DONs working in a health care facility with an ambulance attached to the service to be encouraged to explore alternate ideas about being on call with management. There are four other facilities within Qld with similar staffing ratios that would be capable of implementing the suggestions in the paper. There are 15 facilities in Queensland where a DON is the sole practitioner and the model suggested would not fit but they would still benefit by exploring alternatives to staffing models eg. Up skilling some staff to a certificate four in ambulance care. Qualitative evidence in the form of quotes from previous DON's and current staff will assist to demonstrate the need to look at alternative on call rosters to facilitate work/life balance.

Agricultural health and medicine education: promoting people, places and possibilities across disciplines

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Introduction: Globally, there are few formal programs that train rural professionals in agricultural health, wellbeing and safety. Many who work in these areas only learn through experience and informal methods—through trial, and sadly, through error. Recognising this gap, Deakin School of Medicine developed the only Graduate Certificate in Agricultural Health and Medicine (GCAHM) in Australia. The curriculum reflects the diversity of rural and farming communities and is designed to encourage and develop relationships across nursing, agriculture, health sciences, occupational health, veterinary science and medicine. It is designed with flexibility in mind and is accessible for a range of disciplines, backgrounds and rural locations. Many students are returning to study and this teaching model supports students re-entering or continuing their tertiary education and continue their life long learning.

In 2014 the GCAHM was awarded the prestigious Vice Chancellors award for Teaching Excellence.

Methods: The curricula team demonstrate a command of the AH&M field and is comprised of practicing professionals from medicine, agriculture, nursing, psychology, addiction, rural surgery, ergonomic design, respiratory medicine, and veterinary backgrounds. Problem based learning and student collaboration solves real agricultural community health issues. Immersive experiences (visits to livestock exchanges, working farms) facilitate understanding of environment, social determinants, workplace health and safety, pesticides, machinery and livestock interactions.

Quantitative data were collected from 100+ Agricultural Health and Medicine students from 2010-14. Data were analysed using descriptive statistics, frequencies and the chi-square test. Further detail was sought from qualitative responses to open-ended survey questions.

Results: Over 60% of students (from every state and mainland territory of Australia) responded indicating the high level of commitment to this discipline. Responses were consistent with over 91% agreeing the course improved their ability to diagnose, prevent and treat rural populations. Over

80% of students were practising in rural communities, demonstrating a repeatable and transferable preventive program supporting multidisciplinary care and scholarship while addressing health inequities in agricultural populations.

Conclusions: The GCAHM exemplifies a rural focus and a commitment to widening professional engagement in AH&M. Importantly, it addresses an area of great need in line with growing societal expectations that health professionals make prevention a larger priority and are knowledgeable about specific population-based issues.

Recommendation: Further support to enable better workforce training and education around specific population-based issues (in this case agricultural populations) is vital to address disparity in health outcomes.

National Pain Strategy bringing pain services to the bush

Lesley Brydon

Painaustralia, NSW

Introduction: Pain is the most common reason people seek medical help, yet it remains one of the most neglected areas of health care, with around 80% of people missing out on effective treatment. One in five Australians including adolescents and children live with chronic pain, rising to one in three people aged over 65.¹

Prevalence is greater in rural areas, due to the physically demanding nature of work and lack of effective, timely care for acute pain conditions which can lead to development of chronic pain.² Chronic pain is commonly associated with forced retirement, relationship breakdown, depression and suicide.³

Policy: The National Pain Strategy (2010) provides a nation-wide framework for the delivery of pain management services with a focus on prevention and multidisciplinary management of acute, chronic

¹ Blyth, F, March, L, Brnabic, A, Jorm, L, Williamson, M, Cousins, M (2001), Chronic pain in Australia: a prevalence study. *Pain*. 89(2-3), 127-34

² ABS 2011 4102.0 Australian Social Trends: Health Outside Major Cities, Report by the Australian Bureau of Statistics. Released 25/3/2011. <http://www.abs.gov.au/AUSSTATS/abs@.nsf/Lookup/4102.0Main+Features30Mar+2011>

³ Suicide Prevention Australia's Position Statement on Chronic Illness, Chronic Pain and Suicide Prevention http://suicidepreventionaustralia.org/wp-content/uploads/2012/05/SPA-PositionStatement-April_2012_Final-V4.pdf

and cancer pain. Its recommendations have now been adopted by all state governments and the ACT and investment in new and expanded services is leading to improved health outcomes for consumers. However progress is fragmented and under-funded and Federal Government coordination and leadership is urgently needed.

Progress: Progress in regional areas includes:

- establishment of 14 new regional multidisciplinary pain centres in NSW, QLD and VIC
- community-based services providing pain management education and early intervention in areas in Western Australia, New South Wales, Northern Victoria and Northern Queensland, in partnership with Medicare Locals. It is hoped these will transition to the Primary Health Networks
- outreach services via Telehealth and MSOAP from key centres in all states
- *Pain Heroes* program for Aboriginal and Torres Strait Islander people developed by the Institute for Urban Indigenous Health
- websites providing consumer and health professional resources: WA Health's painHEALTH; NSW Health's ACI Pain Network and Pain Bytes with resources for children supported by Sydney, Westmead and Hunter Children's Hospitals; Arthritis and Osteoporosis WA Bones and Joints School, a website for families, students and teachers
- community support groups, a Pain Hotline and online support forum, all staffed by volunteers
- fact sheets with advice on managing chronic pain are available from GP desk top software, Medical Director and Best Practice.

Workforce challenges: The availability of pain management education and training (online and via webinar) is helping to build much-needed capacity in rural areas. Further efforts are needed to ensure appropriate access to Medicare for allied health services, essential to the effective management of pain.

The change to radiotherapy utilisation in a rural area after the establishment of a local service

Sally Butler, Tracy Drabsch

Central West Cancer Service, NSW

Background: The first radiotherapy centre in Western NSW Local Health District (WNSWLHD) was opened at Orange in 2011. Prior to this patients travelled outside the health service, primarily to Sydney, to receive treatment.

Aim: To investigate if the establishment of a 'local' radiotherapy service in a geographically sparse rural area has impacted on the number of patients accessing treatment. In particular to investigate if change has been widespread and if patients' demographics, cancer and treatment intent changed significantly with the introduction of the new service.

Method: Data were collected on every WNSWLHD patient 17 years of age and above who received radiotherapy in either 2010 or 2012 in NSW or ACT. The age, gender, treatment intent, cancer type and residential town were recorded.

Results: The number of patients who accessed radiation increased from 573 to 667 between 2010 and 2012 ($\chi^2(1)=6.0$, $p=0.014$). The corresponding radiotherapy utilisation rates were 29.3% in 2010 and 33.4% in 2012, an improvement of 4.1%. The change in the number of patients accessing radiotherapy became significant for those living within 150km of the new service ($\chi^2(1)=5.1$, $p=0.02$). There was some improvement outside this area until a distance of 300km from the new service, at which radiation treatments decreased. The number of palliative treatments increased significantly only within the Orange region (95% CI 1.2-3.0, $p=0.004$), with minimal change in the other regions. Male treatments also significantly increased as there were 81 new treatments (292 vs 373, $\chi^2(1)=9.6$, $p=0.002$) as did patients with a respiratory cancer (66 vs 97, $\chi^2(1)=8.7$, $p=0.003$).

Conclusion: A new radiotherapy service in a sparsely populated health district significantly changed the pattern of radiotherapy use by those who lived in the Orange region, particularly those living within 150km of the new service.

Thriving communities and productive lives: mental health-specific challenges in regional, rural and remote Australia

David Butt

National Mental Health Commission, NSW

The focus of the National Mental Health Commission's national review has been to assess the efficiency and effectiveness of programs and services in supporting individuals experiencing mental ill health and their families and other support people to lead a productive life, and to build thriving communities.

The terms of reference for the review included the examination of the mental health workforce, Aboriginal and Torres Strait Islander peoples, suicide, and the specific challenges for regional, rural and remote Australia. Our work reviewed current local approaches, sought out successful and promising approaches in other health and human service systems, and considered the training, education and recruitment strategies needed to sustain and promote service access, good practice and workforce models. Through this analysis we identified the optimal components within mental health services, and proposed a number of strategies to respond to new service and support approaches in mental health programs and services in Australia. This included responding to new initiatives such as the National Disability Insurance Scheme (NDIS).

The dire status of the mental health and wellbeing of Aboriginal and Torres Strait Islander people is of critical concern. Indigenous people have significantly higher rates of mental distress, trauma, suicide and intentional self-harm, as well as exposure to risk factors such as stressful life events, family breakdown, discrimination, imprisonment, crime victimisation, and alcohol and substance misuse. Service and system responses to these poor outcomes are inadequate, and have generally not been designed with the particular needs of Aboriginal and Torres Strait Islander people in mind. A number of recommendations seek to address these issues.

The issues in rural and remote areas of Australia, including inequity of access to mental health services; recruitment, retention, professional development and support of the mental health workforce; the provision of local integrated models and leveraging e-health and technologies, were all canvassed within the Review to see where the evidence pointed to best practice. Flexible and

emerging service models also need flexible workforces for rural and remote Australia, to ensure we close the service gap between those living in rural Australia and their city counterparts.

This paper will outline the work of the Review, our findings, and provide insights into what the Commission heard from practitioners and service and program managers. Additionally, through our submission process and conversations with stakeholders, the Commission's work provides a voice on what is working in our mental health system, what is not and what steps need to be taken to ensure that all Australians experience health and wellbeing through every stage of their lives.

Tackling Indigenous smoking in rural and remote Australia: progress and possibilities

Tom Calma

Commonwealth Department of Health, ACT

Indigenous Australians can expect to live 10-17 years less than other Australians and experience more than twice the burden of disease. A large part of the disease burden is due to high rates of chronic diseases. In 2012-13, 41.6% of Indigenous Australians over the age of 15 smoked, more than 2.5 times the rate of the non-Indigenous population. The health effects of tobacco use are well known, with smoking among Indigenous Australians contributing to chronic disease and responsible for one in five Indigenous deaths.

Indigenous Australians living in rural and remote areas are also more likely to smoke. Half of Indigenous Australians living in remote areas smoke in comparison to 38% of those living in major cities. This difference is largely accounted for by the higher proportion of youth that smoke. However, there is significant potential for change with smoking the number one preventable cause of death and disease in Australia.

In 2009-10, the Tackling Indigenous Smoking Program was launched with the aim of reducing smoking, chronic disease and early death among Indigenous Australians. The national program: established and trained a national network of Regional Tobacco Coordinators, Tobacco Action Workers and Healthy Lifestyle Workers within existing organisations; enhanced national Quitline services to be more culturally appropriate; funded training, including brief intervention training for people working with Indigenous Australians

nationwide; implemented local and national social marketing campaigns, including Break the Chain; and included research projects, such as the Menzies Talking about the Smokes project.

Since the Tackling Indigenous Smoking Program commenced, our communities have responded to national and local tobacco control efforts with significant reductions in smoking rates among Indigenous Australians reported in the National Aboriginal and Torres Strait Islander Health Survey and many lessons learnt along the way. In the 2014-15 Budget, the Australian Government announced that they would continue to focus on improving the prevention, detection and management of chronic disease, while commissioning an independent review the Tackling Indigenous Smoking Program to ensure the program is implemented efficiently and in line with the best available evidence. These findings will help ensure the community receives appropriate support in not taking up smoking, quitting and remaining smoke free. This presentation will discuss some of the reviews key findings, outcomes and recommendations to improve health outcomes of Aboriginal and Torres Strait Islander people nationwide.

Building recruitment and retention for the remote allied health workforce

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Recruitment and retention of the allied health (AH) workforce to remote areas is problematic. Vacancies and staff turnover result in lower population to professional ratios. Reduced access to AH services disadvantages remote area residents who are known to experience poorer health outcomes.

Recent research has described personality characteristics of the remote and rural health workforce. This original research paper builds on that by analysing the personality characteristics of remote AH professionals together with the construing or beliefs of AH professionals about working in remote areas. Using case studies, it will present a powerful picture of the personal characteristics that might constitute a good fit with the demands of the remote work environment.

Method: This study was a national research project using a mixed methods design with two data collection strands. AH professional personality trait data was collected using a standard personality

instrument, The Temperament and Character Inventory (TCI). Repertory grid interviews, a structured interview technique from personal construct psychology, investigated the construing of AH professionals about personality characteristics that contribute to work success in remote areas.

Results: Three case studies from the larger study will be described and compared. Each represents a different section of the workforce. Two are metropolitan novices, one with and one without, intentions of becoming a remote AH professional. The third case study is an experienced and settled remote AH professional. The TCI trait levels for each case are compared with previously published data and with each other. Harm Avoidance, Persistence and Reward Dependence appear to be influential in recruitment and retention.

The repertory grid data revealed job satisfaction and likelihood of successful remote recruitment by comparison of the case studies' ideal job, their current position and a remote position. Remote work was construed as generalist rather than specialist which potentially undermined career pathways. It required flexibility and a holistic approach, as well as investing in relationships and feeling comfortable with dual roles. The isolation and limited support and supervision were construed as reducing retention of novices.

Discussion: This study contributes new information useful for recruitment and retention of the remote AH workforce. It suggests that novices with a pre-disposition to remote work may exhibit traits helpful in managing the work environment successfully but that the stereotype of an unsupported remote work environment may be limiting the potential pool of professionals available for recruitment. Successful retention requires addressing factors that erode job satisfaction.

What oral health services do rural communities think they need?

Karen Carlisle¹, Sarah Larkins¹, Felicity Croker¹, Jane Farmer², Amanda Kenny², Virginia Dickson-Swift², Helen Hickson²

¹College of Medicine and Dentistry, James Cook University, ²La Trobe Rural Health School

The Rural ECOH study is underway in six Australian rural communities across Victoria and Queensland. The study was designed to systematically and robustly evaluate the usefulness of 'Remote Service Futures'; an evidence-based method of community participation that has been successfully used in the

United Kingdom. Using oral health as a focus, the study aimed to invite local people to actively engage in discussions about what their community needed and contribute to the design of fully costed, evidence based strategies to address oral health challenges.

The 'Remote Service Futures' method consists of a structured workshop series and planning tool to capture community views, evaluate evidence relevant to a health issue and culminates in a planning exercise to develop an oral health plan. The developed plan is then implemented and community members monitor implementation. The co-design approach enables communities to determine what is most important to them, rather than relying on a one size fits all approach. In this presentation we will discuss the experience of engaging with the communities, themes from the workshops and present the oral health plans designed by the communities.

To date this three-year study has generated extensive evidence on the value of communities working together to bring different perspectives on the issue of oral health. The study contributes to knowledge on testing new methods for collaborative health planning. Evidence of the impacts of community participation on health planning has relevance at policy and practice levels.

Community breastfeeding mentoring workshops are an effective method to support breastfeeding

Melanie Carter, Susan Tawia

Australian Breastfeeding Association, NSW

Breastfeeding is promoted in Australia because it improves long term health outcomes for mothers and babies. In comparison to the general population breastfeeding rates among Aboriginal and Torres Strait Islander mothers are lower and this increases health risks for mothers and babies.

This paper reports on the development and delivery of a two-day continuing professional development program designed and delivered to enable participants to effectively promote and support breastfeeding. The program was delivered as workshops during 2014 to registered Aboriginal health practitioners/workers and allied health professionals who work with Aboriginal and Torres Strait Islander mothers.

58 participants from mainstream and community controlled health services completed the workshops.

The workshops were delivered at 5 ASGC RA 3 locations and 1 ASGC RA 2 location in 4 states across Australia. Culturally appropriate materials and interactive and practical learning activities were used during the workshops. Participants were progressively assessed during the workshops and received a nationally recognised statement of attainment on successful completion of all workshop assessments.

Participants worked through their own beliefs and attitudes about breastfeeding, gained basic breastfeeding knowledge and practised how to provide effective breastfeeding support.

Two stages of feedback were conducted to evaluate the CPD program. Workshop delivery evaluations were collected on each day of the workshop to track participant satisfaction and immediate response to skills and knowledge learned. This feedback consistently included comments about the value of the role play activities. The second stage of the feedback was conducted at least 1 month post workshop by telephone interview. This feedback indicates participants had been able to make changes to their practice based on their learning from the workshop to better assist mothers to breastfeed.

These workshops have proven to be successful in achieving their outcomes. Significant interest has been expressed for further workshops and a number will be delivered during 2015. Planning has commenced to conduct further research into its longer term effectiveness and to further improve the efficacy of these workshops.



Using telehealth with Aboriginal and Torres Strait Islander people in rural communities

Colleen Cartwright¹, Kelly Shaw², Indra Arunachalam

¹Southern Cross University, ²Department of Health, Tasmania

Aim: This project reports on the evaluation of the *Staying Strong* project, which aimed to enable older Aboriginal and Torres Strait Islander people to better manage chronic health conditions by using telehealth self-monitoring equipment, primarily in their own homes. The project was located in two sites in NSW and two in Qld.

Methods: Base-line and end-of-evaluation surveys were conducted, along with a series of Yarning

Circles and one-on-one interviews with participants, staff and other stakeholders. Readings from the telehealth equipment were recorded in a Central Data Monitoring Centre. Quantitative data were analysed using SPSS 20; qualitative data were transcribed and read by two of the research team to identify recurring themes.

Results: There were 70 'valid' Baseline surveys and 54 follow-up surveys completed by participants. Demographic characteristics included mean age (62), gender (52 females, 18 males), and marital status (22 married; 17 widowed or divorced, 19 single). The majority of participants had five or more chronic health conditions; the most common were diabetes and high or low blood pressure. Attitude to Technology was positive at both survey times and Social Connectedness scores were high. Compliance was generally good. There were 570/27,752 "outside of set parameters" readings, of which 330 were 'high' (red) alerts. Participants demonstrated increased awareness and improved understanding of their health conditions and what impacts those. Project barriers and enablers were identified.

Conclusions: Participants demonstrated a high level of engagement with the technology but some equipment needs to be more user-friendly. Reliable and fast Internet connection is critical for telehealth monitoring. Systematic review of monitoring plans could reduce the number of missed readings. Better outcomes result when GPs and RNs work together.

The impact of significant employment changes in a remote NT mining community: the GP's perspective

Sarah Chalmers, Colin Smith

Endeavour Health Services and Flinders University, NT

Two general practitioners share their views of the impact of significant employment changes within a mining town.

Nhulunbuy is a remote mining town on the North Eastern tip of the NT, population of 4,500. Since the mid 1960s it has been a thriving community based around the bauxite mine and alumina refinery. In November 2013, after 2 years of uncertainty, Rio Tinto announced the curtailment of the refinery, resulting in the loss of 1000 jobs. The following 12 months have been a difficult time for the community, with ongoing uncertainty for the future of the remaining workforce, the community and local businesses.

As the only mainstream general practice in town, we have observed the changes in our community through this adjustment phase. As residents and business owners in the town we have also been participants in the process.

This talk will be an observational narrative of our experiences, and the effects that this had on our families and other staff in the practice.

A case study in transformation of a rural hospital: modelling, leadership and effecting change

Theodore Chamberlain, Nicole White

Maleny Soldiers Memorial Hospital, QLD

This paper is an analysis of a project in transformation of a rural hospital and the health delivery of a community through developing a coherent vision and leadership over an extended period of time. Its focus is not on what was done but rather how it was done so as to draw applicable lessons and present a tool kit of approaches to identify and fulfil the health needs of the community by novel approaches. Its broader aim is to demonstrate how rural health care can be improved one community at a time.

By analysis and interpretation of this case it will be shown how complex problems like diminishing resources, poor health outcomes, lack of work force, the tyranny of distance and bureaucratic inertia can be overcome by appropriate modelling, vision, community involvement, strategic planning and the search for novel and innovative solutions.

The beginning of the transformation is a classic rural hospital, under resourced, under staffed, struggling to maintain workforce, bed numbers reduced and services removed.

The current situation is a vibrant rural hospital whose bed numbers have doubled with the development of a rehabilitation unit and palliative care unit to service the community. Novel programs have been introduced driven by the use of new technology like telehealth. Community outreach programs targeting specific problems are being run in partnership with the community. Novel public-private partnerships have been developed to address lack of resources and provide equitable affordable care to the community and value for money for the Health service.

This paper's aim is to not list these achievements but to provide an analysis of how this was achieved.

and the steps in the process. To draw lessons, suggest approaches and demonstrate how an individual can through appropriate analysis, vision and skilful techniques achieve meaningful, sustainable change through the mobilisation of the community and the building of sustainable teams.

The analysis will demonstrate that despite the complexities of the interactions and the many axes of change, that coherent vision and leadership can provide clarity and direction to each individual problem and integrate the solutions into an organic whole improving the health care of the complete community.



A day in the life of a health extension officer

Dashlyn Chee

Namatanai Rural Hospital, PNG

Namatanai Rural Hospital sees 40,000+ patients a year, yet has only recently been connected to power and running water. This presentation will explore the “tight-rope” approach needed to deliver quality health care in such a restricted context. It will begin by setting the context for health care delivery in PNG, particularly looking at the political and budgetary fragmentation since Independence. It will then use the lens of a “Day in the life of a HEO” to explore issues such as resource allocation, staff-burnout and maintenance of minimum clinical standards. Particular attention will be paid to the role HEOs play in delivering health services in the absence of medical officers. The presentation will finish by arguing that it will only be possible to deliver quality health services at the hospital if non-government or private service providers become involved.



Challenges of postgraduate medical education in Timor Leste and the Family Medicine Program

Antony Chenhall

Hospital Nacional Guido Valadares, Timor-Leste

This talk will discuss the challenges of postgraduate medical education in Timor Leste, particularly those related to the large influx of recent medical graduates. It will also describe the Family Medicine Program, a postgraduate program aimed at these recent graduates.

Timor Leste is a young nation, at independence there were very few Timorese doctors (less than 50). Since then there has been a large increase in the number of Timorese doctors thanks to undergraduate medical training cooperation with Cuba. The first cohort of new Timorese doctors graduated in 2010 and with up to 400 doctors in each cohort, there are now approximately 850 new Timorese doctors. There will be a total of 1000 new doctors by the end of 2015.

This large influx of junior doctors brings a new set of challenges for medical workforce development.

Many of these newly graduated doctors have been posted directly to rural community health centres, where they have minimal supervision. The Timorese MoH has recognised that these doctors need up-skilling to independently manage all the conditions they are required to manage in the CHCs..

The Family Medicine Program is a two-year program of postgraduate medical training for recently graduated Timorese doctors in the skills needed to work in community health centres in Timor Leste.



Equalising access to speech pathology services for country children: a telehealth approach

Kim Casburn, Megan Feeney, Robyn Ramsden, Richard Colbran

Royal Far West, NSW

Being able to communicate clearly is a critical life skill because effective communication underpins successful relationships, educational and work success and psychological health. There are a significant number (12-15%) of children with speech, language and communication difficulties in the school population in Australia. This is a significant issue because research shows that having speech problems early in development correlates with negative long term outcomes including; higher rates of school failure, lower employment rates, greater likelihood of being involved with the criminal justice system, and higher incidence of mental health issues and social issues such as antisocial behaviour.¹

While some language problems resolve with time, many children face difficulties which become pervasive. Early identification and intervention are crucial to limit the disadvantages experienced by

¹ Law et al., 2009

children. However, access to speech pathology services is particularly problematic in rural and remote areas of Australia. The shortage of services is due to workforce distribution—only 3.9% of speech pathologists provide services in regional, remote or very remote areas whereas 13.4% of the population live in these areas. Providing services via telehealth has been proposed as a solution to this issue. Royal Far West has developed and evaluated a telehealth speech pathology program to address the needs of children in rural and remote NSW.

The aims of the telehealth intervention were to:

- provide regular services to children from rural and remote NSW
- measure improvement in children identified with speech and language issues (operationalised by increases in goal attainment scale scores)
- identify appropriate cases where telehealth maximises clinical improvement.

81 children from 11 schools and preschools in rural and remote NSW were remotely assessed and identified as needing intervention, and were enrolled into the Come N See program. They received 6 weekly telehealth speech pathology sessions. Children's progress on individualised goal attainment scale measures were assessed at conclusion of the program. Overall, children made statistically significant improvements, with 79% of children meeting or exceeding their treatment goals. The results of the evaluation will be discussed in detail. The presentation will also discuss the strengths and challenges of adapting speech pathology services to telehealth delivery. Specific areas to be addressed include the appropriate identification of participants, engagement of schools and parents in therapy and the role of capacity building, and the findings in relation to the economic benefits of the program.



Refugee voices: healing refugee and asylum seeker trauma

Caz Coleman

Melaleuca Refugee Centre, NT

A multi-media presentation of 20 minutes that addresses the health needs and key components that clients identify as providing for their wellbeing.

Based on the trusted relationships founded on the Melaleuca Torture and Trauma Survivors Service over 18 years, the voice of people will be heard at

three places 'in' Darwin—within detention, in community without permanent residency, and resettled in Australia as refugees and permanent residents.

Recorded interviews will be shared directly relating the significant factors that support people experiencing considerable struggle, hardship and persecution to retain health and wellbeing as they see it; and identify what it is about health services or other factors that best meets those needs. The presentation will be over-laid with Melaleuca's insight and understanding of the impact of trauma following violence, dispossession and displacement, of relevance to many communities that have experienced inter-generational and historical conflict and trauma.

Innovative professional development for primary care nurses—a rural paradigm

Marnie Connolly, Eleanor Mitchell, David Campbell

Monash University School of Rural Health, VIC

Introduction: Primary care nurses working in rural General Practice are quintessential to the Australian Government's model of health care delivery of primary care services. There is a rural workforce shortage of General Practitioners in rural areas resulting in primary care nurses often taking on further workloads.

Primary care nurses employed within the General Practice setting in East Gippsland are required to provide an extensive range of clinical skills to their communities. Management of these presentations requires critical thinking and best practice knowledge.

With the increasing requirement for nursing to maintain skills acquisition and best practice knowledge the primary care nurses in the East Gippsland region with the support of the Monash University, School of Rural Health—Bairnsdale formed a Practice Nurses Education Group (PNEG) to fulfil their professional development needs.

Aim: The aims were to:

- initiate and support educational activities for primary care nurses in the region
- encourage performance and knowledge expansion
- strengthen patient safety through reinforcement of knowledge and rehearsal of clinical skills

- provide opportunity for nurses to network and form alliances
- seek linkages to other educational activities that might be advantageous to all.

Results: The results showed:

- the workshops were well supported by nurses in East Gippsland
- most nurses who attended had been practicing for more than 20 years
- nurses travelled up to 120kms to attend the education activities
- nurses mostly attended the workshops as an opportunity to network and socialise, refresh clinical skills and remain up to date with contemporary knowledge
- subject matter covered was sufficient, and relevant to their needs
- nurses felt confident in utilising the knowledge and skills learned to implement into their clinical practice.

Conclusion: The PNEG program has demonstrated that General Practice nurses in the East Gippsland region have enhanced their knowledge and acquisition of clinical skills for better patient outcomes.

The opportunity to network with other nurses in similar circumstances has generated collaborative learning and formed alliances amongst a group of nurses who tended to work in isolation to each other.

Educational events driven by this group addresses the learning needs of the group, and decreases the times nurses have to travel to metropolitan areas for professional development.

This program is now recognised regionally and formed relationships with other educational providers, resulting in further collaborative education sessions.

The straightforwardness of this program, with support from its members makes this program unique and easily replicated to other rural and remote areas where nurses require further educational activities.

A model of podiatry care in remote Central Australia

Sara Coombes

Kempsey Podiatry, NSW

Since 2009 a model of podiatry care has been developed and evaluated in 16 communities in Central Australia to the north-east and north-west of Alice Springs. Prior to this time these communities had minimal and erratic podiatry service.

The logistical aspects of the new service model were addressed and a sustainable model of care developed. A key issue was an acceptable cost per patient. Previously the service had been 3-4 day clinics in one community, with less than optimum numbers of patients seen per day, and staff then returning to Alice Springs. A lack of equipment (including autoclaves) had also previously been a problem.

The revised model has been developed from the Indigenous Diabetic Foot program, with an emphasis on educating and treating the clients and upskilling clinical staff in basic foot care. The paper will discuss the method of education used to engage clients in their own foot care, the development of links with high care services at Alice Springs Hospital and the logistics of provision of service to this group of communities at a reasonable cost.

Notable outcomes include reduced callous formation, improved shoe wear habits, and self-referral to the podiatry clinic as soon as we arrive in the community. Provision of services is broadening the impact of foot health on the communities, with increased awareness of basic foot care and working with younger clients to prevent foot injuries. We are now offering rehabilitation for foot injuries, pre-football stretches and strengthening and first aid for feet. We encourage clients to adapt their foot care and footwear habits adjusted to their own foot health outcomes.

In the future the service will analyse data of visits over the past 5 years and relate this to amputation rates of lower limbs at Alice Springs Hospital. This data would include the percentage of diabetics in each community that are accessing Podiatry services regularly in accordance with Best practice recommendations. Other data for High risk foot diabetics will be collated for length of time from first ulcer to surgical intervention compared with town camps. It will also be possible to check on average cost per service in the 16 subject communities compared with other NT communities.

Keeping kids safe during resuscitation

Simon Craig^{1,2}, **Catherine McAdam**^{1,2}, **Megan Barnett**¹, **Deana Lynn**¹, **Annie Moulden**¹, **Paul McCallum**^{1,3}, **Paul Machet**¹

¹Monash Children's Hospital, ²Monash University, ³Royal Children's Hospital, Melbourne

Resuscitation of critically ill children is a rare (and stressful) event.

There is the potential for drug errors during paediatric resuscitation. They may result from problems with weight estimation, dosing, calculation, dosing, prescribing, communication, and administration errors. Stress and fatigue (eg night shift) also pose significant risks.

"Traditional" teaching regarding paediatric resuscitation is provided by courses such as APLS, which requires candidates to perform calculations on a whiteboard prior to commencing scenarios.

Emergency clinical practice does not always provide an opportunity to "do the maths" before a patient arrives. Attempting calculations of medications during a stressful paediatric resuscitation may lead to significant errors.

This presentation describes the development and preliminary evaluation of a weight-based paediatric emergency medication book. The book was developed by a working group of clinical staff from paediatric wards, emergency departments, anaesthetics and ICU, and provides a weight-based guide to:

- clinical instability/MET call criteria
- medication doses in resuscitation settings (such as cardiac arrest, intubation)
- endotracheal tube size and positioning
- emergency management of seizures, anaphylaxis, asthma, and electrolyte abnormalities.

In rural and remote health care settings, experienced paediatric assistance is often provided by retrieval services, which may be delayed by a number of hours. The provision of this resource has the potential to improve patient safety in this setting.

Aboriginal and Torres Strait Islander health practitioners and workers: strengthening professional skills through CPD

Lisa Crouch¹, **Zell Dodd**², **Shelly Reynolds**²

¹Greater Northern Australia Regional Training Network, QLD, ²National Aboriginal and Torres Strait Islander Health Workers Association, SA

With national registration of Australia's Aboriginal and Torres Strait Islander Health Practitioner (ATSIHP), the need for policy and tools to support continuing professional development (CPD) of the workforce has emerged as a key issue.

Northern Australia's health services rely heavily on the capacity of ATSIHPs to deliver comprehensive primary health care in a range of settings to both Aboriginal and Torres Strait Islander people and non-Indigenous people.

A commitment to CPD as part of ongoing professional development process is well understood by many health professional and supported within industrial relations and enterprise business agreements. However for many ATSIHPs the concept of CPD to maintain professional registration is a new concept and therefore is less well supported by tools and policies.

GNARTN is a cross jurisdictional partnership between the health departments and Integrated Regional Clinical Networks (IRCTN) in the NT, WA and QLD, funded by recently dis-established HWA. In 2014, GNARTN in partnership with NATISHWA worked closely with health services, training providers, and policy staff within government and the NGO sector, to co-invest in the development of range of culturally acceptable tools to support CPD activity, with the aim of leading to organisational cultural understanding and change, while providing practical tools to support CPD.

This presentation will describe the process, the challenges and the issues that arose as result of the consultation and developmental stage, and will outline the opportunities that have emerged to drive policy and organisational cultural change, in support of strengthening Aboriginal and Torres Strait Islander health practitioners and Aboriginal and Torres Strait Islander health workers in northern Australia.

Emerging infectious diseases: Australia is not an island

Bart Currie

Global and Tropical Health Division, Menzies School of Health Research, NT; Infectious Diseases Department, Royal Darwin Hospital, NT

Multidrug resistant organisms have become the norm for many of Australia's near neighbours. Untreatable tuberculosis, gram-negative sepsis and malaria are looking like the reality for our region. There also remains the certainty of future pandemics of influenza, with Asia/Southeast Asia a predicted source of origin. New zoonotic infections are also likely to emerge from the diminishing rain forests of Borneo and elsewhere. Global air travel now makes us all near-neighbours, as evident with SARS, MERS and ebola.

Sugar gums

Linda Cutler¹, Lyn Mayne²

¹RFDS SE Section, NSW; ²Dental Service, Royal Flying Doctor Service

Diabetic patients are at significant risk of developing periodontal disease. This project focused on the population of Menindee in Far West NSW, a remote community with medical and dental services provided through regular outreach clinics. A clinical Review of patients' medical history indicated high HbA1c levels in diabetic patients. A multidisciplinary approach was taken to reduce HbA1c levels in patients with levels greater than 7, by providing oral health education, dental treatment, educational posters and distributing home care packages. Results achieved included a reduction in HbA1c in 66% of patients, with a significant reduction of 0.5 or more in 22% of participants. More efficient use of workforce and reduced public dental waitlists were also achieved. Periodontal disease is a chronic inflammatory disease, which results in the loss of supporting structures of the teeth, through the formation of pathological pockets around the diseased teeth. Periodontal disease is responsible for a substantial proportion of tooth loss in adults. Periodontitis is recognised as the sixth complication of diabetes (Harold Löe 1993).

Generally, maintenance of diabetic patients HbA1c levels is a good indication of the stability of the disease. Diabetic patients are referred to a number of Specialists but are not routinely referred for oral health checks. Referral to oral health services provides an opportunity to maintain glycated

haemoglobin levels, decrease acute exacerbations of the Diabetes, and maintain patient's teeth for longer. Improvements in oral health and the maintenance of a patient's own dentition enables better nutrition and the better mastication of food.

This project was established to encourage people with Diabetes to make healthy choices, by educating individuals' on the importance of oral health and the impact it has on blood sugar levels, specifically targeting high risks groups such as the elderly, Aboriginal people and people with chronic disease. Aboriginal people are 3–4 times more likely to have diabetes (Diabetes Australia 2013) and 1.3 times more likely to have periodontal disease (Roberts-Thomson KF 2007), this project aims at closing those gaps.

The project supports individuals, families and communities to make healthy lifestyle choices, by targeting the public health priorities of both Diabetes and oral health, by improving outcomes for risk groups and by decreasing the risk of acute diabetic episodes. An added bonus is the positive impact it has on public dental waitlists.

The Write Road to mental health and wellbeing—the power of story to shape confidence, courage, identity and destiny

Stephanie Dale

The Write Road, NSW

A woman walks into a wooden hall in a small settlement 200 kms from anywhere—bent, huddled over her walking stick, leaning on her husband. Two writing workshops later, she leaves three inches taller, swinging her walking stick.

What happened in those few hours?

The Write Road is a creative initiative that takes writing and communications workshops to people in remote areas. The project makes skills and resources that are readily available to urbanised Australians accessible to the bush and beyond.

Since May, we have partnered with a range of community services to deliver writing workshops to more than 200 people, mostly in NSW's far west.

The Write Road was founded on the belief that to be well, humans must create. Most people long to tell a story—family histories, community anthologies, the sharing of wisdom learned. However, phenomenal

numbers of people are immobilised about how and where to start—and this adds to burdens of stress.

Research shows creative expression is vital to wellbeing. Yet even though everyone encountered by *The Write Road* longs to write—most feel that to do so would be ‘wasting time’.

On the surface, *The Write Road* offers writing workshops. In fact, the project’s currency is optimism and courage.

The processes delivered assist people to clarify their thoughts, solve problems and establish clear pathways for the way forward as they pursue life, family and work goals.

The project works on the principle that there are many ways to tell the same story—it’s your story and you can tell it any way you like: *this is true power*.

The workshops develop confidence and open expression in individuals, reinvigorate often fractured social networks and strengthen community connections.

A young Indigenous woman, seven months pregnant and in need of a great deal of support, attended a creative journaling workshop. At the end of the session, she said: “I would like to read my writing.” And so she exacted the attention of seven white women and shared her private journey (please, picture that scene). Later that week, she said to her support worker: “I have never felt as calm as I have since that workshop.”

A presentation about *The Write Road* would:

- outline the project—philosophy, documented experience, outcomes
- highlight examples—people have gone to astonishing lengths to attend these workshops and/or achieved life-changing results
- reference available research
- showcase the breathtaking quality of writing projects newly underway
- give conference participants a ‘taster’—two brief exercises
- aim to illuminate the importance of creative expression to mental health and wellbeing.

The Write Road is a proactive mental health strategy.

Human beings must create to be well.

We must witness others.

We must share our stories.

The health of remote communities depends on it.

‘I’m here for my women’s check up’: health promotion in the context of cervical screening

Genevieve Dally

Family Planning and Welfare, NT

Australia celebrates its successful cervical screening program with significantly low incidences of morbidity and mortality associated with cervical cancer. Health promotion campaigns that align with this biennial program are heralded, globally, as measures of effective recruitment and retention into a program with well understood health benefits. In rural and remote Australia, Cervical screening is colloquially known as a ‘women’s check up’ and occurs within a context of opportunistic screening, health assessment and education. This paper aims to explore what really goes on when a woman attends for her ‘women’s check up’ and the implications for a future screening program that proposes five yearly intervals between testing.

A clinical audit was undertaken to determine the likelihood of additional women’s health issues being addressed as part of a Cervical screening consultation. Data was collected from a Darwin sexual and reproductive health service from the month of June 2014, Electronic software, Medical Director and DME client were used to extract data and verify demographics, consultation details and reason for attendance. Issues that were earmarked as being regularly identified included breast health, STI screening, contraception management of menstrual symptoms, incontinence, fertility, pregnancy options and lifestyle issues.

Of the sixty-eight consultations that took place in June 2014, the vast majority involved discussion, education, advice or referral pertaining to one or more additional women’s health issue. This occurred despite the reason for attendance given as Cervical screening only. The clinical audit clearly demonstrated that women present for a ‘check-up’ as a result of raised awareness about cervical screening but are then given opportunity to manage other issues and conditions that could have significant negative health repercussions if not addressed efficiently.

In a landscape of advanced technology, HPV vaccination programs and sound evidence to support changes to Cervical screening intervals, challenges exist for health practitioners in addressing women's health needs in a timely and acceptable manner. Health promotion campaigns will need to normalise health seeking behaviour and support women to access services outside of established recommendations.

Far West Mental Health Recovery Centre: a partnership model of recovery focused mental health inpatient care

Susan Daly¹, Sue Kirby²

¹Far West Local Health District, NSW; ²Broken Hill University Department of Rural Health, NSW

Providing health care to scattered rural and remote communities is no walk in the park. Morbidity is high and clinicians are few. It can be hard to attract and keep enough clinicians to provide the services the community wants and needs.

This report discusses a cost effective model of mental health inpatient care that meets community need, solves patient flow issues, increases employment opportunities in rural and remote areas and eliminates the need for expensive, and often fruitless, recruitment campaigns.

It describes the partnership between Far West Local Health District (FWLHD) and Neami National, a Community Managed Organisation (CMO) in remote NSW to provide step-up, step-down sub-acute mental health inpatient care using a local workforce.

This paper provides background about the setting and service; details of the workforce model and evidence of the beneficial outcomes from the activity data.

The implications of the workforce model for cost effective care and sustainability in a rural location are discussed. The model: accesses a new type of health workforce that is readily available in every community; is less expensive to run than a hospital ward and it focuses on empowering the people who use the service to manage their own lives. This is a cost effective solution. Because the 10 bed Recovery Centre costs approximately \$1m less to run each year than the 6 bed mental health inpatient unit it is sustainable. The implementation of this model opens the door to a different type of workforce that is available in every community and it is transferable to other locations. It offers mental

health consumers hope and a chance to recover and manage their own lives.

This study is targeted towards health service managers and policy makers to facilitate context specific transferability.

Rural research capacity building: a five-year case study

Eleanor Mitchell, Angelo D'Amore, David Campbell

School of Rural Health, Monash University, VIC

The concept of local research support for rural communities has been an increasingly important development. Health and education innovations often need to be locally-run and tailored to be relevant to the local audience. Therefore they also need to be evaluated. These research and evaluation outcomes can then be fed back into improving future activities. Therefore, to ensure that this process becomes embedded there is a growing demand for local research support in rural areas. In particular, there is a need to increase the number of rural health workers and educators with knowledge and skills in evaluation and research methods. Five years ago, the appointment of a full-time academic at the School of Rural Health-Bairnsdale started the development of research support in the East Gippsland area. The program of research support developed was based on principles embedded in capacity building such as workforce development, organisational development and collaboration. Health professionals and educators had opportunities to learn about research methods and evaluation. Importantly, they were given the opportunity to then embed their learning, through engaging in their own research or evaluation. These projects were heavily supported by the local academic. The majority of this support involved one-on-one mentorship, alongside support for the project from their organisation to cover the health professional's time.

This presentation will outline the outcomes of 5 years of research support in East Gippsland. Outcomes have primarily been measured on staff engagement in research activities and conventional research outcomes. This presentation will highlight some of the research and evaluation support and activities conducted; as well as the enablers and barriers to embedding research and evaluation into everyday activities, and obviously where to from here. In conclusion, the early achievements

demonstrate the potential of such a presence to have a real impact on activities in rural areas.

Technology to improve health indicators and reach young rural South Australians

Jill Davidson

SHine SA

This presentation will provide the process and the lessons learned in establishing a website to reach young South Australians and provide them with information and access to STI testing. Young people are particularly at risk of contracting and transmitting Chlamydia and Gonorrhoea. The evidence has led to the identification that young people aged 15-29 years of age are one of the four key priority populations for the purposes of developing an on line Chlamydia testing program.

In the range of health performance indicators, the health status of Australians have 10 focus areas— Incidence of: heart attacks; cancer; sexually transmitted infections and blood borne viruses; end stage kidney disease; injury and poisoning; activity limitation; self-assessed health status; psychological distress; infant mortality rate and life expectancy. Of the 10 areas there are 2 areas where the trends are of concern. This project addresses the significant concerning trend in the rising incidents of chlamydia in young people. By using technology a website was developed that enables young people across South Australia and in rural and remote areas to access STI testing without attending a general practitioner.

There are barriers to accessing of health services in rural and remote communities and this is particularly a problem for young people with sexual health issues who are not prepared to visit their local family doctor in a small country. SHine SA has developed a website for young people to access information on sexually transmissible disease and enable the young person to access a pathology test where often they would otherwise not access testing due to concerns around confidentiality.

Young people in rural and remote areas experience access issues in regard to sexual health, contraception, teenage pregnancy and support for gender questioning issues. This project has focused on STI testing for young people. Often a barrier to accessing sexual health is the concern with respect to privacy in country towns leaving young people extremely reluctant to disclose their health status concerns, this projects reduces the need to access the local doctor for a pathology request form.

This current website increases the State's response to STI testing rates by leveraging IT technology including the ability to use iPhones and Android phones in downloading pathology request forms and accessing testing without a visit to a GP.

The outcome is that young rural and remote people who would otherwise not get checked due to privacy concerns, will do so.

Collaborative partnership to implement oral health care into primary health care

Margaret Dawson¹, Jo Leonard²

¹Royal Flying Doctor Service, QLD; ²Oral Health Services, NT

Most up to date universal thinking strongly advocates that 'health' should be inclusive of oral health; something not traditionally embraced by the general health sector. An integrated partnership approach is needed to reduce the risk of oral disease and promote good oral health.

Poor and untreated dental decay can affect quality of life including our ability to eat, drink and speak; social confidence and self esteem and directly impact on our general health as we get older. Dental caries is the single most common chronic disease of childhood. Around 50% of pre-school aged children in Australia have already had some experience of tooth decay by the time they commence school. There is a strong link between socio-economic status and health which is often reflected in patterns of oral health and disease. Aboriginal children have on average twice the dental decay rates as non-Aboriginal children and are estimated to be up to 4 times higher in remote and very remote areas. Oral disease is a preventable condition but prevention must be started early.

In partnership with a government remote oral health service (GROHS), a non-government rural and remote health service (NGRRHS) has utilised the GROHS's training package to train registered non-oral health professionals across Queensland. Training has been delivered by both a face to face theory and practical workshop and through online theory modules with a shortened face to face practical workshop.

Child and Family Health/Clinical Nurse Specialists, Community Nurses, Aboriginal and Torres Strait Islander Health Practitioners, Remote Nurses, General Practitioners and Paediatricians are much better placed than oral health professionals to access, engage and guide new parents in their

communities about the importance of oral health. Aboriginal and Torres Strait Islander Health Practitioners, in particular, have significant potential to improve oral health outcomes for their families and their communities.

Inclusion of a Lift the Lip oral health risk assessment, the provision of age relevant anticipatory guidance/oral health messages and the application of fluoride varnish in Early Childhood Health Checks is an acknowledgement of the importance of good oral health from an early age in primary health care.

The NGRHS's engagement with its stakeholders sees remote health care staff being trained in the underpinning oral health knowledge and practical skills that will enable them to effectively complete these oral health components.

The Program is a population health program based on a continuum of preventive oral health care. NGRHS has faced a number of challenges in delivering the full range of preventive oral health strategies to Queensland children. The presentation will discuss these challenges; however it will present the considerable achievements that have been realised by working in partnership with the GROHS, Queensland dental authorities and with our remote health stakeholders.

Chronic disease, medications and lifestyle: perceptions from a regional Victorian Aboriginal community

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It is well established that there is a disparity in health and health standards among Australian Aboriginal populations compared to non-Aboriginal groups and that life expectancy for Aboriginal people remains significantly lower than that for the non-Aboriginal population. Many Aboriginal people are medicated for chronic health conditions and it has been suggested that poor medication management may contribute to the increased morbidity and mortality of Aboriginal people. Much of the literature to date has focused on the perceptions of health care providers rather than on the perceptions of the Aboriginal people themselves, hence a paucity of available information regarding

the perceptions of Aboriginal people and their management of chronic illnesses and medications. This study aimed to gather information about the perceptions of a group of Victorian Aboriginal people with diagnosed medical conditions requiring medications regarding their lifestyle, disease management and medication usage. Study participants represented a purposive sample of 20 Aboriginal people over 18 years of age, who attend a local Aboriginal Community Controlled Health Service and who take medications as part of their chronic disease care. Participant interviews were conducted by Aboriginal Health Workers in a culturally appropriate and competent manner using a semi structured *yarning* process. Verbatim transcripts were validated by cross-check between members of the research group including the AHW research partners and coded for descriptive statistical analysis. The findings may help facilitate better health outcomes for this population by: (i) informing health care providers about issues that are important to Aboriginal people in their medication usage and self management of chronic illnesses; (ii) highlighting the inappropriate use of the term "non-complier" when describing Aboriginal people; and (iii) promoting the efficacy of the delivery of care by the Aboriginal Health Services in order to inform mainstream health care providers of the role they can play to improve the use of medicines by their Aboriginal patients and support patient empowerment and self-management.

Engaging and empowering clinicians to provide a sustainable telehealth service

Lisa Deeth

Darling Downs Hospital Health Service, QLD

The key to a sustainable telehealth service is to engage and empowering clinicians.

Planning a sustainable telehealth system involves some key elements that need to be met to ensure the system will become embedded and seen as normal work practice. Some of the key elements include initial engagement with management, ensuring all parties are consulted, policies and procedures are in developed, correct technology is used, data is recorded accurately, patient and staff satisfaction surveys are completed and then all this data collated and fed back to all parties, assessed and adjusted.

The telehealth team in the Darling Downs Hospital and Health Service have successfully engaged many clinicians across the disciplines to create a

sustainable telehealth service which is now embedded into normal work practice and are currently leading the state in regards to the number of telehealth occasions of service.

In the rural setting where allied health clinicians are required to travel to various facilities, telehealth offers a service allowing the clinician better utilisation of time for themselves and for the patient.

When establishing a new service the key element is engagement of management. This includes attending management meetings, educating and providing documentation to have their support. Further education with teams and departments is required to give an over view of how to incorporate telehealth into everyday practice. Identifying key team members who will be the drivers to discuss further how to details.

Where possible it is important for the telehealth team to be involved in the first interaction/consultation in the form of checking equipment, processes and providing guidance where required.

We have developed work instructions and procedures to ensure telehealth is systemised and is not person dependant. We have an overarching governance/procedure and then local work instructions on how to apply telehealth in the local department.

We ask that patient satisfaction surveys are completed from clients as well as clinician satisfaction surveys, which provides valuable information and where the system is failing and where it is doing well.

To create a sustainable service, each department must take ownership of their own service and make it their own. The telehealth team advise on the best practice but local processes must be put in place according to their staffing levels and local processes.

If the key elements are all met and regularly reviewed, telehealth can be embedded and become a sustainable service.

★ The geography of wellbeing across four longitudinal surveys

David Dennis, Fiona Skelton

National Centre for Longitudinal Data, Department of Social Services, ACT

The Department of Social Services (DSS) aims to improve the lifetime wellbeing of people and families in Australia. The Department has invested in a number of longitudinal studies that provide policy relevant data and insights into wellbeing at varying levels of geography across the life course. The new National Centre for Longitudinal Data at DSS includes four longitudinal datasets about Indigenous and non-Indigenous children, households and humanitarian migrants.

Preliminary results will be flagged from *Growing Up in Australia*: the Longitudinal Study of Australian Children (LSAC) and *Footprints in Time* the Longitudinal Study of Indigenous Children (LSIC); each study having released five waves of unit record data about, collectively, more than 11700 children and their families. More than 12 waves of data about more than 7,500 households are available to researchers from The Household, Income and Labour Dynamics in Australia (HILDA) study and Building a New Life in Australia: the longitudinal study of humanitarian migrants (BNLA) will soon release data about more than 2,500 respondents.

This presentation will highlight relationships to morbidity uncovered in cursory analyses that deserve further exploration with the data sets. For example, in HILDA and LSIC psychological distress reduces with remoteness and mental health tends to increase but there are no differences by geography for LSAC parents or BNLA participants. LSIC children's social and emotional difficulties scores are higher in remote than urban areas. Nearly two thirds of LSIC children eat bush tucker, which is bivariately related to lower BMI z scores in each wave of the data. The consumption of bush tucker is much more common in more remote (90%) areas than in urban (30%).

While social and emotional wellbeing sometimes improves with increased remoteness, the factors contributing to social and emotional wellbeing are often poorer for those in remote areas. Recently arrived humanitarian migrants experience similar rates of financial hardship to that of Indigenous parents and carers. Experiences of racism, discrimination or prejudice can affect health and wellbeing. Humanitarian migrants report these negative experiences more often in regional rather

than urban Australia; however the reverse is true for Aboriginal and Torres Strait Islander primary carers in LSIC.

Conference participants will also hear how longitudinal data has been used for policy development and how to apply for the data for their own research work.

Speaking Easy for Living and Learning: school-based service-learning for speech pathology students

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¹Flinders University, NT; ²James Cook University, QLD;

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The overview: Service learning is increasingly being recognised as an important part of health curricula and contributes to the community engagement of universities. As part of their final year clinical placement, speech pathology students from James Cook University and University of Sydney provided speech and language assessment and therapy where appropriate for children and families within a primary school which services disadvantaged families. Students also assisted with referrals to community and health services and contributed to teachers' professional development relating to classroom support of speech and language development and management of children with difficulties in these areas.

The model: The Broken Hill community—campus partnership service learning model was adapted to the local situation to help address the well-recognised lack of allied health services in rural and remote areas. As a result, a strong and dynamic partnership between universities, primary school and local communities developed with all members of the partnership contributing time, equipment and other resources without external funding. In 2014, funding was obtained from the Australian Government funded Northern Territory Regional Training Network to appoint a part time discipline specific supervisor on site; interprofessional and remote supervision were also provided?.

The outcomes so far: The positive outcomes of this ongoing project are already becoming evident. Teachers report that families are now engaging with the school and tackle previously unaddressed speech and language problems. Other community organisations have become aware of the value of these initiatives and are discussing possible

expansion of the program within the wider community. The speech pathology students improved their understanding of program design that facilitates community engagement and the complex issues affecting learning outcomes and school success for Aboriginal families and communities. Students are now in active competition for these placements recognising the invaluable professional, teamwork and cultural learning experiences such placements provide.

The future: This service learning model can be used in a primary school setting to benefit communities and to provide valuable learning opportunities equally for students and the partners. The key elements of success are the strong commitment from the services and people involved and the ongoing engagement by families. The program enables access to allied health services, engages communities and enhances service provision across sectors, while contributing to the health promoting environment in the school. This model can be applied in other primary schools and can incorporate other health disciplines, and has potential to be applied in other rural and remote locations with limited access to allied health services. All that is needed is ongoing commitment (not a problem) and funding for locally based clinical educator support (more of a challenge).

Prevalence and type of partner abuse reported by metropolitan, regional and rural women

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There have been few Australian studies into regional differences in partner abuse, especially with regards to abuse type. Studies from Canada and the USA indicate that rural women who experience partner abuse may be subjected to more severe physical abuse and are more often sexually assaulted by partners than their urban counterparts.

Aim: To investigate prevalence and type of partner abuse in a sample of Australian women, and examine differences across metropolitan, regional and rural areas.

Method: This study utilises data from the Australian Longitudinal Study of Women's Health sixth survey (2012) of the 1973-78 birth cohort (n=6429, mean age 36.3yrs). Information about prevalence and type of abuse experienced in the past 12 months was

gained from the Community Composite Abuse Scale (CCAS), a 28-item survey instrument that identifies four abuse types: physical, emotional, sexual and harassment.

Past 12-month prevalence (reporting at least one positive response to a CCAS item) and type of abuse were analysed with respect to area of residence categorised as: major cities, inner regional and rural (combination of outer regional, remote/very remote areas).

Results: Past 12-month prevalence of partner abuse in the cohort was 13.7%. There was no significant difference ($p \geq 0.05$) in prevalence rates between major cities (13.6%), inner regional (14.0%) and rural (13.5%) areas.

With regards to type of abuse, there were no significant differences in the rates of reporting across regional areas for any abuse category. Emotional abuse was the most common abuse, reported by 12.5% of women in the sample. Regional rates of emotional abuse were: Major cities 12.4%, inner regional 13.0%, rural 12.3%. Physical abuse was reported by 2.5% of women, with regional figures of: major cities 2.7%, inner regional 1.9%, rural areas 3.0%. Harassment was reported by 2.8% of women, with regional figures: major cities 2.9%, inner regional 2.6% and rural areas 2.4%. Sexual abuse was reported by 0.6% of the sample, with regional comparisons being: major cities 0.4%, inner regional 0.8%, rural areas 0.5%.

Conclusion: This study contributes new knowledge about the prevalence and type of intimate partner abuse experienced by young women across different geographic regions. It reports on data from a large population-based study, and found that the prevalence of partner abuse is consistent for metropolitan, regional and rural women. There were no significant differences in the reported rates of emotional, physical sexual or harassment abuse across regional areas for women of the study cohort.

Too Much Hush Hush! Rural women tell their stories about access to abortion services

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Introduction: Little is known about Australian rural women's overall experiences of accessing an

abortion service and the barriers they encounter. Whilst there are clear barriers such as geographical distance and lack of services in the local community there is a paucity of research that explores women's experiences when they seek access to health care or of the barriers to care at a time of life crisis. Around one in three women access an abortion at some point in their lives, so it is a significant women's health issue. A study was done to fill a knowledge gap, provide insight into factors that can impact on rural women's health and contribute to better women's reproductive health policies.

Aim: To identify factors that rural NSW women experience in accessing abortion services.

Methods: In-depth qualitative interviews were undertaken with rural women living in NSW, who had an abortion in the previous 15 years.

Results: Thirteen women participated in the study. Women travelled between 2-9 hours one way to access an abortion. Several women borrowed money for the abortion fee. Common themes related to stigma and silence; jumping through hoops for referrals and access; logistics such as early morning child-care, travel and accommodation. All women had a surgical abortion and many were unclear about choices for medical abortion.

Relevance: Abortion is a safe medical procedure and rural women have a right to access appropriate care, to information and referrals and to make decisions about their health care. These rights are recognised in international and national guidelines. Women's health care needs supportive and multi-disciplinary care to assist in good outcomes through significant life changes. Women who are already isolated should not feel more isolated by barriers to medical care and attitudes that may affect real access.

Conclusion: Rural women in this study experienced many barriers to accessing an essential health service for their unanticipated pregnancy. Despite welcome legal and pharmaceutical reform in Australia, results from this study indicate that there is a long way to go "remove the hoops" and let go the "hush hush" on issues rural women experience in their process of accessing reproductive health care. Continued advocacy for policies that support women's reproductive health are needed to ensure rural women have access to appropriate, affordable, available and acceptable health care. They need services closer to home and non-judgemental care by health professionals at a time of crisis.

Birthing in the bush overseas: models that work

Rosie Downing

Midwifery Group Practice, Alice Springs, NT

At the present time, around one in four women living in the Northern Territory, Australia, are expected to leave their homes, families and community in preparation for the birth of their child in a setting where there are appropriate staff and resources at hand (Thompson, 2013). Leaving their home is not without risk; the emotional, cultural, spiritual, social, financial and physical risks that may ensue in this arrangement are well documented in many studies, reports and research articles. However, women and their families must juggle these risks with the risks of planning to birth in a remote setting with variable access to skilled maternity carers, appropriate resources and knowing the geographical barriers to accessing emergency care if it becomes necessary. For many families, there are also the inherent complexities and challenges of negotiating a dominant colonial health care system.

From a service provision point of view, there are many barriers to be overcome if maternity services are to be sustained in the remote setting. The oft-quoted 'tyranny of distance', inclement weather and its impact on road or air access, variable and transient population sizes, shifting government structures and funding, and the difficulty of recruiting and retaining skilled maternity carers are all factors that will affect how maternity care can be planned and organised, and what that care will be like. And yet, facing similar barriers and complexities, there are services in other rural and remote communities around the world who provide safe maternity and birthing care.

The award of a Peter Mitchell Churchill Fellowship allowed me to travel to Scotland, Nunavik (in Canada), and Aotearoa/New Zealand, to visit midwives and communities who have successfully established and continue to sustain birthing services in their remote communities. Each of the communities I visited have their own unique and appropriate solutions to the barriers they encounter; what they showed me is that where there is a will, there is a way.

This presentation will discuss different ways in which these birthing services address some of the barriers to birthing service provision in the remote context. Some services I visited were relatively recently established, while others had been

revitalised from near the point of closure. Stories, photos and 'case study' in-depth consideration of how these services function will allow me to share what I have seen and learnt from visiting these successful, sustainable birthing services in rural and remote communities.

Rural multidisciplinary sub-acute collaborative care. What matters most?

Tracey Drabsch

Western NSW Local Health District, NSW

Background: People living in rural towns who require acute specialist care are likely to receive this care in a regional facility which is often a long distance from their home town. If it is not safe for them to return home it is likely they will return to a rural facility for inpatient sub-acute care. The complex nature of such inpatients places pressure and expectation on a generalist rural workforce to provide their health care needs. Care delivered across long distances, within different facilities and by a number of different teams may jeopardise continuity of care. To address this, an innovative multidisciplinary hub and spoke model was implemented by the Sub-Acute Care Team (SCT), based in a regional facility, to collaboratively care for this patient cohort. After the implementation of the SCT research evidence demonstrated an increase in the adherence to clinical practice guidelines in rural facilities. Funding cuts subsequently halved the number of senior clinicians in the SCT.

Aim: To explore key mechanisms which are effective in enabling and sustaining adherence to sub-acute clinical practice within rural sites.

Method: This prospective study enrolled inpatients admitted to a 200 inpatient bed regional facility for specialist care who were transitioned to a 20-50 bed rural facility for sub-acute care.

Interventions: The SCT prioritised sub-acute care processes including case conferencing, comprehensive assessment and multidisciplinary SCT handover and follow up of inpatient progress and team processes in the rural site.

Results: This research is in progress and will complete data collection in early 2015. This presentation reports on Functional Independence Measure (FIM) changes for rural facility inpatients, rural clinician impressions of the model of care within their facility and rural inpatients' satisfaction with health service delivery.

Conclusion: Understanding the key components, 'what matters most', is likely to enable health services to sustain continuity of care and deliver effective sub-acute care management of complex rural facility inpatients.

Assessing measurement tools of health and wellbeing for evaluating a community intervention

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Background: Often in public and rural health, interventions are proposed or implemented with a community or a group of individuals to improve their health and wellbeing. Those with an interest in evaluation often want information about what tools that are available and those that are best suited to measure improvements that could be attributed to their intervention. There are obvious benefits from using efficient and standardised tools of measurement and for which population norms are available.

This study evaluated tools that measure community health and wellbeing, which could potentially be used before and after an intervention.

Methods: A literature was undertaken on the following health and sociological databases—Medline/PubMed; ERIC; JSTOR; Proquest etc. Articles that mentioned community, overall health, wellbeing or quality of life and included widely used named measurement tools were extracted. These tools were evaluated by a further search of the literature of their psychometric properties. Each tool was scored (good=1; mediocre=0.5, poor=-1 or missing =0) for a number of fields including: internal consistency; length, use in cross-cultural setting, global health and wellbeing assessment, use of subjective measures; clarity; measure of health; measure of wellbeing; responsiveness; validity; and test-retest reliability. A composite score was made from the sum of field ratings divided by number of fields available for a tool.

Result: Of 958 articles that were screened, 152 articles were extracted for review. From those articles 27 measurement tools were identified and assessed.

The composite scores for tools ranged from 0–1. Six tools had a rating of excellent.

Conclusion: Use of any of the 6 tools rated as excellent is recommended for before and after an intervention based on the criteria in this article. Cost is another issue, which also may be important for implementation. The recommended tools will be discussed at the conference.

Composite score	No. of tools	Rating
1–0.9	6	Excellent
0.89–0.7	6	Good
0.69–0.5	10	Mediocre
<0.5	5	Poor

Our journey preparing a protocol to collect Aboriginal people's stories of diabetes care

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The possibility for research to better meet the needs of people living in rural and remote places is not just a nice idea, it is a necessary practice as governments, organisations and individuals strive to close the gap between Aboriginal and non-Aboriginal Australians.

We would like to inspire others to challenge 'scientific' research practices to undertake research that gives Aboriginal people an authentic voice.

We will share our story of developing a research protocol for a study where we have collected Aboriginal people's stories of diabetes care. This is a collaborative story between an Aboriginal Medical Service, a state health service and a Medicare Local told by four Aboriginal Health Workers and a non-Aboriginal researcher.

We will share aspects of our qualitative study design which we believe value Aboriginal people and invites their participation in research. Our presentation will include discussion of coercion and the consent process and an explanation of how we resolved this. We will demonstrate a method of data collection using conversation cards and a conversation map to facilitate discussion in focus groups and we will describe how we valued the expertise of Aboriginal Health Workers in all aspects of our research.

Imposing 'scientific' research designs and practices on Aboriginal people and communities without

consideration that each community is unique has the potential to cause further harm and disempowerment. In sharing how we have approached our research, we encourage others to challenge methodological norms to come up with new research methods with their community to allow the unique voice of their community to be heard, and listened to. The possibility of more powerful research is exciting and will bring better understanding of the factors that impact on the health and wellbeing of people in rural and remote places.

Forward to Fellowship—a response to Lost in the Labyrinth

Vivienne Duggin

Rural Health West, WA

Background: In response to a medical workforce crisis in early 2013, Kalgoorlie-Boulder and Kambalda has seen a rapid increase in the number of general practitioners in the last 18 months. Of the 39 doctors currently working in general practice, 28 are non-vocationally registered and more than 24 have arrived from overseas in that time.

Consequently, the current status is that more than 80 per cent of the general practice workforce in Kalgoorlie-Boulder and Kambalda gained their primary medical qualification overseas. This compares to 52 per cent of the whole of rural and remote Western Australia and 40 per cent nationally.

Aim: International medical graduates have access to high quality education at the local level by supporting them individually with exam preparation to enable them obtain fellowship of either The Royal Australian College of General Practice or Australian College of Rural and Remote Medicine.

Also, provision of social and cultural support program to enable doctors and their families integrate into the local community.

Methodology: A Forward to Fellowship Governance model was established underpinned by the collective impact of eight local agencies and two agencies that have a state-wide remit, thus ensuring the most efficient use of collective resources and the prevention of duplication.

The Forward to Fellowship program commenced in September 2014. A Professional and Clinical Mentor was recruited to develop and lead the education and clinical support for Forward to Fellowship. Three

local medical educators were recruited to provide on-line learning modules, face to face education sessions held at the Rural Clinical School, external clinical teaching visits, and mentorship. One medical educator is an international medical graduate who completed his Fellowship exams in 2013. He is now supporting other international medical graduates. To date, 13 candidates have joined Forward to Fellowship.

A social support model was developed to provide the interface between the international medical graduates, their families and the community to assist with their assimilation into the community and their sense of being valued.

Conclusion: Once fellowship is obtained the current international medical graduates will then become the future trainers and supervisors of medical students, medical registrars and international medical graduates in the region. Forward to Fellowship will ensure the community has access to the best qualified medical practitioners who will deliver sustainable services for many years to come.

Provision of social and cultural support for international medical graduates and their families is integral to them remaining in the region long term.

Getting the message right: making the social determinants of health matter in the Northern Territory

Breanna Ellis, Liz Kasteel

Chronic Conditions Strategy Unit, Northern Territory Department of Health, NT

Background: The Northern Territory has the highest burden of disease of all jurisdictions with high rates of chronic conditions in the Aboriginal population. Health data indicates a strong link between the Social Determinant of Health (SDoH) and the likelihood of developing a chronic condition. Addressing poor social determinants is one of eight key action areas in the NT Chronic Conditions Prevention and Management Strategy (NT CCPMS) 2010-2020.

Methods: Throughout the development of the 2014-2016 Implementation Plan for the NT CCPMS, it was recognised that there was a need to develop a coordinated approach to how the SDoH are communicated across the Northern Territory including how to communicate the SDoH to the non-health sector so that they understand the a SDoH

approach can and should be used to progress their core business.

Results/discussion: While it is evident that action on the SDoH is everyone's business, converting a theoretical framework into a concept that is understood and accepted by a broader audience has been difficult. It appears that there is a lack of understanding across the Northern Territory regarding the SDoH and what it means at both a strategic and operational level. It also appears that there is not one consistent message that is being conveyed. These factors contribute to the inability to communicate a clear and consistent message regarding the importance of the SDoH across all sectors in the Northern Territory.

The project aims to develop a communication framework that describes the SDoH in a format that is relevant to the Northern Territory. *The Northern Territory Communication Framework for the Social Determinants of Health* will provide individuals, programs and government departments with a consistent understanding of the SDoH

Conclusion/implication: The extensive consultation process will result in a Framework that improves the awareness of SDoH, promote an understanding of working within a SDoH approach, and provide guidance to frame health messages addressing the SDoH for the health and non-health sector. It is expected that the Framework will promote and encourage future actions across the Northern Territory which will address the SDoH and improve the prevention and management of chronic conditions.

Online physiotherapy delivered using video games

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Background: Recovery after stroke is significantly improved with intense and challenging physiotherapy. It is impossible to deliver supervised physiotherapy in rural and remote areas of Australia. Online physiotherapy, comprising a cloud-based management platform and video games, can deliver expert therapy programs, undertaken unsupervised in the home.

Aim: To determine if there is a positive relationship between duration of therapy and outcome for

patients with hemiplegia after stroke undertaking online upper-limb physiotherapy unsupervised in their home.

Subjects: Ethical approval and informed written consent were obtained. 80 patients (55 males), mean age 63 years, range 33-84 years were recruited, 41 within 4 weeks of stroke (Acute), mean time from stroke 2.3 weeks, range 0.9-4 weeks; 39 in the Chronic phase, mean time from stroke 1.8 years, range 0.5-9.7 years.

Methods: Patients undertook online physiotherapy unsupervised in their own home over 12 weeks. Physiotherapy was delivered using the video game Circus Challenge, professionally produced specifically for upper limb rehabilitation and controlled by 100 different bimanual movements. The time performing these therapeutic control movements (not simply playing the game) is automatically recorded.

Upper limb function was evaluated using the Fugl Meyer Upper Extremity Assessment (FMUEA) and the Chedoke McMaster Arm and Hand Activity Inventory (CAHAI), assessed at baseline and 12 weeks. A MANOVA was performed for Acute and Chronic patient groups—*Dependent variables:* Change in FMUEA and CAHAI scores; *Fixed factors:* Sex, Hemisphere of stroke; *Covariates:* Therapy Dose—total time performing therapy moves, Baseline scores, Age, Time from stroke.

Results: (mean \pm SE) *Baseline Scores*—FMUEA, Acute: 41 ± 3.0 , range 12-59; Chronic: 39.9 ± 2.3 , range 13-60. CAHAI, Acute: 32.4 ± 2.3 , range 11-51; Chronic: 31.5 ± 2.2 , range 11-58.

Therapy Dose—Acute: 182 ± 35 minutes; Chronic: 337 ± 57 minutes.

Change in Scores—FMUEA, Acute: $+13.7 \pm 2.5$ ($p < 0.001$); Chronic: $+5.3 \pm 0.8$ ($p < 0.001$). CAHAI, Acute: $+16.6 \pm 2.4$ ($p < 0.001$); Chronic: $+4.3 \pm 0.8$ ($p < 0.001$).

MANOVA revealed a main effect for Therapy Dose: Change in FMUEA; Acute $p < 0.001$, Chronic $p < 0.05$; Change in CAHAI; Acute $p < 0.001$. For acute patients there were also main effects for Age, $p < 0.04$ and Time from Stroke $p < 0.02$.

Conclusion: Patients aged up to 84 years play therapeutic video games, unsupervised in their own home. Time spent performing therapeutic control actions significantly predicted improvement in upper limb function. This positive dose-response relationship was observed in both acute and the

chronic patients, indicating benefit can be gained even several years after stroke.

Specialist training in rural—does setting impact on quality of training?

Donna Fahie

Australian and New Zealand College of Anaesthetists, VIC

Over the past seventeen years the Australian Government has undertaken a major expansion of its investment in medical education. This expansion has resulted in medical education being delivered in a range of non-traditional settings such as rural areas and private hospitals.

The Australian and New Zealand College of Anaesthetists (ANZCA) has been contracted by the Australian Government to expand the range of training experiences and settings through the Specialist Training Program. In addition to ANZCA this program supports 12 medical colleges across 18 vocational training programs, varying in duration from three years (eg. general practice) to six years (eg. neurosurgery).

Persistent geographic maldistribution of the medical workforce has been documented in recent reports such as *Health Workforce 2015* and the Senate Inquiry into *The factors affecting the supply of health services and medical professionals in rural areas*. The majority of specialist vocational training still occurs in public sector metropolitan hospitals. In this presentation, I discuss the key elements of the Specialist Training Program and how it is helping address the shortages of specialist anaesthetists and specialist pain medicine physicians in rural and regional areas.

Currently there is limited evidence on the quality of training in more diverse training settings such as rural and remote hospitals. The College is keen to understand the impact that the diversification of training settings may have on the quality of service offered in those settings and the quality of training. Factors to be considered include barriers and benefits of training in rural and regional areas and possible safeguards required to ensure high quality training is not compromised.

To help answer this question, we have commenced a study to answer the following question: *Does setting impact on quality of training?*

The study will also explore issues of training in expanded settings for anaesthetists and pain medicine specialists. The presentation will deliver an

outline of the study and its methodology, as well any early research findings.

Enhancing child health systems in the Northern Territory to improve anaemia outcomes

Heather Ferguson

Department of Health, NT

Background/relevance: Anaemia is highly prevalent in young children in remote Northern Territory and has remained a persistent problem despite children having very frequent contact with health services.

Clinician's adherence to anaemia treatment is documented to be poor with only 30% of children identified with anaemia receiving full treatment according to current protocols.

Aim: To improve effectiveness of identification and treatment of anaemia in children under two years of age according to current protocols, by developing a systematic approach to identification and treatment.

Method: The Healthy Under 5 Kids (HU5K) Program provided the platform and reach for targeting children under two years in remote clinics in NT and ensuring a standardised approach to identification, treatment and monitoring of anaemia. The HU5K program is a schedule of visits at key age milestones that was developed to provide a universal and consistent platform of care, support and information for parents, to address key determinants of child health.

Tools were developed to facilitate a standardised approach to management of child anaemia as outlined in current protocols utilised by general nurses, Aboriginal Health Practitioners and/or specialist child health nurses. Timely feedback to staff is provided as monthly reports highlighting the number of children aged 0-2 years who are:

- tested for anaemia when due using a haemoglobinometer
- identified with anaemia (Haemoglobin less than specified cut-offs according to current protocol)
- had correct treatment initiated (Anaemia Care Plan)
- completed treatment.

Results: The program has been commenced in four health centres in remote NT since January 2014.

The monthly reports are proving valuable in identifying children with anaemia and providing a useful list for clinical staff of children who need follow-up. Child health staff in an additional thirty-one communities have voluntarily begun participation in the program, in total representing two-thirds of the government health centres in the NT. Where the program has been implemented well, there has been a reduction in anaemia.

Conclusion: Consistent implementation of this systematic approach indicates a trend to reducing anaemia in young children. The tools have been effective in assisting staff to identify and treat children with anaemia, and ensure appropriate follow-up. Recording and reporting has ensured that children with anaemia are visible and systematically followed according to current protocols. Work continues to integrate the monitoring and reporting process into usual care practices.

Cobweb of help to stick supports together for a holistic health journey

Kelly Foran

Friendly Faces Helping Hands Foundation, NSW

We started our cobweb of services and advocacy to strengthen health support networks to weave a net and stop people falling through the cracks of health care. We link government, private and not-for-profit services and organisations to create an easier holistic multidisciplinary health journey that looks at the patient, family and community. To minimise the overwhelming feelings of isolation and frustration, and give people the power of information. Things like help with finding accommodation, travel from an airport to a hospital, contact with a social worker will ease the stress and panic. Mental health becomes a very real issue therefore we connect with mental health services.

I would like to briefly tell our personal story because it is the reason we exist. When I say I feel incredibly lucky, it may seem hard to believe. I have battled cancer, brain surgery, a premature labour, stroke, a diabetes diagnosis and a life-threatening bout of meningitis—all in just three months. To make matters worse, I was just learning to walk and talk again when our baby boy, who was also born with multiple health issues (largely as a result of mine), was diagnosed with a life-threatening cancer of his own. Worry, feelings of guilt, financial stress and inability to “do something” also led my husband to depression.

It was after reaching some of the darkest points of our lives that this foundation was born. Our aim is to make long stints in hospitals as stress-free for country people as possible, so they never have to experience the trauma we went through. I am telling our story because we understand. We have walked the walk. We stumbled and struggled through seven hospitals in two states and three health systems.

We can talk the talk. We know the problems and pitfalls and we have ways to help. Since we began, we have helped and supported over 45,000 people with their health journey. We help everyone. But sometimes it is the smallest struggle that tips people into the next illness to fight—mental health.

From our traumatic time, we learnt how hard it is ... but it does not have to be so hard. The information is out there—you just need to know where to look.

We have been described as an inspiring speaker. Help us to help others.

Using the ABS Patient Experience Survey to inform on rural health care

Lauren Ford

Australian Bureau of Statistics, ACT

The Australian Bureau of Statistics (ABS) Patient Experience Survey is conducted annually and collects national data on access and barriers to a range of health care services, including general practitioners, medical specialists, dental practitioners, hospital admissions and emergency department visits. Data are also collected on aspects of communication between patients and health professionals.

Results from the 2013-14 ABS Patient Experience Survey will be presented, with a focus on access and barriers to health care services in regional and remote areas of Australia. These results will highlight service usage and barriers to accessing health care such as cost and long waiting times faced by persons in regional and remote parts of Australia, and how these compare to major cities of Australia. Time series analysis will be provided where possible.

In addition, the presentation will highlight how the ABS Patient Experience Survey data can be utilised to inform evidence based policy within rural health care.

Looking deadly! A systematic approach to improving eye care for Aboriginal Victorians

Susan Forrester¹, Jimi Peters¹, Mitchell Anjou², Uma Jatkar², Jonathan Jackson³, Genevieve Napper³

¹Victorian Aboriginal Community Controlled Health Organisation, ²Indigenous Eye Health, Melbourne School of Population and Global Health, University of Melbourne, ³Australian College of Optometry

With a systematic and collaborative approach, significant improvements have been achieved in eye care access and outcomes for Victorian Aboriginal communities since 2010. The Victorian Aboriginal Community Controlled Health Organisation (VACCHO) has worked in partnership with a broad range of stakeholders and the Victorian Government to improve eye care for Aboriginal and Torres Strait Islander community members in Victoria.

Community control within a regional approach:

The University of Melbourne published the Roadmap to Close the Gap for Vision in 2012 and this national, sector-endorsed framework provides an evidence-base for community controlled eye health initiatives. The Roadmap recommends a regional close the gap approach for vision, within a jurisdictional support structure, so as to ensure sustainable and successful implementation and outcomes.

VACCHO is the peak Aboriginal health body representing Aboriginal Community Controlled Health Organisations (ACCHOs) in Victoria. VACCHO builds the capacity of its membership, and advocates on key issues on their behalf. A Statewide Eye Health Project Officer is engaged at VACCHO and provides a pivotal role, linking and supporting ACCHOs, strengthening stakeholder relationships and support networks, increasing workforce development opportunities, and supporting regional eye health workers. Project officers are based at a number of VACCHO member organisations, and work toward improving eye care pathways and stakeholder engagement regionally.

The Victorian Aboriginal Spectacle Subsidy Scheme (VASSS) is an additional subsidy to the Victorian Eye care Service, managed by the Australian College of Optometry, and offers a specifically selected frame range, extends eligibility to all Aboriginal and Torres Strait Islander community members resident in Victoria, and provides a fixed and reduced patient contribution of \$10 for glasses.

The Department of Health and Human services Victoria currently provides financial support for the Statewide Eye Health Project Officer, the VASSS, the regional project officers in four (of eight) Department of Health and Human Services regions, and facilitates a Victorian Aboriginal eye health committee. An advisory group governs these projects, comprising Victorian, federal and regional stakeholders, and oversees the funded programs. Regional eye health committees made up of local and regional stakeholders support the regional ACCHOs and project officers.

Conclusion: A planned and collaborative approach with effective stakeholder engagement has provided opportunity for significant improvements in service delivery, access and outcomes in Aboriginal eye care in Victoria. Community knowledge and acceptance of eye care programs is being achieved, and elements of the approach in Victoria may be of value to other states and territories.

The impact of inter-hospital transfers in acute coronary syndrome, in Perth WA

Rene Forsyth, Rachael Moorin, Jan McKay
Curtin University, WA

Background: Cardiovascular disease is recognised as the leading cause of death and disability in Australia and Acute Coronary Syndrome (ACS) alone accounts for 20% of deaths in Western Australia (WA). Morality rates in acute myocardial infection (AMI) are halved when treatment is initiated within the first hour from symptom onset. Rural and remote populations are more at risk of adverse outcomes due to the sheer distance and associated travel times to attend appropriate medical facilities.

Aims: With all rural and remote western Australian ACS patients requiring transfer to metropolitan hospitals for primary interventions, the study aimed to look at the impact of being transferred to a hospital capable of primary interventions on key performance indexes (door-to-balloon, door-to-ECG times), length of stay and in-hospital mortality.

Methods: De-identified primary hospital data were collected from one tertiary hospital in Perth WA between 01/06/2013 and 31/12/2013. Data collected were age, sex, postcode of residence, primary diagnosis, primary procedure, date of presentation, time of symptom onset, time of arrival to referral hospital, time departed referral hospital, time of arrival to tertiary hospital, time of ECG, time of

activation of cardiac catheterisation lab, procedure length, discharge date, mode of arrival, disposal code and length of stay. Data were analysed using SPSS Statistics.

Relevance: This study is a preliminary needs-analysis of the challenges associated with rural and remote populations receiving equitable and timely management during an ACS event.

Results: The cohort consisted of 106 WA patients, with a mean age of 59.72 years (35-87 year range), 81.1% were male, in hospital mortality was 5.7% and the median length of stay was three days (0-32 days range). There was a statistically significant difference with experiencing door-to-balloon times within the recommended 90 minutes between transferred and direct-presentation patients ($p=0.02$). Patients who were transferred experienced statistically significant higher median activation-to-balloon ($p=0.000$), door-to-balloon ($p=0.032$) and ECG-to-balloon ($p=0.000$) times than those who presented initially to the tertiary hospital but no statistically significant difference in ECG-to-Activation times between groups ($p=0.146$).

Conclusions: Key performance indices were poorer in the transferred cohort, particularly door-to-balloon times. This study was not able to assess the effect of transfers on mortality rates due to the small sample size. The rationale of achieving door-to-ECG and door-to-balloon times within recommended time frames is due to previous findings of improved survival. The higher median times experienced by transferred patients could potentially be associated with more adverse outcomes.



The impact of tuberculosis on children in Timor-Leste

Josh Francis

Royal Darwin Hospital, NT

Tuberculosis frequently affects children in endemic settings. Diagnosis of paediatric TB is challenging, leading to under-recognition and delayed diagnosis in many settings. The estimated incidence of TB in Timor-Leste is among the highest in the world, but children are under-represented in national notification data. Diagnostic capacity is limited in Timor-Leste, and improved case finding and use of investigations to optimise diagnostic clarity are needed. Strategies for prevention of TB in children include BCG vaccination for infants, as well as isoniazid preventive therapy for young children at risk of latent TB infection. Implementation of these

strategies is occurring in Timor-Leste, with opportunity for further improvement.

The Remote Health Standards and Accreditation Program

Peter Frendin

AGPAL Group, NSW

The Remote Health Standards and Accreditation Program (RHSAP), jointly endorsed by Australian General Practice Accreditation Limited (AGPAL), Australian College on Healthcare Standards (ACHS) and the Royal Australian College of General Practitioners (RACGP), is a framework for the provision of safe, high quality health care to people living in remote areas of Australia. It is envisaged the RHSAP will assist the effective community control of remote health services and support better health outcomes for people living in remote areas, including people of an Aboriginal or Torres Strait Islander background.

This presentation outlines the history and development of the standards as well as the benefits of specific health care based standards for remote areas within Australia.

The role of health literacy in reducing health disparities in rural CaLD communities

Rhonda Garad^{1,2}, Lauren Waycott¹

¹Jean Hailes for Women's Health, VIC; ²Deakin University

Background: Approximately one-third of the Australian population live outside of major cities. Those who live outside of major cities experience health disparities, higher levels of preventable deaths and experience a five year mortality gap when compared to metropolitan dwelling persons. Health disparities are defined as differences in the health outcomes of persons served by the same health system.

Preventable deaths are those that occur prematurely that might have been avoided through better preventive health activities such as screening, good nutrition and healthy habits such as exercise. Evidence indicates that persons with low levels of health literacy have lower levels of participation in preventative activities.

74% of migrant and refugee groups have lower levels of health literacy compared to the general Australian population (59%) with many residing in

regional and rural areas as a consequence of Australian Government settlement policies. These factors increase the risk for this cohort of preventable illness and premature mortality.

The association between the health literacy abilities and health beliefs of culturally and linguistically diverse (CaLD) groups and health disparities has not yet been fully explored. This study seeks to address this gap.

Methods: Semi-structured interviews were conducted (=45) with three CaLD groups (Somali, Chinese and Indian) from metro and regional areas. Interview content included inquiry into health beliefs, disease attribution, health information seeking and health behaviours. Data was analysed using an NVivo coding process and thematic analysis.

Results: Results show an association between health beliefs, disease attribution, health information seeking and health behaviours and engagement in the areas of: prevention, screening, early intervention and treatment compliance.

Discussion: Alternate health beliefs such as magico-religious, Ayurveda and in traditional practices may contribute to health literacy barriers, health disparities and poorer health outcomes. This study has shown that there is marked variance in health beliefs, disease attribution and health seeking behaviours between the three CaLD groups and this information may assist those supporting the health of these rural communities to develop or adapt local level responses which account for the variance.

#IHMayDay: showcasing Indigenous knowledge and innovation

Lynore Geia¹, Melissa Sweet²

¹James Cook University, QLD; ²Canberra University, Sydney University

Twitter is a vibrant platform for advocacy and for the dissemination of news, views and resources about Aboriginal and Torres Strait Islander health. It is enabling the formation of new, open networks and self-organising communities united by an interest in improving the health and wellbeing of Aboriginal and Torres Strait Islander communities and peoples. This paper reviews the inaugural #IHMayDay—a 15-hour Twitter-fest of discussions about Indigenous health that took place on 1 May 2014. The event provided a platform for Aboriginal and Torres Strait Islander peoples to share views and knowledge about wide-ranging issues affecting health. Non-Indigenous people were encouraged to participate

by retweeting and listening. The event can be seen through multiple lenses: as an act of self-determination, a form of community development and engagement; an intervention in health promotion; and as an innovation in journalism. This presentation will examine the decolonising methodology that informed the event; the impacts of #IHMayDay, and the broader lessons that can be drawn from this event, which was run on zero budget. #IHMayDay trended number one nationally on Twitter at several times and achieved nearly 26 million Twitter impressions. It led to new connections and opportunities for participants. Importantly, it helped challenge the “deficit model” so prevalent in professional and public discussions about Indigenous health. This presentation will be informed by interviews with a sample of participants, and will also address the question, what next for #IHMayDay? It will also consider lessons for the wider rural and remote health field. The authors argue this submission is:

- Current and relevant. This is a timely paper given the upheaval and uncertainty facing Indigenous affairs more broadly, and the need for ongoing advocacy and public debate about related issues.
- Analytical. This paper takes a multidisciplinary approach to examining #IHMayDay, using a decolonising methodology to make specific recommendations for policy makers, organisations and professionals working in rural and remote health and Indigenous health more broadly.
- New knowledge. #IHMayDay is thought to be the first such event globally. Learnings will be valuable across a range of fields.
- Conference themes. In many ways #IHMayDay exemplifies these—showing the potential of Twitter as a platform for connecting diverse peoples in many places with new possibilities.
- Broadening health: The process, content and outcomes of #IHMayDay illustrate an innovative approach to broadening discussions around the determinants of health.
- Quality: This paper provides a novel and valuable addition to the emerging literature around decolonising methodologies and social media, and particularly considers the implications for rural and remote health.

What prevents or facilitates fruit/vegetable intake among rural Western Australian children?

Stephanie Godrich¹, Amanda Devine², Jillian Darby², Christina Davies³

¹Edith Cowan University, WA; ²School of Exercise and Health Science, Edith Cowan University, WA; ³School of Population Health, University of Western Australia, WA

Aims: Identification of key barriers and facilitators of WA children's fruit and vegetable consumption to inform a) policies to support provision of affordable, quality fruit and vegetables to rural/remote areas and b) tailored community-based interventions.

Methods: Existing literature was reviewed and key informant interviews were guided by a semi-structured interview guide relating to amounts, barriers and facilitators for fruit and vegetable consumption; relationship between food insecurity and fruit and vegetable consumption; motivation towards and strategies to increase consumption. Fifteen interviews were conducted with 19 informants (one interview included five participants) and were transcribed verbatim, de-identified and categorised by occupation type. A thematic analysis using QSR NVivo 10 grouped commonly occurring themes.

Relevance: In the Australian and WA context, a dearth of literature relates to children's fruit and vegetable consumption in regional/remote locations, contributing to the lack of understanding regarding underlying barriers. This research will influence policy and facilitate relevant and tailored health promotion interventions specific for WA issues.

Results: Over 30 per cent (n= 6) of participants were Government health professionals, 21% (n=4) were non-Government health professionals, 10% (n=2) Aboriginal health professionals, 10% (n=2) independent education professionals and one quarter (n=5) were Government education professionals. A total of 156 statements related to two sub-themes: i) barriers (91 statements) and ii) enablers (65 statements) to children's fruit and vegetable consumption. Barrier sub-themes—price, quality, availability, knowledge/skills, storage facilities, ethics and culture, and enabler sub-themes—school provision, education, and food preference—were identified.

Price was a key barrier and described as 'horrendous' and 'exorbitant', while ethical issues related to over-inflated prices, biased ordering and selling of old produce, e.g.:

"Our food is terrible ... things [have] been sitting in the fridge for weeks and weeks and weeks ... and they still sell it. In some ways I feel like our store owners take advantage of that, because they know they can't get anywhere else"
(Government health professional).

The school environment facilitated consumption via school breakfast or lunch programs or school/community gardens. Children gained nutrition knowledge through school education and cooking programs.

Conclusions: Health practitioners should utilise this evidence to create informed community initiatives while policy-makers can base future policies on positively influencing the most significant barriers and enablers to fruit and vegetable consumption in regional/remote areas based on findings of this research.



The emerging double burden of malnutrition in Timor-Leste—a time to act

Heather Grieve, Joao Bosco da Costa

Australian Embassy and Aid Program, Timor-Leste

The recent and first ever, comprehensive food and nutrition survey in Timor-Leste, revealed slow but declining rates of under-nutrition coupled with slow but inclining rates of overweight in some groups. This presents a particular concern for a post conflict country, still classified as *least developed*. It also presents an opportunity to act now, before the burden reaches prevalence rates similar to other neighbouring countries in the region.

Continuity of medication management from hospital discharge to primary care in Central Australia

Mary-Jessimine Bushell¹, Fran Vaughn²,
Isabel Gundani³, Feng Chien Sung⁴, Angela
Young⁴, Lisa Wark¹

¹Charles Darwin University, NT; ²Centre for Remote Health, NT; ³Port Pirie Regional Health Service Pharmacy Department, SA; ⁴Alice Springs Hospital Pharmacy Department, NT

Background: Continuity of medication management can be described as the accurate transfer of medicines information across different health care settings. Pharmacists within the health care team play a primary role in ensuring that this service is being provided to patients. When a patient is admitted to hospital for treatment or care, there are often alterations made to a patient's regular and often longstanding medication regimen. Revised chronic medication regimens are typically intended to be continued after discharge from hospital in the community or primary care setting.

Aim: To identify if alterations made to a patient's medication regimen in the hospital setting reflect what is dispensed in the community/primary care setting in rural and remote Central Australia.

Method: Retrospective chart audit. Data from inpatient records, specifically discharge medications were matched with records for the same patient with dispensing records in community pharmacies or electronic health records 4-6 weeks after discharge. Inconsistencies were noted and match rates examined.

Results: When pre-admission medications, examined from inpatient records, were compared with those recorded at discharge, 56/57 (98.2%) of patients had changes to chronic medication therapy. From the data collected 40.4% (23/57) of patients' hospital discharge prescriptions exactly matched dispensing history records in the community setting 4-6 weeks post discharge. The development of Medication Management Plan by a clinical pharmacist did not show a significant relationship with the continuation of discharge medication care or to the provision of discharge summary (Chi-Square test: $p=0.238$, $p=0.585$ respectively). Discharge summaries were more likely to be forwarded to primary care providers if the patient received their ongoing medication from an urban or remote Aboriginal Health Service ($p=0.001$). This may be due to the introduction and use of specialised electronic health records in the Northern

Territory. Such specialised electronic health records enable effective communication between different health care providers working across large demographic areas and in relatively isolation.

Conclusion: Communication and collaboration between hospital and primary health care providers needs to be improved to minimise DRPs for patients in the period directly following discharge from hospital. The availability of Electronic Health Record systems in rural and remote health settings may improve continuity of care.

The Western NSW Eye Health Partnership Program

Rose Ellis¹, Colina Waddell², Anne Vail³, Joanna Barton⁴, Jane Hager¹

¹NSW Rural Doctors Network, ²Brien Holden Vision Institute and Vision CRC, ³Western NSW Medicare Local, ⁴Outback Eye Service

The achievements and challenges of the Western NSW Eye Health Partnership Program will be discussed in this presentation. The program, funded by The Fred Hollows Foundation and managed by the NSW Rural Doctors Network, aims to improve the access to eye health services for populations in Western NSW, *with a particular focus on eye care for Aboriginal populations*, by developing a coherent and sensible system of coordinated eye care in the region.

The program is underpinned by a partnership of eighteen service providers and key stakeholders including nine Aboriginal Community Controlled Health Services, the Bila Muuji Aboriginal Health Services Inc, The Fred Hollows Foundation, Brien Holden Vision Institute, Vision CRC, the Outback Eye Service, the Western NSW and Far West Medicare Locals and the Western NSW Local Health District.

The challenges faced by the partnership included: the lack of coordination given the myriad of service providers; the lack of information regarding services and referral pathways; the lack of advocacy and brokerage; as well as some gaps in services particularly for Aboriginal patients.

The value of the program has been in bringing a multidisciplinary focus to all three levels of eye care (primary, secondary and tertiary) as well as highlighting the strengths of embedding eye care in all Aboriginal primary care services including chronic care programs.

Analytical findings from Services Mapping and Services Planning exercises and insights from qualitative research will be presented and issues that remain to be solved will be discussed.

Mental health and wellbeing strategies through a new lens

Anita Hansen, Lynne Halliday

Royal Flying Doctor Service, NSW

Enhancing the mental health and wellbeing of people living in rural and remote Indigenous communities has been a focus across the decades. Even with income management, case conferencing and mandatory school attendance there can be an ongoing struggle to manage and eradicate antisocial and unlawful behaviour in groups of young boys and occasionally girls. In the communities of focus for this study behaviours included: stoning buildings, motor vehicles, and service providers; physically assaulting teachers and teachers' aides; bullying younger children; torturing and assaulting animals; and breaking into buildings and vehicles to steal and criminally damage property. The communities were struggling with these behaviours and felt unable to manage them at the community level.

This paper discusses a unique approach to working with communities on these issues where comprehensive assessments of the cognitive, social, and mental health status of a group of children were undertaken, thus enabling service providers to focus interventions within the context of the actual social and emotional wellbeing of the children. The study enabled an appropriately qualified and experienced psychologist to conduct a program of assessment and to make evidence-based recommendations about how to improve behaviour and academic achievement.

In undertaking this unique approach, community and leadership groups as well as the education provider were sought to commit to the work prior to commencement. The project was not limited to assessment and reporting but also provided additional intensive support for these families with a focus on assisting the case managers in their work, assisting in the behaviour management functions of the school, liaising with parents and carers with a focus on improving school behaviour; and providing counselling and support to students and parents as required.

The project provided assessment services to sixty students across several communities so that within-

school comparisons could be completed and a better understanding of differences could be developed. The process of conducting valid assessments of troubled youth who regularly 'act out' and who are apprehensive and untrusting of strangers requires a period of engagement and familiarisation prior to anything official being commenced. As such the project started slowly but demonstrated outcomes that are significant.

This presentation aims to detail the processes utilised and the outcomes of this ground breaking work as an option for other communities with like challenges.



Have cape, will travel

Ralph Hampson

Starlight Children's Foundation, VIC

Since 2006 the Starlight Children's Foundation (SCF) has provided programs in the Northern Territory. This paper will explore how the program started, how it has expanded and developed and the opportunities for future service delivery in partnership with Aboriginal communities, NT government and health organisations.

The program involves Captain Starlight working alongside health professionals providing distraction through activities including art, music, story-telling, comedy and games—alleviating boredom and supporting children in both inpatient, outpatient and remote communities.

There have been many lessons learnt as the program has developed and we will share these experiences focusing on the development of our:

- Community Outreach Program—Captain Starlight CS also performs shows and leads activities that help to deliver key healthy living messages such as washing your hands and face, brushing your teeth, keeping your community clean, and developing healthy eating habits.
- Health Education—development of shows that incorporate health education messages focusing on nutrition, exercise, nose blowing, ear cleaning, washing hands, tooth brushing and mental health.
- Healthy School Aged Screening (HSAK)—CS accompanies health professionals to attend paediatric clinics in remote areas of the NT.

- attendance at Paediatric Multidisciplinary Clinics.

The key areas we will explore are how we have established partnerships with Aboriginal communities; the factors that have allowed the programs to flourish; and how we are planning for future developments in this area.

How one AMS is closing the gap—the power of data

Garry Hansford

Goondir Health Services, QLD

An efficient data reporting system is integral to planning, delivering, monitoring and evaluating primary health care services, particularly those that proactively aim to close the gap. Most services periodically report on national closing the gap efforts, real time data management and reporting is required to ensure operational targets are achieved; operations are continually improved; and quality, safety and risk are all managed.

One health provider with multiple clinics across 160,000 square kilometres in regional Queensland has developed and implemented a reporting system that provides clinicians, managers and the executive with up-to-date data that allow quick evaluations and informed clinical and management decisions to be made.

The Clinic Performance Dashboard combines clinical data from the patient record information system, organisational data from the quality management system and financial data into one service planning and management tool. It was developed to overcome service coordination and delivery challenges in a multidisciplinary clinical setting working with over 1,800 Aboriginal and Torres Strait Islander patients, many diagnosed with multiple chronic diseases.

The Dashboard operates at a number of levels, with data tailored to suit multiple audiences. There's a 'one page' overview with the high level performance metrics of most interest to executives and the Board; there's a 'snapshot view' of key metrics that managers use to plan and evaluate service delivery; behind which lies the detailed data and analyses that allow team leaders and clinicians to drill down to what matters for them.

The Dashboard helps management define what is important, educates staff about the things that matter, sets goals and expectations for clinics,

teams and individuals, helps the executive sleep at night because they know what's going on, encourages action to be taken sooner rather than later to address issues and problems, communicates progress and success. Most importantly, the Dashboard provides a 'place', a common interface for interacting with and analysing important organisational data, and places the patient and the community at the centre of all of health services activities.

Where once the organisation relied on multiple data sources and anecdotal advice to guide service planning, the Dashboard now provides clear evidence which can be accessed by staff, managers and the executive to inform decision-making that can lead to successful service delivery and improved health outcomes.

In this presentation the Dashboard will be showcased, the development process explained, and policy implications explored.

Growing rural general practice through business support

Laura Harnett, Kelli Porter

Rural Health West, WA

Background: Studies have identified that the viability of rural and remote general practice rests not only upon such factors as financial incentives and rural training, but also upon issues to do with the business and human resource management of small rural practices.

As a leader in rural and remote health workforce information and knowledge, Rural Health West established the Practice and Business Support Service in early 2011 to assist rural general practices develop, enhance and deliver quality, viable general practice services, through the provision of business and human resource management support.

Aim: The aim of the Rural Health West Practice and Business Support Service is to assist rural general practices with the ongoing needs of managing a viable business that provides quality health care to the local population.

This aids in improving retention rates of the health workforce and increasing the attractiveness of practices to staff to support succession and expansion planning, as well as enhance the profitability of the practice.

Services provided: The Rural Health West Practice and Business Support Service provides a range of services to assist rural general practices with business processes including;

- practice assessment visits
- accreditation preparation
- scholarships for training of Indigenous workforce, templates and resources including contracts, business plans, position descriptions, learning guides and fact sheets
- Practice Management Business Support Tool
- Practice Policy and Procedure Manual
- webinar training sessions.

Services are tailored to the individual practice and designed to address the education, training and support barriers of distance and isolation commonly experienced in rural and remote Australia.

Results: To date the Rural Health West Practice and Business Support Service has provided rural general practices with 85 contracts and employment agreements for practice managers, practice nurses, medical receptionists and medical practitioners; 152 Practice Management Business Support Tools containing 91 fact sheets, resources and templates; 21 rural and remote practice assessment visits with follow-up reports, personalised support, training and assistance; seven fully paid scholarships for Aboriginal and Torres Strait Islander health practitioner training; three Rural General Practice Manager of the Year awards and 42 webinar training sessions attracting over 200 practice registrations.

This presentation will demonstrate the need for ongoing business support for practice principals, practice managers and staff in rural and remote areas to ensure the delivery of quality, sustainable health care.

Doors swing freely in Southern NSW Local Health District

Zoe Harris, Karla Calleja, Ingrid Evans

Southern NSW Local Health District, NSW

Health service planners in SNSW LHD—do we make a difference or do we produce paper plans that are used as door-stops?

Our team

- three people—one full time, two part time
- all work from different towns—only meet face to face infrequently
- keep in touch constantly via email and phone
- share a joke, whinge, share the good and the bad.

What we do

We are the 'Planning Department' for our district with many tasks, however for this paper we will concentrate on the development of a clinical service plan.

How we do it

We facilitate a process as opposed to imposing our view:

- we provide in depth analysis of demographics, population health, activity, trends and flows, relevant policies, guidelines and frameworks to lead discussion for change
- we provide a platform to facilitate the development of new clinical service models
- we provide the avenue for all staff and community to be involved in decision making
- we articulate the ideas of staff and community into a written document.

How we are viewed

The first few meetings are always a struggle:

- staff have been 'told' to do the plan, we are not 'one of them', we are from the 'DISTRICT'
- community members are antagonistic and view us as coming to take services away
- staff see us as a nuisance and just want to tick the box and get rid of us.

But the three musketeers will not be put off. We persevere with pulling ideas from all and sundry. By end of process we receive compliments. At some point in the process the light goes on and we are seen as a great asset for improving their services.

What our planning process really does

Our planning process:

- gives staff the opportunity to voice their ideas away from their managers
- provides community members the opportunity to question why we are changing
- gives the people on the ground the ammunition to make the changes they have been thinking about but did not know how to progress
- breaks down the reluctance to change—staff love seeing their contributions in a plan and want to lead and implement the change.

Do we make a difference?

YES we do. We give staff and the community the opportunity to be involved in decision making.

And all doors swing freely in Southern NSW LHD—not a door-stop in sight.

Improving Aboriginal heart health in Western Australia: bringing everyone on the journey

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Background: Bettering Aboriginal Heart Health WA [BAHHWA] research provides epidemiological and qualitative information about cardiac care and outcomes for Aboriginal people in WA. Aboriginal people experience both illness and death from heart disease at higher rates and a much earlier age, and many are further disadvantaged by living in rural and remote areas. This underscores the urgency to direct efforts towards primary/secondary prevention and earlier, community-based detection and intervention. To ensure continuity of care, access to high quality primary health care, improved integration (e.g., multidisciplinary teams) and continuity (linkages between primary and specialist/hospital care) through augmented discharge processes, strengthened Aboriginal Health Liaison Officer programs and up-to-date information technology solutions are vital.

This paper describes the knowledge translation [KT] processes involved in using BAHHWA research to initiate and support state-wide health system change. Initially focused on the development of the

Information for Action (IFA) Report to disseminate the BAHHWA research results, this work has broadened to include many other KT strategies.

Methods: Through iterative consultative processes the BAHHWA team has collaborated with relevant WA and national stakeholders, through a variety of mechanisms including: joint workshops, sharing of resources and partnership development.

Results/discussions: KT initiatives and resulting actions have included:

- a series of workshops and reference group meetings with relevant Aboriginal and non-Aboriginal stakeholders informed the development of the IFA report, including themes covered and framework used. The ongoing engagement of Reference group members supports broad dissemination of the report
- a conference presentation that included a questionnaire to gauge GPs' knowledge needs resulted in planning for a 2-day heart health multidisciplinary primary care forum in the Pilbara for GPs, AHWs, allied health and administrators
- engagement of stakeholders in writing case studies about their work has led to further collaborations, for example with the Aboriginal Health Improvement Unit
- an Indigenous business conference panel has involved a broader range of stakeholders in the KT process
- a meeting with the WA Health Clinical planners.

Conclusions/implications: It is insufficient to demonstrate health inequity through research; it is vital that researchers also identify, initiate and support actions to implement what can be done to address the challenges raised by the research. Stakeholder engagement is an essential component of this process and must reflect the intersectoral collaboration needed, such as facilitating better service integration. Bringing all stakeholders on the journey means key messages and actions must be adapted to reflect different partnership needs.

The relevance of trauma informed care to Aboriginal primary health care services

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Aboriginal Medical Services Alliance of the NT

Within Aboriginal Australian health there are histories of traumatic events that have occurred from colonisation, including dispossession of land, forcible removal practices and the oppressive legislative policies of the day. There is extensive evidence to indicate that historical events continue to impact significantly on Aboriginal Australian peoples in the form of complex trauma. In recognising the significant health issues for Aboriginal Australian peoples, it is important to acknowledge that living remotely presents additional challenges. This presentation argues that recognising, understanding and responding appropriately to trauma is critical for those working with Aboriginal Australian peoples, due to the greater level of complex trauma. If trauma is overlooked, unresolved trauma may reduce the effectiveness of services provided within trauma affected communities, and place individuals, communities and also the workers at risk of further harm.

Aboriginal Community Controlled Health Services (ACCHSs) have established a significant role in the effective delivery of Comprehensive Primary Health Care (CPHC) services to Aboriginal people within Australia. These services address social and emotional wellbeing, alcohol and other drug concerns. CPHC has been highlighted as a critical component of reducing the gap in health equality that exists for disadvantaged populations worldwide. Becoming trauma-informed or articulating our trauma-informed practices may help us understand how to work better with people when providing services in rural and remote Australia. The following are identified as key to trauma-informed service provision: preventing re-traumatisation; awareness, understanding and education; safety; control and choice; relationships, connections and collaboration; empowerment, strength and resilience; and, cultural competence and diversity. These principles are in line with evidence to date of what *works* and *improves* social and emotional health with Aboriginal Australian peoples.

There are a number of ways that the principles of trauma-informed care and ACCHSs align. They both aim to increase the accessibility of services, promote self-reliance, participation, collaboration

and control, and recognise the underlying social determinants of health. We conclude that with its compatibility with the principles of ACCHSs, an integrated trauma-informed approach represents another possible step forward. Our organisation is currently supporting our services to become more trauma informed, by facilitating comprehensive community consultation, to ascertain what trauma informed practices are in place, and what trauma informed practices may be introduced if requested. This strength based, holistic and culturally appropriate approach inspires the possibility of greater outcomes for Aboriginal Australian peoples.

Factors that influence Australian medical graduates' preferences and rural workplace rotations

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Background: Severe medical workforce shortages in rural Australia has prompted research about factors associated with medical graduates working rurally. The University of Notre Dame Fremantle (NDF) medicine course has a strong rural focus, aiming to meet areas of unmet need, including rural workforce shortages.

Aims: To (i) identify factors influencing whether Australian medical graduates prefer to or actually work in a rural location, and (ii) determine if NDF medical graduates are more likely than graduates of other Australian medical schools to have a preference for or work rurally.

Methods: Longitudinal data from the Medical Schools Outcomes Database (MSOD) were analysed using univariate and multivariate logistic regression, in the setting of twenty Australian medical schools. Participants included Australian or New Zealand citizens and Australian permanent residents who commenced medical school in 2006 and 2007. Outcomes of interest were preferred and actual work locations one (PGY1) and three (PGY3) years post-graduation.

Results: There were 3968 participants, 155 (3.91%) of whom were NDF students. Self-reported preference for rural practice location at medical school commencement was the strongest independent predictor of whether a PGY1 graduate would have a rural location preference (odds ratio [OR], 7.32; 95% CI, 5.44-9.85) or work rurally (OR, 2.14; 95% CI, 1.69-2.71). Students of graduate-

entry programs (OR, 0.63; 95% CI, 0.52-0.78) or with dependent children (OR, 0.56; 95% CI, 0.38-0.82) were less likely to have worked rurally during PGY1. Despite being a graduate-entry program with a significantly higher proportion having dependent children, NDF graduates were no more or less likely than graduates of other Australian medical schools to have a preference for or work rurally. PGY3 outcomes will be presented at the NRHC.

Conclusions: The strongest associated factor with rural preferences and work location was students' preferred location of practice at medical school commencement. Although educational opportunities for children are known to influence rural workplace decisions, the negative association between having dependent children, and graduate-entry programs, on rural workplace outcomes have not previously been well documented. NDF medical graduates were equally likely to have a preference for and work rurally during PGY1. Further evaluation is required to assess the influence of rural preference at medical school commencement, having dependent children and graduate-entry programs on rural workplace outcomes beyond PGY1 and PGY3. This emphasises the importance of using future MSOD data to evaluate the effectiveness of, and provide local evidence for, Australian medical school selection policies and rural health curricula.

How do we engage them? How do we keep them engaged?

Cindy Hinterholz¹, Lisa Taggart
Robinvale District Health Services, VIC

Engaging with the most vulnerable families within our community had always been a struggle. We knew they were out there but ... How do we engage them? How do we keep them engaged?

Working collaboratively with services within the organisation (midwifery, maternal child health, the Early Years program, allied health) we have developed a better way to engage vulnerable families with our services.

It's about warm referrals, soft entry points and progression through services. These encourage the families to see access to our services as easy, with information about services and how to access them. And of course there are helpful staff.

It's basically about building good relationships with vulnerable people. It requires perseverance and time—things that funding bodies don't always acknowledge! We have discovered the positive

benefits of technology in the use of social media in communications with families.

It is also important for service providers to meet families where they are most comfortable—to let the service reach out, including by actively visiting places where vulnerable families and children will be. Services are offered in various venues as well as in family homes. Good relationships and trust need to be developed in order to be able to share our knowledge of services and to enable families to have continuity of care through services.

We work to develop an accurate picture of a family's needs and preferences—and this information is used to guide our service provision

We offer support to other organisations and service providers to meet a family's needs through our strong early years network meetings.

By improving people's access to health information and their capacity to use it effectively we empower families to make their own informed life choices

Our efforts have shown an increase in children's school readiness through AEDC data which we hope will transfer into children's educational outcomes, which as research shows, filters through the families

Flexible Funding opportunities have been a major contributor to being able to offer this type of service provision as we have been granted time and flexibility to find what works for our community.

Improving end-of-life care for Indigenous Australians: the role of PEPA

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Aboriginal and Torres Strait Islander patients (hereafter referred to as Indigenous) with life-limiting conditions have complex needs, experience reduced access to and uptake of treatment, and have lower utilisation of palliative care services than the general population. Lack of understanding of the role of palliative care and poor availability of culturally-safe services has an impact on Indigenous people's end-of-life decisions. The Program of Experience in the Palliative Approach (PEPA) offers a range of flexible training models to better equip

health staff with the skill to care for Indigenous patients in a culturally sensitive manner. Since 2007, one focus of PEPA has been on training Indigenous Health Workers (IHW).

Aim: To evaluate Indigenous PEPA and the impact this training has had on the delivery of end-of-life care in a culturally-appropriate manner within Indigenous communities.

A qualitative approach was taken for the evaluation. This involved semi-structured In-depth interviews that occurred in two phases. **Phase One** examined the history and processes of the implementation of Indigenous PEPA. **Phase Two** evaluated the impact of PEPA participation on Indigenous Health Workers (IHWs) and the communities within which they work. Interview content was analysed thematically utilising key focus areas to determine similarities across jurisdictions and whether program objectives were met.

Many factors impacted upon program achievements at the program and the service delivery level. However excellent outcomes were evident where there was support for Indigenous workers to attend training from their line manager. The impact of the training within the service and the community improved when IHWs were well supported by their health team. Many of those interviewed commented on the need for additional education on Advance Care Planning as this assisted patients and their families with end-of-life preparation.

Despite key areas for improvement being identified, Indigenous PEPA provides a flexible, clinical learning experience for Indigenous health professionals enabling them to offer culturally appropriate palliative care to Indigenous Australians across the health continuum. Additionally it emerged that appropriate end-of-life support had a positive impact on the patients and their families as well as on the health team that cared for them.

Recommendations include more direct engagement with clinic and hospital managers to improve their understanding of PEPA and the role IHWs can play in providing palliative care for Indigenous patients; recognise the important role that supervisors play in post-placement mentoring and support; trial longer workshops that include all members of the health team and incorporate a session on Advance Care Planning.

1★ Perceived barriers to health support seeking among rural men

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Background: There is substantial inequity in the quality of physical and mental ill health experienced by people who live in rural Australia when compared to their urban peers. Practitioner availability, cultural norms and stigma are barriers to accessing health services in rural areas and exacerbate poor health. It is often assumed these barriers are particularly problematic for farmers. However, little research has explored the differences between farmers and the non-farming rural population in regards to the specific barriers that impact their access to health care.

Objective: To identify attitudinal and concrete barriers to seeking support from health services among Australian farmers compared with other rural adults.

Methods: Adults from three rural regions in South Australia were randomly selected from the electronic White Pages to participate in a Computer Assisted Telephone Interview (CATI). The *Barriers to Help Seeking Scale* was adapted and measured participants' perceived barriers to seeking support from health professionals. Participants responded to either a physical or mental health scenario that was concerning but not incapacitating. Five domains comprising 39 individual items were assessed, with items rated from 1 (strongly disagree) to 5 (strongly agree). Item responses were averaged to form domain scores. Analysis of covariance, with age as the covariate, was used to compare domain responses between farmers and non-farmers for the mental and physical health contexts separately. To remove the likely confounding influences of gender and work status, only males in full- or part-time employment were considered for analysis.

Results: 406 adults (40% response rate) participated in the CATI (average age = 60.4±14.4y), of whom 64 were male farmers and 103 were non-farmer males and were included in this analysis. There were no significant main effects for any of the domains in either the mental or physical health contexts. There was a significant interaction effect between the Need for Control domain and age (p=0.0006), for the mental health

context. A comparative analysis stratified by age showed that Need for Control was a larger barrier to seeking help for a mental health issue ($p=0.03$) among younger farmers and a smaller barrier ($p=0.02$) among older farmers, compared with their non-farming rural counterparts.

Conclusion: Along with the wider literature showing young males are at highest risk for suicide in rural Australia, our findings indicate that understanding attitudinal barriers to support seeking may be particularly important in the design and provision of acceptable and effective health services for younger male farmers.

Road Safety All Stars—rocking a community message near you

Vanessa Hutchins

Artback NT

The Road Safety All Stars were created in April 2014 as a way of creating a viable message product to engage Indigenous peoples in road safety.

Indigenous community ambassadors are at the forefront of delivery and advocacy for change in their communities. Using Indigenous peoples for messages to their community is empowering and fundamentally satisfies any language or cultural challenges

The Road Safety All Stars are a group of talented Indigenous Northern Territory musicians who have come together for the first time in 2014, to write, play and record music about staying safe on the roads. Their lyrics tell stories and send messages without preaching and their music has listeners tapping their feet and reaching for the volume control.

As ambassadors the group was keen to evaluate road safety issues and translate them into a message that is relevant to their peoples, using both language and dynamic music to set the tone.

We targeted issues that were relevant to Indigenous peoples living in the Northern Territory, and familiar with many Australians living in remote and regional areas. We took a different approach to the “Don’t do this and don’t do that campaign” and orientated the message to prompt the thinker to own their own message.

The over-arching theme of the messages was to take responsibility and ownership of road safety and

create music and messages that will change the way people think.

We targeted behavioural problems common in remote community living and focused our messages on the following:

- promoting the philosophy of shared responsibility
- educating and encouraging road users to comply with road rules
- encouraging road users to drive unimpaired from alcohol and drugs
- to stay alert to stay alive
- respect the country you are driving on and act according to the prevailing conditions
- that action will be taken against those who break the rules.

We recognised that all people living across the Territory are affected by road safety in some manner, and realised the importance of understanding that humans make mistakes. Talking about this openly and honestly depends on us sharing responsibility and implementing the initiatives ourselves. This became an important driving force behind the music.

The project is still building momentum as the music circulates community radio and social media. We would like to share this project including its music to the 13th National Rural Health Conference.

Increased self-efficacy is associated with rural career intent in Australian Rural Clinical School students: a FRAME sub-study

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Background: Self-efficacy is a psychological construct that has been well described in career choice models. Self-efficacy is associated with motivation, educational development and interest levels. The role of self-efficacy in rural medical career intentions has not been studied. The purpose of this study is to investigate medical student’s self-efficacy at the time of finishing their Rural Clinical School (RCS) placement and factors associated with self-efficacy. Secondary aims are to explore

whether interest levels or self efficacy are better predictors for rural career intentions.

Methods: Data were derived from the 2013 Federation of Rural Australian Medical Educators (FRAME) survey. Questionnaire responses were analysed from 656 medical students from regional Australia. All respondents had completed their final term at an RCS.

Results: 83.8% of all students recalled an increase in their interest levels for rural medicine as a result of their RCS experience, however only 26.9% indicated an actual intention to work in a rural area. Bivariate analyses showed female gender ($p=0.003$), rural background ($p<0.001$), an RCS preference for clinical training ($p<0.001$), and general practice intentions ($p=0.004$) were factors associated with higher levels of self-efficacy. Self-efficacy was associated with an increased interest in both general practice ($p<0.001$) and rural and remote medical practice ($p<0.001$). Step-wise regression analyses showed that inclusion of self-efficacy in the model explained 20% of the variance in rural medicine interest levels. Self-efficacy in the model explained an additional 4% of the variance in rural practice intent (Model included gender, rural background, preference for RCS, generalist intent, rural practice interest and self-efficacy).

Conclusion: An RCS placement is associated with self reported interest in rural medicine. Self-efficacy is associated with increased interest levels for rural medicine and rural medical career intent.

Technological innovations in ARF/RHD: are we ready?

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Menzies School of Health Research, RHD Australia

RHDAustralia has recently developed two innovative, technology based resources designed to provide education and support for patients affected by Acute Rheumatic Fever (ARF) and Rheumatic Heart Disease (RHD), and for the health professionals who care for them.

ARF is an autoimmune sequelae of group A streptococcal infection mostly affecting children 5-14 years of age. Recurrent episodes of ARF lead to cumulative heart valve damage and the development of RHD. RHD is a chronic, often fatal, disease. Australia has one of the highest rates of ARF in the world affecting primarily Aboriginal and

Torres Strait Islander people, many living in rural and remote areas.

A timely diagnosis of an initial ARF episode and subsequent use of antibiotic secondary prophylaxis is the best method of preventing RHD. The newly developed resources target two key issues contributing to the recurrences of ARF and the continued risk of children developing RHD:

- the difficulties in the early and accurate diagnosis of ARF
- the low adherence rates to secondary prophylaxis among Indigenous youth.

The new ARF Diagnosis Calculator (an update to the existing ARF/RHD Guideline app) will provide clinicians with the knowledge, information and a simplified tool to navigate the complexities of diagnosing ARF. The Diagnosis Calculator provides a text and visual reference at each stage of the diagnosis. While diagnosis remains a clinical decision, the Calculator provides accurate, instant information to minimise error and inconsistency with diagnosis, referral and management of ARF.

The ARF/RHD Facebook application is an interactive reminder service for young Indigenous people on secondary prophylaxis. The tool is designed to appeal to the 13 to 25 age group through customisable design features and attempts to address the massive challenge of engaging a patient over a treatment period of at least 10 years with injections at least every 28 days. While Facebook is widely used in health promotion and there are a plethora of smart phone health apps this is a unique use of a Facebook application as a treatment reminder tool.

These resources have only been recently launched and are exciting and innovative. However, only time and rigorous evaluation will demonstrate their worth. There is increasing interest and investment in the e-health field but so far limited evidence of the effectiveness of technology based health interventions. Whether the clinicians and patients we are trying to reach are ready or able to engage with the new and shiny tools remains to be seen.

Disclosure of interest: The RHDA National Fever Strategy is a Commonwealth funding initiative housed at Menzies School of Health Research in Darwin.

Evolution of the nurse practitioner role at a rural health service

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The nurse practitioner (NP) model at our rural health service has evolved into an expanded trans-boundary role since commencing in October 2011 and continues to evolve as service needs change. The role was initially seen as a means to address service gaps in unplanned urgent care presentations, however it has expanded providing support and advice to 60 aged care beds and expert clinical leadership to the organisation. The experience of adapting to local needs provides valuable information for other rural health services and contributes to the literature on sustainability of the NP role in rural and remote communities.

Unique aspects of our model are the NP:

- works an on-call roster collaborating with the two local GPs—each providing a week on call service to the organisation enabling two weeks clear of call duties
- has admitting rights to the organisation, enhancing continuity of care and improved outcomes for community members
- is supported by a locum NP who covers 2 days of the local NP's on call week
- provides high-level clinical advice and support to all areas of the organisation, including aged care
- liaises closely with local ambulance, regional health service and retrieval services
- is respected and supported by the local community and GPs
- is a local nurse with strong family ties
- has taken a clinical leadership role in relation to quality and safety standards particularly Standard 9 Deteriorating Patient.

Evaluation of the NP role demonstrates enhanced care for the local community with positive outcomes and include:

- decreased transfers to the Regional Health Service, reducing congestion of unnecessary referrals, reduced transport costs and more appropriate and convenient care to local consumers

- advanced health assessments undertaken and prompt initiation of treatment of symptoms that improve outcomes, including community based palliative care
- enhanced care of residents in our aged care facility by providing assessment, treatment and management of chronic illness complications, reducing transfers to an acute facility
- providing support and clinical expertise to nurses and mentorship and encouragement to registered nurses undertaking the RIPERN (Registered Isolated Practicing Endorsed Registered Nurses) course.

Evaluation of the NP role at our rural health service has demonstrated the importance of adapting to the local environment to ensure improved outcomes for consumers and ensuring care to consumers is provided by the right practitioners at the right facility. We wish to promote the learnings made to ensure the future sustainability of NP roles in rural and remote areas.



Challenges of TB control in Papua New Guinea

Lucy John

National Department of Health, Papua New Guinea

PNG ranks second in the Western Pacific Region, next to Cambodia, in terms of estimated TB prevalence, incidence and mortality.

Among all the provinces, National Capital District has been identified as the hot spot, which contributes to 25% of the country's TB burden, despite being home to only 5% of the country's population.

While the majority of the PNG population lives in rural areas, the urban areas bear the higher burden of TB.

Several factors contribute to the spread of TB in PNG. Health system weaknesses are cross cutting factors contributing to the spread of TB. Overcrowding in settlements, poor hygiene and poor nutrition makes TB transmission easier.

In order to address TB, in addition to guaranteeing optimal TB care to all those who need it, parallel actions are required on multiple fronts aimed at improving health care system, mitigating risk factors and addressing socioeconomic determinants.

Getting patients to and from urgent after-hours care in the Grampians region: the role local taxi providers can play

Meredith Johnson, Deidre Rennick

Grampians Medicare Local, VIC

Aim: To provide cost savings in the health dollar spend in our region by providing transport to patients who would otherwise require non-emergency ambulance transport to or from urgent after-hours care, or who would put pressure on our local hospitals by being admitted due to lack of transport options in the after-hours period.

Methods: Most rural townships have a local taxi service that operates in some or all of the after-hours period. We negotiated with these local taxi companies to provide transport for patients who need to get to or from urgent after-hours care but where an ambulance is not clinically required. Transport is coordinated by the local Patient Streaming Service provider, an existing local call centre provider. We liaise with and promote the service to all the local health providers to ensure they are aware of the service and encourage the use of it, including General Practice, Health Services and Ambulance Victoria.

Results: Since its commencement in July 2013, 734 transports have been coordinated at a total cost of \$30,807 or an average cost of \$42 per transport. This is a significant saving of the health dollar as patients are not required to be admitted to hospital, subjected to lengthy stays in the ED or requiring transport by ambulance. Getting patients out of the ED after treatment reduces bed block, reduces the pressure on the system and frees up staff to see to more patients.

Conclusions: By utilising existing providers we have designed a fully integrated after hours transport system that is effective at reducing the impact on the health dollar in our regional and rural areas without putting pressure on other areas of the health service.

★ Evolution of a remote paediatric disability program

Hannah Johnston, Claire Pilkington

Office of Disability, Top End Remote, NT

Indigenous Australians experience disability at almost twice the rate of non-Indigenous Australians.

Indigenous children with a disability have been described as 'doubly disadvantaged' and many children and their families experience significant barriers to accessing services. Despite high rates of disability in childhood, remote Indigenous communities across the Top End experience a chronic lack of disability services, including access to specialist allied health.

The Remote Paediatric Therapy Program (RPTP) was developed in response to growing inequities in disability service provision between urban and remote areas of the Top End. RPTP was established as a pilot program in 2010, with the program's unique design reflecting a scarcity of literature around Indigenous children with disabilities and provision of services for this population.

RPTP's initial aim was to provide intensive, multi-disciplinary intervention for children with disabilities. In the early years, the team travelled frequently and widely across the Top End to consult with children, families and schools in a number of remote communities.

Initial evaluations of the program were completed in 2010 and 2012, via survey of key community contacts (KCs). Survey results highlighted that RPTP's capacity to provide therapy intervention was limited, given the large geographical area, high rate of childhood disability across the Top End and infrequency of RPTP visits to each community. This feedback highlighted the need for RPTP to shift focus from providing therapy to building capacity of key community partners.

Using learnings from the initial years, the program has evolved to become a support structure for KCs, who are a regular presence in community and form close working relationships with children and families. The most recent evaluation (2014) identified the success of RPTP in building capacity of KCs to work with children with a disability. This is done through joint community visits, case conferences, mentoring, videoconferencing and resource development.

Given the complexity of paediatric disability in the remote context, the learnings and principles from RPTP should be considered in the rollout of the NDIS in the NT. Many allied health professionals have little or no experience in paediatric disability or working in remote communities. Adequate support structures, such as RPTP, are essential in ensuring safe and evidence-based practice for this vulnerable population.

Monitoring the use of alcohol and other drugs in rural Australia

Jennifer Johnston

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Introduction: The misuse of alcohol and other drugs (AOD) is a significant public health issue, and may be associated with physical and mental health problems and have negative social and legal ramifications for users. Accordingly, problematic drug users often require support from a wide range of services, including specialist AOD services, hospitals, GPs and other primary health providers, as well as mental health and social services.

Knowledge of patterns of use and associated outcomes are needed to inform clinical and policy responses to AOD use. Although drug monitoring systems such as the Illicit Drug Reporting System (IDRS) have been implemented nationally for more than a decade, such projects focus only upon metropolitan centres. Indeed, very little research examining AOD use or interventions and service needs has been undertaken in rural Australia, and consequently little is known about these issues. This lack of knowledge is a concern as illicit drug markets, the characteristics of users and the harms they experience, and thus the services they require, are likely to vary between rural and metropolitan areas.

This presentation will provide an overview of what is known about the use of AOD in rural Australia, and consider how the implementation of a RDMS could address significant gaps in the knowledge and so inform appropriately targeted clinical and policy responses.

Methods: Consistent with the need to use multiple data sources in drug monitoring systems, the Rural Drug Monitoring System would monitor trends in rural drug use and associated harms by triangulating three data sources:

- existing indicators of drug-related issues and harms
- a quantitative survey of sentinel populations of drug users
- qualitative interviews with key experts who have regular contact with illicit drug users.

Importantly, the design of the proposed RDMS would build on the strengths of the rural AOD and related workforce and research community to ensure its sustainability and local relevance, whilst

at the same time recognising the constraints and challenges of working in rural Australia.

Outcomes and implications: Accurate and timely information describing the substance use patterns and related issues facing rural communities is needed to identify which sub-populations are experiencing the greatest harm and inform improvements to and/or the development of new programs. A RDMS would provide the evidence required to ensure that evidence-based policies can be developed and services appropriately target those in need.



Get the picture? Use of participant drawings in a novice's qualitative research

Sally Josh

Southern NSW LHD, NSW

Introduction: This paper discusses participant drawing as data in an interpretive phenomenological research project underway in a rural hospital. It considers how participants became involved with the method and researcher impressions on how the method has been working, with a view to informing and encouraging other novice and early researchers about the possibilities of the method in rural health research.

The 'Documenting in the Medical Record: Experiences of Engagement' (DIMREE) project, due for completion in June 2015, explores experiences of engagement around medical record documentation for participants (patients and health professionals) in a rural hospital. The project employs semi-structured interviews, and participants are also asked to draw their experience. Visual creative methods, well established within interpretive phenomenology, can 'give voice' where words sometimes cannot be found. Using a drawing, the aim was to facilitate more nuanced expressions of participant experience, emotions, thoughts and concepts.

Method: Field notes, research memos, reflective research journal entries, transcripts of the interviews, participant drawing interpretations, and the drawings themselves were reviewed. Further reflective notes summarised impressions and interpretations about use of the method.

Results: Of nine participants interviewed, eight completed the drawing, with surprising enthusiasm. Participants interpreted or 'de-coded' the drawing for

the researcher, keen to establish what was and was NOT meant by their drawing, helping to exclude over-interpretation during analysis. Several participants referred back to the drawing during the interview to emphasise or explain. Three participants added detail to the drawing as the interview progressed. The interpreted drawing enabled the researcher to clarify meanings within the interview.

Review of coded transcripts is indicating that the drawing activity brings to the surface early in the interview the facts, concepts, feelings most important to the participant: discussion can then move quickly to the kernel of participant's experience. Drawings are revealing complex spatial and personal relationships; abstract concepts, sometimes schematic or diagrammatic representations. Drawings are always alive with feeling. Compared to text alone, drawings seem able to present a more global and less linear illustration of experience.

Conclusion: The method facilitates participants' dialogue about their experience, adding tone and meaning to textual discussion. De-coding of the drawing by the participant helps avoid over-interpretation. Although the method adds additional time to interview, transcribing and analysis it is recommended that qualitative researchers, both experienced and novice, consider the possibilities for its use in the rural context.

Models of Mental Health Services Rural Remote Areas program delivery across the Northern Territory

Le Smith, Tim Keane

Northern Territory Medicare Local, NT

Background: The Mental Health Services in Rural and Remote Areas (MHSRRA) Program funds non-government health organisations to deliver mental health services by appropriately trained mental health care workers including psychologists, social workers, occupational therapists, mental health nurses, Aboriginal health workers and Aboriginal mental health workers.

The MHSRRA Program provides funding for mental health professionals in communities that would otherwise have little to no access to mental health services. MHSRRA is designed to address inequities in access by targeting rural and remote areas.

The MHSRRA program also addresses workforce shortage issues by providing flexible employment models suited to local needs and conditions.

NT Models of MHSRRA: The Northern Territory Medicare Local region covers a jurisdiction of 1.3 million square kilometres, which is sparsely populated with approximately 233,000 people, including a significant constituency of Aboriginal people.

The Northern Territory Medicare Local (NTML) Mental Health Service Rural Remote Areas (MHSRRA) Program is considered a highly effective and appropriate model for rural and mental health service delivery. A variety of service delivery models are utilised to meet the needs of specific communities and regions in the NT.

NTML does not provide direct services but commission health services through service providers including Aboriginal community controlled health services (ACCHSs), the private sector such as allied health professionals, not-for-profit companies and other providers. In commissioning health service providers, the design of health programs is informed by population health and health care needs assessments.

The MHSRRA program is the main vehicle that funds and supports the NT Aboriginal Mental Health Worker Program and thus builds capacity by providing local employment, expertise and understanding of family and cultural dynamics and cultural components of care and support in serviced communities. Wider aims of MHSRRA are to develop and support the NT rural and remote mental health workforce, including Aboriginal Mental Health Worker models.

This presentation aims to discuss the pros and cons of three different models of MHSRRA mental health service delivery across three regions of the NT:

- Outer Rural Darwin, Sole Contractor, Psychologist Model
- Katherine, Sunrise Aboriginal Health Service, Social Worker Model
- East Arnhem, Miwatj Aboriginal Health Service, Aboriginal Mental Health Worker Model.

Implementing a healthy food policy at an Indigenous community festival: a case study

Angela Kelly

Skinnyfish Music, NT

Barunga Festival was first held in the small Indigenous community of Barunga in 1985. The festival is a celebration of contemporary Indigenous community life based on music, sport and culture. Audience numbers from all over the NT and, increasingly, interstate and international destinations, have reached 3000 over the last two years.

External food providers are engaged to feed the crowd (70% Indigenous) as they camp out for three days of activities. At 27 of 29 Festivals, food vendors and the Barunga Store have sold whatever they wanted, generally deep fried food with little nutritional value and foods heavy on salt, fat and sugar.

When the Traditional Owners awarded the management of the Barunga Festival to Skinnyfish Music for 5 years in 2013, a healthy food policy was implemented at the behest of the local Festival Organising Committee. The vision of the committee is that food and beverages available at the Festival will encourage healthy lifestyle choices. The committee sees the festival as an opportunity to promote good eating habits and introduce new healthy food options to the community and the many visitors.

It is well known that healthy eating habits reduces the occurrence of nutrition-related chronic disease and improves nutrition-related health outcomes of vulnerable groups.

The Australian Dietary Guidelines 2013 inform the Barunga Festival Healthy Food Policy, particularly guidelines 2 and 3:

- enjoy a wide variety of nutritious foods from the five food groups every day;
- limit intake of foods containing saturated fat, added salt, added sugars and alcohol

Sources: Department of Health and Ageing, NHMRC.

In 2013 expressions of interest were accepted from food vendors who were asked to abide by the healthy food policy. The five vendors did so, but unfortunately, another vendor who sold junk food set up several days prior to the opening of the festival

and sold hot chips, dagwood dogs and fairy floss for the next week. However, the 5 healthy food vendors did extremely well and reported unexpectedly high sales to Indigenous people. The community store threw away their deep fryer after the festival and now prepares baked food in preference.

In 2014, only sanctioned food vendors were in attendance and all five reported a 100% increase in Indigenous people eating their healthy food options.

Barunga Festival Organising Committee and Skinnyfish Music will continue to improve the Policy after each event.

Help-seeking and support after suicide and accidental death in farming communities

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Aims: The aim of this research was to explore and compare factors that influence adverse affects and resilience within farming families exposed to suicide and/or accidental death.

Methods: Qualitative, semi-structured interviews were utilised to explore the lived experience of 24 adult members of Australian farming families bereaved by suicide and/or accidental death.

Relevance: Australia's rural farming communities are exposed to higher rates of suicide and accidental death than both rural people generally and those living in major cities, yet little is known about how this affects those bereaved by these deaths. Expanding knowledge in this area will assist with the development of both appropriate and acceptable responses when tragedy occurs in a rural farming community and work towards breaking the cycle of ongoing suicide risk.

Results: This paper reports on the bereaved research participants' patterns of help-seeking. This includes the perceived and actual avenues of physical and emotional support available to and utilised by (or not) members of farming families in the wake of suicide and/or accidental death. The tendency for members of farming families to volunteer support rather than ask for it, was also reflected in the response to bereavement. Not all participants required or readily accepted support, although offers of practical support were frequently

forthcoming. Amongst participants requiring emotional support, access was restricted to those with appropriate social networks and an ability to express emotional vulnerability in a context of established trust, shared experience and shared interests.

Conclusions: The impact of exposure to traumatic death is heavily influenced by the unique psychological, geographical and social context in which farming family members frequently live and work. Exploring how behaviour is shaped and regulated within this unique context improves our understanding of bereavement even further. Recommendations are made for both appropriate and acceptable modes of support drawing on the lived experience of adult members of farming families bereaved by suicide and/or accidental death.

Managing expectations and being flexible for sustainable course delivery

Emma Kennedy, Sarah Chalmers
NT Medical Program, Flinders University, NT

For many years, the Northern Territory Medical Program, Flinders University, has placed final year medical students in Nhulunbuy, a small very remote Northern Territory town, for 6-12 week placements. These students learn much from exposure to a broad breadth of patient presentation. They learn through placements in the regional hospital, Aboriginal Medical Services and General Practice. The curriculum is defined by daily events within the context. The main goal of these placements is to strengthen the students' exposure to clinical medicine and the remote context.

In 2014 NTMP offered a 6 month duration placement in the local hospital for students in their penultimate year. The difference for these students is the important curriculum focus on learning clinical knowledge and developing clinical reasoning skills despite context.

The context of this remote town was one in significant and rapid change impacting on the population health. This change was brought about by the loss of more than 1000 jobs at the alumina refinery.

This presentation will explore the strengths and challenges of learning the fundamentals of clinical medicine within a remote community. In particular we will present the specific issues identified by the students and the teaching staff as the time

progressed and importance of a flexible responsive relationship with the university program. The impact of the refinery closure on the student learning experience will be discussed.

Access early intervention: an eHealth solution to childhood behavioural disorders

Jessica Kirkman, Mark Dadds
The University of New South Wales, NSW

In Australia, only one in four children with behavioural and emotional problems access evidence-based interventions (Sawyer et al., 2000). In rural areas, access rates are even lower, and mental health services are simply not available. Treatment in the city can involve significant travel and time away from home, and services can only be brief and intense. The current project involves the development and preliminary evaluation of one of Australia's first online treatments for parents of children with behavioural disorders. Run within the University of New South Wales, participants reside outside the Sydney catchment area in regional and rural New South Wales. Parents of children with conduct problems received either in-person parent training or parent training via an e-health platform. The Access Early Intervention program requires families to watch video modules, before connecting with a psychologist through videoconference each week. While previous research on e-health programs have examined outcomes, this is the first study to address if this alternative mode of delivering therapeutic services is acceptable to clients. The study compares processes and outcomes associated with in-person treatment-as-usual versus the e-health treatment. Specifically, it compares parents' and therapists' engagement, acceptability, satisfaction, and attitude towards the two treatment modalities, as well as, the therapeutic alliance formed, changes in parenting knowledge and confidence, and finally, improvements in child behaviour problems. Data will be presented on the first 40 families who have completed treatment, including follow up assessment. Results provide preliminary support for satisfaction, engagement and acceptability of the Access Early Intervention program. This project takes the first steps in making a well-established and evidence-based treatment available to thousands of rural families who currently have no access to help, and allows for in-depth analysis of the client experience.

The Broadband for the Bush Alliance: unlocking the digital potential of the bush

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Access to reliable functional broadband and 3G/4G mobile services is the norm for most Australians. However, remote Australia has not been able to fully engage and participate in the digital revolution because of inadequate or lack thereof of telecommunications infrastructure, affordability issues and, for most, poor digital literacy. Given distance and isolation in the bush, broadband has an even greater potential to make a positive economic, social, and service delivery impact for people living in remote Australia. The Broadband for the Bush Alliance was formed in 2012 with the aim of advancing the digital capacity and capability of remote Australians through a range of activities, including policy formulation, lobbying activities, sharing knowledge and building expertise through activities such as: its annual forum, research and networking. Originally set up by six organisations, the Alliance membership is expanding and brings together a range of stakeholders with expertise in communications, remote service delivery, and community engagement. This paper seeks to give an overview of key policy recommendations developed by the Alliance and identified at the last Broadband for the Bush forum, which have potential to unlock the digital potential of the bush. This includes:

- need for a dedicated communications strategy for remote and outer rural Australia, which should encompass the expansion of mobile coverage, getting digital infrastructure right, developing smart last mile solutions for small towns and communities, affordable pricing for mobile calls in remote and rural Australia, improving digital literacy and improving Indigenous communications programs
- expansion of mobile coverage and expansion of Extended Zones program to remote mobile and pre-paid mobile services
- need for a range of billing models such as a pre-paid NBN satellite billing model to be developed, especially to meet the needs of Indigenous remote communities
- IT training and support programs for remote areas to be delivered by community organisations. 3.7 million Australians do not

access the Internet regularly, and the number of these people living in remote Australia is disproportionately high

- planning for the transition from the Interim Satellite Solution to the Long Term Satellite Solution should be made a priority
- the establishment of an innovation budget for development of infrastructure solutions for remote areas. As a one size fits all approach fails in the bush, remote areas often demand tailored telecommunications and broadband solutions, such as for last mile connectivity.



Sovereignty in health—towards a new paradigm in the Pacific

Stevenson Kuartei

Palau Health Foundation

The presentation is about sovereignty in health, not health sovereignty. Sovereignty in health alludes to the ability of people to live in a society where health—ultimately wellness—is attainable through informed health choices. Wellness as a public good must be pursued relentlessly by governments, communities, clans, families and individuals because traditional cultures of the Pacific have limited options and poor health outcomes in 'health' systems dominated by disease.

This presentation will review several issues: health versus disease; wellness as a public good; an ecological model for the pursuit of wellness; and the Palau Health Foundation as an example of a possible Pacific solution to achieving sovereignty in health. The goal is to present a platform for debate about disease versus health focused strategic approaches in trying to achieve wellness in the Pacific. Health-focused approaches and systems must be relentlessly pursued by the Pacific Island countries, if they are to address their disease burden, vulnerabilities, resiliencies and survivability. Even more so, the pursuit of wellness must be at the epicenter of developments in small and isolated island countries of the Pacific—especially in a world dominated by hugeness, borderless commerce and globalisation.

Trachoma arts based health promotion brings hygiene to life in remote communities

Fiona Lange

Indigenous Eye Health Unit, VIC

Trachoma is the world's leading cause of infectious blindness, which was eradicated from most countries 100 years ago through improvement in living conditions. Australia is the only high-income country among 53 developing nations with endemic blinding trachoma and has made a commitment to its elimination by 2020 using the WHO endorsed SAFE Strategy (Surgery, Antibiotics, Facial cleanliness and Environmental improvements).

Trachoma is one of four readily treatable eye conditions that lead to 98% of vision loss in Indigenous Australians. Caused by bacteria, trachoma is transmitted by direct contact with infected eye and nose secretions most commonly in young children who live in poor, crowded living conditions, where personal and environmental hygiene are limited. There are 204 remote communities at risk of trachoma and adults across the country can be found with scarring and in-turned lashes (trichiasis).

Improved coordination and coverage of screening and antibiotic treatment programs has led to considerable reduction in trachoma prevalence, from 14% in 2009 to less than 4% in 2013. However for sustainable trachoma elimination behaviour change around facial cleanliness and holistic hygiene practices must be encouraged along with the provision of safe and functional bathroom and washing facilities.

Culturally safe trachoma health promotion resources in use since late 2010 have been the basis for an extensive range of multi media and social marketing initiatives to promote trachoma elimination. These include; television advertisements and jingles, a 5-part women's radio series and community services announcements, mascot Milpa the Goanna, children's TV character Yamba the Honeyant, music and dance DVDs, on-line teaching resources, The Yamba and Milpa Trachoma Roadshow and annual AFL football clinics with Indigenous Trachoma Ambassadors. All are aimed at supporting clinics, schools, early childhood and family services in remote communities where trachoma is endemic. In addition, a creative commons approach to sharing art-work and resources has forged partnerships with services and brought to life dozens of adaptations of

trachoma resources to reflect local agency priorities and different language and culture.

Clean faces and good hygiene practices are not only vital for eliminating trachoma, but also to reduce infectious diseases common in young children in remote Indigenous communities. Arts based trachoma health promotion initiatives have shown a capacity to support and revitalise hygiene programs. Creatively encourage hygiene behaviour change may help to reduce the burden of childhood infectious disease and eliminate trachoma by 2020.

Physical activity of rural residing children with disabilities: perceptions of parents/carers

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Introduction: Physical activity (PA) has been shown to be an essential component of children's health and development. Evidence suggests that children with disabilities are less active than their similarly aged peers and face multiple barriers to PA. Additional research shows that rural and remote children of all abilities face barriers to PA. As yet, there is no research investigating the level of participation in PA or the barriers faced by rurally residing children with a disability. Therefore the aim of this project was to describe parent's perceptions of PA undertaken by rurally residing children with disabilities and possible barriers to further participation in PA.

Methods: Participants were parents and carers of school aged children with a disability (5-18 years), who resided in a rural or remote area and were recruited through a local disability organisation or private allied health service. A paper based semi-structured survey was developed enquiring about participant demographics, child's characteristics, child's participation and barriers to PA and mailed out through these organisations. Quantitative data was analysed using frequencies and proportions whilst the qualitative data was thematically analysed using generic qualitative methodology.

Results: Thirty-four surveys were returned with participants from inner regional (n=13, 38%), outer regional (n=20, 59%) and remote (n=1, 3%) areas of New South Wales. The majority of the respondents were female parents/carers (n=30, 88%) with an

average age of 44 years (SD \pm 7.72, range, 28-67 years). The majority of the children were male (n=19, 59%) with a mean age of 11 years (SD \pm 3.90, range, 5-18 years). Children included had a range of disabilities including; behavioural disorders (n=15), neurological conditions (n=11), genetic conditions (n=7), digestive disorder (n=1), endocrine disorder (n=1), hearing loss (n=1), respiratory conditions (n=1) and unknown (n=2). Seventy-four per cent of children were not meeting the daily recommendation of PA. Twenty-seven participants (79%) indicated that there were barriers to their child participating in PA. From the qualitative data three main themes emerged: segregation, access to facilities/resources and barriers specific to the child.

Conclusion: This study has provided evidence that rurally residing children with a disability are not undertaking the recommended amounts of daily PA and face added barriers to participation. Whilst there is clearly further research needed, this study is the first of its kind in Australia to specifically investigate parents' and carers' perceptions of PA undertaken by rurally residing children with disabilities and the barriers preventing participation.

Getting research evidence into rural health policies: what does it take?

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University and government libraries are replete with academic publications, journal articles and reports relating to rural health. While these publications help us to better understand rural health issues and recommend ways to improve rural health outcomes, often this research evidence is not taken up in rural health policies or implemented in rural health programs. This paper outlines one approach to improve uptake of rural health research into policy.

Clearly one key requirement is to present research results in a format that is relevant, concise, timely, and easily assimilated by bureaucrats and politicians. What is not so easily recognised is the need to harness and monitor research take-up to show how it can produce positive outcomes and allay the risk-aversion so often characterising governments with respect to innovative ideas.

This paper demonstrates a new tool for recording and monitoring the impact of research, and shows how its use can help maximise the take-up and

implementation of research evidence into rural health policy and practice. This new '*research impact database*' builds upon an innovative conceptualisation of knowledge transfer. It shows (i) how research evidence impacts upon different constituents, including consumers, practitioners, policymakers, governments and professional bodies, (ii) the nature and scope of the impact, and (iii) how the research evidence can be organised to target the problem effectively.

This new '*research impact database*' helps researchers, funders and policymakers in several ways. First, they can gauge who is affected by the research outcomes. Secondly, by organising the ways in which the research impacts on activities, the database helps to identify the nature of any economic, political or other 'risks' associated with adoption of research evidence into policy and practice. Thirdly, the summarised output helps identify what steps may be needed to ensure effective implementation into policy and practice.

Unless rural health researchers can demonstrate the impact of their research, and the effective take-up and implementation into policy, rural health problems will persist unnecessarily. Moreover, previous studies may be unnecessarily replicated in the quest to find solutions to the existing unacceptable urban-rural health divide.

Assessment of diabetes and cardiovascular disease in visitors to rural field day events

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Issue: Approximately 1 million Australians are diagnosed with diabetes including an estimated 130,000 people with type 1 diabetes. Diabetes is a key risk factor for cardiovascular disease, the leading cause of death in Australia. Diabetes is often undiagnosed with many people being on the cusp of diabetes or unaware that they have it.

Aim: To assess the benefits of an outreach diabetes and heart disease risk assessment program, for visitors to rural field day events, developed and delivered by two NGOs working in partnership.

Methods: A health screening protocol was developed and training provided for volunteer medical students to provide basic health assessments for attendees at three field day events. Visitors to these events were given a basic health

screening and provided with individual written reports, accompanied with tips to improve or maintain good health. Follow-up telephone calls were made one month post-assessment.

Results: A total of 667 people completed a health risk assessment. 36 (6%) were found to have probable diabetes ($HbA_{1c} \geq 6.5\%$) and one in three (229, 35%) people were found to be in the pre-diabetes range (HbA_{1c} between 5.7 and 6.4%). The majority (517, 78%) were overweight or obese and more than one in three (259, 39%) people had elevated blood pressure. According to the AUSDRISK classification, more than half (350, 54%) of people surveyed were deemed at high risk of developing diabetes within the next five years. Overall, there were clear gender and region differences in prevalence of pre-diabetes and hypertension. A total of 535 (80%) people assessed were contacted one month later and 74% of those advised to see a GP on the day of their assessment had seen or planned to see a GP. One in three (86,32%) people had received follow-up GP care which included additional tests, routine monitoring, initiation or titration of medications, dietary and lifestyle advice or referral to other health care professionals.

Conclusions: Diabetes and cardiovascular disease risk assessments at rural field day events are well received among attendees and are effective in identifying people at risk and encouraging early GP consultation to prevent disease escalation.



The FIVE project—addressing the stigma of mental health through community arts engagement

Andrea Lewis, David Doyle
DADAA, WA

The stigma around mental health has been identified as a key barrier to people seeking help for a mental health issue or stepping up to help a friend, colleague or family member. In rural and regional settings, this is exacerbated by social isolation, lack of access to services and other factors.

The effects are of concern. According to the Mental Health Commission, the suicide rate in Western Australia stands at one person per day. High-risk populations include Aboriginal people, FIFO workers and their families, people living in rural and remote regions, and young people.

Using a community arts and cultural development model, the arts project FIVE aims to break down this stigma by using participatory arts to promote dialogue around wellbeing and to facilitate social connection within a community.

Established in 2013 and having worked in five regional communities around WA—Busselton, Geraldton, Paraburdoo, Derby and Esperance—FIVE has engaged more than 7,000 participants in arts activities and much broader audiences through its public events, art exhibitions and online presence.

A project-wide evaluation shows, to date, that the whole-of-community projects, as well as smaller projects targeting specific at-risk demographics within a community, have delivered strong impacts around 'belonging' and 'connectedness.'

In August 2013, FIVE won a silver award at the national Mental Health Services annual awards ceremony in the category of 'Mental Health Promotion or Mental Illness Prevention.'

This paper will present the FIVE project, arguing for its model of working and highlighting the most innovative elements and noteworthy outcomes from the project. One example will highlight the engagement of mine workers in the creation of a large, permanent sculpture for the Pilbara town of Paraburdoo that used blasting techniques to create sculptural forms for the work, and reactivated the Paraburdoo Men's Shed to complete the work.

FIVE is a partnership between DADAA and Rio Tinto, with funding from Australia Council from the Arts. It was designed in collaboration with the WA Mental Health Commission whose 2020 strategy calls for specific actions around early intervention, suicide prevention, building a sustainable workforce and addressing the needs of specific populations.

Given pressure on health systems, ongoing FIFO arrangements and the rising mental health burden across Australia, policy makers might more seriously consider the role that meaningful participatory arts can play as prevention and intervention strategy at the level of both individual wellbeing and community resilience.

Reading the Signs

Tania Lieman¹, Alex McInnes²

¹CemeNTworx, ²CemeNTstars

Reading the Signs is a theatre production exploring communication challenges for people with a disability. Who sets the agenda for making meaning, being understood and ensuring communication doesn't malfunction? What happens when it goes awry? The production explores the lighter side of when it does go wrong and also the deeper consequences; how it can be put right and in whose hands we could differently place the power. The full production of *Reading the Signs* will be staged during Disability Awareness Week, September 2015.

Streamlining chronic disease management in the Torres Strait

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The Torres Strait region is home to some of the highest rates of chronic diseases in Australia. Challenges that arise in the management of chronic diseases in this region include extreme geographical isolation, high health workforce turnover rates, difficulty accessing health care, and significant social and environmental determinants of disease.

This presentation covers the results of a qualitative study that was performed by interviewing 15 health practitioners in the Torres Strait. The study aimed to identify key issues associated with chronic disease management in the Torres Strait as perceived by clinicians in the region. The study also assessed the feasibility of establishing a regional chronic disease registry and integration of the registry with the recently established shared electronic health record system for better regional data collection.

The presentation also aims to illustrate how regional data on chronic disease rates in the Torres Strait can be used in a more streamlined approach to the management of chronic diseases in the region, and how such an enhanced approach may help address some key issues and improve health outcomes of the Torres Strait Islander people.

Recruiting participants in the 21st century: Australian longitudinal study on women's health

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Aims: To recruit a representative sample of at least 10,000 women aged 18-23 from across Australia using traditional and innovative methods, and to identify and evaluate the different recruitment methods.

Methods: In 2012-2013, five broad recruitment strategies were used to encourage 18-23 year old women to enrol in a longitudinal study that involves completion of annual online surveys. Focus group data were used to develop methods that would be attractive to this age group and to target advertising to groups that might be hard to reach, such as women living in rural and remote areas. The sample was monitored throughout recruiting, so that successful methods could be augmented and underrepresented groups could be targeted.

Strategies included Facebook (including Facebook advertising that targeted specific groups of women), other web activities (eg Twitter, YouTube, websites), referral, traditional media (eg posters, flyers, radio), and the use of a fashion company promotion. Respondents were asked to indicate which strategy led them to the online survey. Demographic characteristics of each recruitment group were compared with the Census. Multinomial logistic regression was used to compare demographic characteristics of each recruitment group with the reference group (ie Facebook).

Results: The aim of recruiting at least 10,000 women from across Australia was met, the sample of 17, 069 women was found to be broadly representative of women in Australia aged 18-23 on measures of area, age and marital status, with some overrepresentation of women with higher levels of education. Of the women who enrolled, 70% indicated Facebook, 5% other web activities, 7% referral, 5% traditional media, and 13% the fashion company promotion. Census comparisons showed women recruited via Facebook had similar age, area and relationship distributions as women of the same age in the Census. Women in all groups had higher educational qualifications and were more likely to be studying than women of the same age in the Census. The fashion company promotion attracted more urban women than the other categories, and Facebook attracted a greater proportion of women

with less than Year 12 qualifications. Specific recruitment strategies that were used to engage women from non-urban areas will be discussed.

Conclusion: In the face of increasing difficulties with recruiting the general public into research studies, a flexible, responsive approach using new and traditional media was found to be successful in recruiting a cohort of young women.



The drug-resistant tuberculosis epidemic in the Asia-Pacific region

Suman Majumdar

Burnet Institute

Tuberculosis (TB) remains a significant global public health problem, disproportionately impacting low-middle income countries. The Asia-Pacific region carries over half the global TB burden. The successes in responding to the global TB epidemic are threatened by the emergence and spread of drug-resistant (DR) strains. The World Health Assembly declared DR-TB a global public health emergency in 2009; however, the international response has been slow and insufficient.

Cases are increasing, however only 1 in 5 patients receive appropriate treatment. Known high-burden DR-TB countries in the Asia-Pacific region include Bangladesh, China, India, Indonesia, Myanmar, Pakistan, Papua New Guinea, the Philippines and Viet Nam. Sub-national hotspots of epidemic spread are increasingly being recognised. The drivers of drug-resistance include health system factors (drug supply/quality), program factors (patient support, treatment regimens) and patient factors (drug metabolism and adherence).

Improved strategies and tools for prevention, diagnosis and treatment of TB are ultimately needed to end the epidemic. While these are developed, focus must continue on scale-up of programs to contain epidemic spread of DR-TB and reduce patient suffering. Greater resources are needed for both drug-sensitive and DR-TB care, prevention and control. The DR-TB crisis provides urgency and focus for coordinated action to improve regional health and development.

CRANApus Clinical Governance Guide: the right people in the right places

Geri Malone, Marcia Hakendorf

CRANApus, SA

Introduction: Over the past two decades clinical governance has generated copious amounts of research and literature responsible for un-packing the essential components towards quality improvement. The translating of the conceptual components of clinical governance into the practical realities of clinical practice is as difficult as navigating through a maze.

Aim: The demystifying and grounding of clinical governance was a key objective for CRANApus when undertaking the Remote National Standards Project (2012-2013) supported by the Australian Government, Department of Health which resulted in the development of *A Clinical Governance Guide for remote and isolated health services in Australia* (Sept 2013).

Discussion: The crafting of this Guide was specifically for clinical service managers and clinicians in remote and isolated areas to provide a level of understanding of 'what it is', 'why we need it' and 'how we do', Clinical Governance in the context of remote and isolated primary health care settings.

The Project embraced an action research methodology inclusive of an extensive consultation process to acquire information from a broad range of professional expertise across Australia, whose profiles were predominately grounded in experiences in the provision of health care delivery within the remote sector. The consultation process captured, by means of a 'snap shot' survey, forums, and interviews, a number of gaps in clinical practice, limited understanding of clinical governance, roles and responsibilities, and what and how resources needed to be in-place to ensure safe, quality clinical care. This evidence formalised the design of the Guide based on the criteria and actions of National Safety and Quality Health Services (NSQHS) Standards 1 and 2.

In recognising 'we do it differently, same challenges, different care setting'—remote and isolated practices—the Guide was adapted from *NSQHS Standards Guide for Small Hospitals* (rural and remote) to be responsive and reflective of primary health care services and settings in the remote context.

Conclusion: An accessible, 'common sense' approach Clinical Governance Guide, grounded in the realities of remote and isolated primary health care practices, providing these clinicians with direction and guidance to ensure their health services has a robust clinical governance process.

If we have the right people with the right knowledge and capability in remote places with the right tools and the right resources to assist them, then the possibility is increased for doing the right thing and making it difficult to do the wrong thing.

A public–private partnership model for a rural physiotherapy service

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Health care accessibility and sustainability are priorities for health services. Achieving accessible and equitable health service delivery for rural and remote Australia presents significant challenges, for example in managing service gaps and recruitment/retention of appropriately skilled health professionals. There is a need to explore new ways to facilitate health service delivery in rural settings.

Alternative models of service delivery such as utilising Allied Health Assistants have strong potential to provide long-term solutions to chronic service gaps. However such service models remain dependent on accessing experienced allied health professionals to provide clinical assessment/care planning for clients/consumers, and training and supervision of Allied Health Assistants.

Private sector physiotherapists with established practices in rural and regional communities present an opportunity to develop effective business models to address service gaps. These businesses have made a long-term commitment to their communities and are less likely to suffer from the recruitment and retention issues experienced by public health organisations.

The aim of this project was to test the viability of a business model that utilised three different funding streams (local health district, Medicare Local and private) to establish a physiotherapy service to rural communities in south western NSW. Target clientele included acute and post-acute clients of the local health district, patients with chronic disease referred under a GP Management Plan, and privately funded clientele. The private physiotherapist outreached from a regional township to two rural communities

where service gaps in physiotherapy had been identified. Allied Health Assistants were utilised to enhance the service between visits from the physiotherapist. Shared governance arrangements were established between the local health district and the private physiotherapist to train and supervise allied health assistants.

Initial results indicate good uptake of previously unavailable services across primary care, residential aged care and acute/sub-acute care across a broad geographical area.

During the pilot project period there were 754 physiotherapy and allied health assistant occasions of services across the following funding streams:

- Compensable 1%(3)
- DVA 3%(7)
- EPC 6%(17)
- HML 77%(210)
- Private 6%(15)
- Public/MLHD 7%(19)

Phase two of the project is now in place across four localities. There is capacity to expand the service to include private residential aged care clients in the region.

Such collaborative activities increase the likelihood of developing consistent yet flexible service delivery models that meet the needs of rural communities, address service gaps in primary health service provision and support sustainable business development for private sector allied health.

Co-located pharmacy improves patient engagement within an Aboriginal primary health care service

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A pharmacy service that is co-located within a remote hospital provides primary health care services to the Fitzroy Valley town and surrounding communities in the Kimberley under s100 Remote Area Aboriginal Health Services (RAAHS) arrangements. It is the first NHS approved pharmacy co-located within an Aboriginal primary health care service in remote Australia. The pharmacy has a professional services focus and provides outpatient dispensing, medication

management, compliance programs and general outreach services, focused on the surrounding Aboriginal population.

The presenters will provide an overview of the development and implementation of the initiative and how it is meeting the needs of the community. The predominantly Aboriginal population of the Fitzroy Valley had difficulty accessing pharmacy services due to their remote location and distance to the nearest pharmacy. The burden of chronic disease is significant, with rates of chronic illness higher than the Australian average.

The pharmacy service supplies medicines under s100 (RAHHS) arrangements to all outpatients with appropriate education and follow up. In addition, clinical reviews and medication reconciliation are conducted on all chronic disease clients regularly. Dose Administration Aid services and medication education are provided in a holistic and culturally appropriate manner. The pharmacy has been successful in opening other funding sources in addition to the S100 (RAHHS) arrangements.

This presentation will highlight the accessibility of pharmacists as trusted members of the primary health care team and how the success of the initiative has extensively engaged communities and regional stakeholders. Other services involve collaboration with specialist teams such as Kimberley Renal Service and other regional providers such as the Kimberley Population Health Unit, the Nindilingarri Cultural health Service and the Royal Flying Doctors Service.

The presentation will contend that the primary aim to improve patient engagement and access to pharmacy based services as well as improving health outcomes through increased compliance and education has been achieved successfully. This has resulted in enhanced quality use of medicines.

This forms a sustainable model that may be duplicated in other regional and remote locations.

An engaged approach to workforce planning for a diverse, geographically dispersed workforce

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There are many drivers impacting on the Health and Community Services industry, influencing the way in which services will be delivered in coming years. In

order to deliver competitive and appropriate services into the future, CentacareCQ needs to provide a diverse range of offerings that meet the changing needs of consumers, and an available, appropriately skilled workforce is key to meeting this challenge. This is especially challenging as CentacareCQ covers around 400 square kilometres of Queensland, from Bundaberg north to Mackay and west to the Northern Territory border. In 2013, CentacareCQ began a workforce planning process to identify the drivers and influences that will shape its future workforce. This process was supported by the Health and Community Services Workforce Council (the Workforce Council), and utilised its Workforce Planning Framework©.

To deliver this project, CentacareCQ and the Workforce Council co-facilitated a working group made up of frontline and management staff from across CentacareCQ's geography. The working group undertook research and broad engagement that identified a number of drivers that will influence the shape of the future workforce. The working group interrogated these issues using a number of approaches, including desktop research; staff feedback via annual gatherings; and focus groups within specific areas of CentacareCQ's business. In addition, CentacareCQ sought input from external stakeholders regarding the direction of the research.

Analysis of this information provided a picture of what services at CentacareCQ could look like in the future, enabling the working group to identify the roles required for CentacareCQ to deliver competitive and appropriate services as well as the range of attributes that CentacareCQ staff believe are vital in all of CentacareCQ's workforce to ensure the organisation can deliver on its mission. The resulting workforce plan is a strategic document that shows how CentacareCQ intends to engage a workforce that incorporates these identified attributes along with the necessary skills and knowledge to meet the needs of the Central Queensland community.

This paper will unpack the application of the Workforce Council's Workforce Planning Framework, discuss the roles of CentacareCQ and the Workforce Council in delivering the plan, and provide insights into the challenges and rewards of the engaged approach used.

Adolescent early intervention services: better mental health for rural adolescents

Trevor Marshall, Ruth Mulligan, Robert Taylor, Lisa Neville, Matt Taylor, Emma Ghys

Alpine Health, VIC

Introduction: In 2001 Alpine Health established an Adolescent Early Intervention Service as a consequence of a significant number of referrals being made to the regional Child and Adolescent Mental Health Service (CAMH Service). There were long delays between a young person being referred to the CAMH Service and being assessed, which often exacerbated the issues that were presenting for that young person.

The Alpine Shire is a rural area divided into two main valleys, which have a significant influence on the movement of the population in the area. The Ovens Valley population (comprising Bright and Myrtleford) mainly uses Wangaratta as its regional centre outside of the shire, while the Kiewa Valley population (comprising Mount Beauty) mainly travel to the Albury/Wodonga region for their specialist health care. These main centres are 50-100 kilometres outside the Alpine Shire

Aim: To meet the mental health and wellbeing needs of young people through the establishment and delivery of locally accessible youth services.

Method: This aim has been met through the development of the following positions:

- adolescent health worker
- two health promotion officers
- youth worker.

Results: The outcomes that have been achieved through the combined delivery of these services over the past ten years have included:

- between 2005/10 the Psychiatric Hospitalisation rate has reduced from 10.2% per 1000 adolescent population to 6.5% per 1000 adolescent population. (VCAMS Portal)
- full time school participation at aged 16 years in 2011 was 89.7% in the Alpine Shire which is an increase from 2006 of 81%
- reduction of intentional self-harm as evidence through the data reporting of VCAMS Portal

- increased engagement of young people in local activities and decision making e.g. Youth Council, Youth Clubs and Communities that Care.

Conclusions: The positions have worked closely together in addressing the health and wellbeing of young people in the Alpine Shire. Through a strong partnership approach with other key stakeholders we have seen:

- reduced waiting times to access specialist mental health services
- reduced risk factors and delays in responding to young people's needs
- local service provision—out of the 'Mental Health System'
- reduced stigma of having a mental health issue
- greater access to positive health and wellbeing advice
- greater responsiveness and earlier intervention reducing the escalation of issues and conditions
- capacity building within the schools and the community to identify and respond appropriately to health and wellbeing of young people.

Growing up in the country—in their own words

Gregory Martin¹, Karen Paxton², Georgina Luscombe², Catherine Hawke², Katharine Steinbeck³

¹Department of Psychology, University of Sydney; ²School of Rural Health, University of Sydney; ³Academic Department of Adolescent Medicine, Children's Hospital Westmead

Aim: To describe new qualitative evidence from the ARCHER (Adolescent Rural Cohort, Hormones, Health, Education, Environment and Relationships) study related to the adolescent rural experience.

Method: The ARCHER Study is a three-year multidisciplinary longitudinal rural cohort study (n = 342) of adolescents (recruited 10-12 years) from central west NSW. The ARCHER study includes an extensive yearly parent and child questionnaire including the Child Behaviour Checklist and Youth Self Report and a range of qualitative measures. Qualitative data from the ARCHER study at baseline and first year follow up will be coded and analysed statistically. These measures provide new information on the experience of rural life: likes,

dislikes, concerns and personal strengths of adolescents and concordance between child and parent responses. Differences in responses are explored emphasising temporal, social and geographic variables including remoteness, age, gender, Indigenous identity, and household socioeconomic status.

Results: Preliminary analysis of baseline data reveals systematic differences in responses across temporal, social and geographic variables of ARCHER adolescents. Indigenous youth were more likely to report facets of the built environment as elements of their experience that they 'liked' whereas non-Indigenous youth were more likely to list facets of the natural environment. It also appeared that younger participants were more likely to 'like' the natural environment than older participants. 'Dislike' of the built environment was more common for older participants. Furthermore, facets of community and relationships were greater 'liked' by Indigenous youth than non-Indigenous youth, and were more likely 'disliked' by males than females. Further analysis will examine relationships between 'likes' and 'dislikes' of country living and characteristics of the children at both baseline and first year follow up. Concordance between child and parent responses related to concerns and strengths will also be explored.

Relevance: Findings are of value to those engaging with rural youth; health professionals, educators, community groups and parents. Such information provides valuable data for understanding rural populations and informs future research and policy that seeks to improve rural health and wellbeing.

Conclusion: This research provides novel information about the rural experience of distinct subgroups within rural populations. Young people in the ARCHER study provided rich information on their perceptions of living in a rural area. There appear to be associations between personal or household characteristics and viewpoints, which may reveal insights into the diversity of the rural experience.

Expressions—promoting wellbeing and social inclusion within a rural community through the arts

Lee Martinez, May Walker-Jeffreys, Mellissa Kruger

University Department of Rural Health, UniSA

The new '*Bringing it all together*': Guidelines for Arts and Mental Health Projects developed by Country Health SA and Country Arts SA has a main aim of increasing opportunities for social connection using arts and culture as an opportunity to improve wellbeing.

'Expressions', an eight week program, provided an opportunity for rural consumers of mental health services to participate in an 'arts in mental health' program within their local community which resulted in an exhibition of their work being held during South Australian Living Artists (SALA) festival at a local gallery space.

Artistic expression was the main aim of this community arts project, with participants demonstrating varying levels of prior arts knowledge and ability.

This presentation will discuss the engagement process, provide an insight into the process of delivering such a program, pre and post evaluation of participants using a baseline social inclusion scale and provide insight to public response to an exhibition of works from the program.

We believe that art plays a valuable role in engaging people who may be marginalised due to having a mental illness. It allows participants to switch off from issues that may be distressing them, promoting wellbeing and social inclusion.

We anticipate that this presentation will add to the evidence base of how arts and mental health can strengthen community connections.

Scope of practice in rural Australia—horses for courses? Or a one-horse race?

Jenny May

University of Newcastle, Department of Rural Health, NSW

Background: Scope of practice for GPs in undergoing considerable change. This has been particularly evident in the last 10 years with feminisation of the medical workforce, an increase in

the number of medical students being educated and a reduction in the number of rural facilities providing procedural services such as obstetrics.

Within the medical workforce the number of specialists has increased comparative to the number of general practitioners. With increasing specialisation, rapid population aging and an increase in the number and complexity of diagnostic tests, the impact of these changes on rural Australian has not been evaluated. Thus the aim of this paper is to explore the scope of general practice in rural Australia with a particular focus on the relationship between specialists and GPs.

Methods: Following a comprehensive literature review and ethical clearance, a PHD study was conducted considering medical workforce in regional centres. Semi structured interviews were completed with 66 specialists and 62 GPs residing in two inland and two coastal regional centres. Following ethical clearance the results were analysed using SPSS and the qualitative responses were thematically analysed. The quantitative and qualitative elements related to scope of practice are discussed in this paper.

Results: Scope of practice in regional centres as measured by hospital access and after hour's involvement was less common than in small rural hospitals where GPs provide hospital and often procedural services. Younger GPs were less likely to provide hospital care and those residing at the coast were less likely to do so than that resident in inland centres.

Scope of practice of GPs was more extensive where specialist access was poorer. In fact many GPs valued the variety of work and skills that they were able to utilise and considered this "scope" as highly important in both their recruitment and retention to regional centres. Specialists described difficulty maintaining some sub specialities in inland regional centres due to critical mass and after hour's issues.

Discussion and implications: These findings and other recent evidence suggest that there may be more than one way or one skill mix that suits rural Australia. An increasingly sub specialist model of practice may not be either practical or cost effective. However the worth and value of a generalist skill set may only be measured by its absence when the race is "run". Whilst in metropolitan areas specific models of after-hours and subspecialist services are the norm, the capacity of regional centres and smaller centres to develop a critical mass of specialist practitioners is questionable. Ideally scope

of practice, should be aligned with community need and should occur in responsive to viable models of service delivery.



What works with an Indigenous workforce: an evaluation of the remote AOD workforce

Lauren Buckley, Diane Mayers, Asman Rory

Remote AOD Workforce, NT

The award-winning Remote Alcohol and Other Drugs Workforce was funded in 2006 through the Council of Australian Governments to enable the establishment of an alcohol and other drugs workforce tasked with delivering services to remote communities. This unique workforce currently operates from over twenty urban, regional, remote and very remote communities across the Territory in both Aboriginal Community Controlled Health Organisations and Department of Health primary health care centres. The workforce seeks to address substance use through a direct client service delivery and community development framework. It is an Indigenous workforce comprising local people in their communities using their languages, cultural knowledge and kinship relationships to provide a culturally appropriate service. The workforce is well-supported by a Program Support Unit that provides clinical direction, guidance, supervision and support as well as advocacy, leadership, and professional development and two-way learning. The workers use culturally-adapted tools and resources that are developed collaboratively within the team for the Northern Territory.

A recent evaluation by 2013 by Menzies School of Health Research found the workers feel well-supported in their roles as part of a Territory-wide family. Qualitative feedback demonstrates that workers are satisfied by their roles as evidenced by a 40% retention rate since the program's inception in 2008. In 2013, the workforce received the Chief Minister Award for Excellence in Enhancing Health and Wellbeing.

Conclusions: Implementing and supporting an Indigenous workforce in the Northern Territory requires cultural consultation, adapted tools and resources, and extensive cultural awareness, knowledge and skills. It requires respect for Indigenous languages, knowledges, practices and flexibility in service and program delivery.

This presentation will be delivered together with Indigenous workers from the Remote Alcohol and Other Drugs Workforce.

National Arts and Health Framework Roundtable

Maz McGann

Institute for Creative Health

The National Arts and Health Framework has been unanimously endorsed by Ministers of Health and Ministers of the Arts of every Australian State and Territory and recognises the pivotal links between the two sectors. This roundtable will explore the key message in the Framework and engage with the full range of arts and health practice. We will discuss ways that the broad range of practitioners in arts and health can and benefit from the recently launched National Arts and Health Framework, its relevance to practice in regional areas and will build on the conversations that were begun in Victoria and Tasmania in 2014. The Framework will be placed in the context of 'real world' practice, and the next steps will be discussed.

City to bush: health outcomes for Aboriginal and Torres Strait Islander people

Sally Rayner, Charmaine McGowan

Australian Bureau of Statistics

The health of Aboriginal and Torres Strait Islander people varies considerably depending on whether they live in urban or remote parts of Australia.

This presentation will showcase data from the recent ABS Australian Aboriginal and Torres Strait Islander Health Survey (AATSIHS), which is the largest and most comprehensive health survey of Aboriginal and Torres Strait Islander people ever undertaken. The AATSIHS was conducted across Australian States and Territories in urban, regional and remote areas, including discrete communities.

For the first time, the survey collected detailed information about diet and nutrition, and utilised pedometers to measure Aboriginal and Torres Strait Islander people's levels of physical activity. It also included the largest ever biomedical collection for Aboriginal and Torres Strait Islander adults.

Results from these new topics will be presented, with a focus on rural and remote areas, along with information on key risk factors like smoking, alcohol

and obesity. Comparisons over time will also be included where available.

An overview of primary health care needs and opportunities in the Pacific

Lachlan McIver

James Cook University

Primary health care has long been recognised as the backbone of any health system.

The imperative for effective primary health care and the identification of obstacles to its delivery are of paramount importance in developing countries, including the small island developing states of the Pacific region.

Health policies in the Pacific are guided by the principle of 'Healthy Islands', which provides a framework for health systems development linking health and wellbeing with island environments and society.

This opening session briefly summarises some of the key challenges and opportunities related to primary health care in context of over twenty countries and territories covering tens of thousands of islands across the 'Blue Continent'.

Building an allied health workforce in mental health

Carol McKinstry, Siann Bowmann

La Trobe Rural Health School, VIC

There is a recognised need to increase access to mental health services for rural Australians. This paper will outline the strategies used to promote mental health as a career option to graduating occupational therapists and capacity building initiatives to increase placement opportunities for students. A regional occupational therapy program with the major aim to supply a rural workforce commenced in 2009 following consultation with local occupational therapists and health services. As part of the business case to establish the course, it was identified that there were long standing occupational therapy workforce shortages in mental health.

The new course aimed to recruit rural and regional students through ATAR bonuses and direct marketing to secondary schools. This has been achieved with above 95% of graduates from the program coming from non-metropolitan areas and almost all graduates commencing employment in

rural and regional Australia. Initially it was difficult to obtain practice education or placements within practice areas such as mental health, therefore University staff decided to undertake a range of strategies to increase opportunities for students and graduates.

The profile of occupational therapy within local mental health services was low due to the small number of therapists working in local services. To improve the profile of the University within the regional mental health community, a public lecture by Professor Patrick McGorry, a leader in youth mental health was organised in November 2012, inviting local mental health clinicians and secondary school staff with over 150 attending. To increase mental health opportunities for students, discussions were held with the management of the local regional mental health service to establish occupational therapy student project placements in mental health enabling over half of the cohort of final year students to work directly with mental health services. A number of role emerging placements within rural mental health were also organised. The University staff provided assistance with supervision and guidance where there was not an occupational therapist working within the service with the students educating staff and clients about the potential role of occupational therapy.

While a number of graduates from this regional program are now employed in mental health services, in both occupational therapy and generic positions, there are still insufficient graduate positions for allied health professionals. It is recommended that career pathways for allied health professionals need to be established by rural or regional mental health services.



If we can do it, anyone can!

Sharing success stories through media

Bethany Miles¹, Elleni Vassilakoglou², Anthony Clayton¹, Kathleen Clayton¹

¹Department of Health, NT; ²Flinders University

'Ngawa Kurumutamuwi' (We Are Strong) was a three month program that was delivered in Pirlangimpi, Tiwi Islands, from September to November 2014. It aimed to promote smoking cessation, weight loss, and increased fitness through exercise activities, smoking and nutritional education and support, and food supply interventions. The program was championed by local community members and supported by a variety of local and other stakeholders including the

National Heart Foundation, Northern Territory (NT) Department of Sports, Racing and Recreation, NT Department of Health, Tiwi Islands Shire, and the local community store. Many positive outcomes resulted; smoking cessation commenced, waistlines reduced, and fitness improved.

Local staff were proud of the program's success, and wished to share some individual stories in an engaging way. They wanted to disseminate and promote a key community-initiated slogan, "if we can do it, anyone can". By doing so, they hope to inspire Pirlangimpi residents and other Indigenous people in remote communities to initiate health programs and healthy lifestyle choices.

A low budget video was developed to facilitate this process and to disseminate the success story of a community led healthy lifestyle program. Several program participants told their positive stories about weight loss, smoking cessation and fitness improvements. The video showcases the community leadership that contributed to the program's success. A script was developed by a local Aboriginal Health Practitioner (AHP) and a Darwin-based student nutritionist. Filming occurred over 5 days in several locations throughout the community. Staff used a Nikon SLR D7'100 camera and Adobe Premier Pro software to produce a 7 minute video involving interviews with 6 people. The video also included footage from exercise and education activities that were part of the program.

A "Pirlangimpi Boot Camp" Facebook page was used by community members during the program to share activities, exercises, food ideas and achievements. During production of the video, local and non-local staff learnt new audio-visual production skills. This video was disseminated through a community screening in December 2014, social media platforms, online databases and emails. Preliminary evaluation of the video indicates it was an engaging, inspirational tool for lifestyle change, and successfully communicated project outcomes. If we can share healthy lifestyle program successes through low budget media, anyone can.



Mending the road behind and building the road ahead—the journey of a rural generalist in Papua New Guinea

David Mills

Kompam District Hospital, PNG

What does general practice actually mean for doctors in Papua New Guinea's remote corners?

This session is a partly personal, partly philosophic, wholly practical review the lessons gleaned during a career in a new health service in one of the country's more troubled and remote corners.

It seeks to outline some of the history of health care in PNG, a country of nearly 8 million people, and Australia's nearest neighbour and former colonial territory. It discusses the challenges the country faces today and outlines some of the new initiatives particularly in respect to the training of young PNG doctors to take up what is arguably the country's most challenging medical career available—that of the district medical officer.

What mistakes have been made? What of the successes? What has been learned? How can we strengthen partnerships to help move further towards bridging the enormous gap that exists between the status quo and the provision of a basic, competent, accessible and reliable health service for the large majority of Papua New Guineans who still live in rural and remote locations?

Doctors in remote Queensland: they don't stay, do they?

Chris Mitchell, David Wellman, Daniel Gullo
Health Workforce Queensland, QLD

Background: Health Workforce Queensland, as one of the seven national rural health workforce agencies, collects and publishes a minimum data set (MDS) annually related to the medical workforce serving remote, rural and regional Queensland communities (ASGC RA 2-5). The MDS provides a snapshot of the situation at 30 November each year. Published findings suggest considerable workforce 'churn', especially in remote (RA4) and very remote (RA5) locations. In 2013, the number of practitioners commencing work at remote locations accounted for more than 58% of the total remote medical workforce ($n = 134$). However, what has not previously been looked at is the rural and remote work history of medical practitioners commencing at remote practices.

Method: Retrospective secondary analyses of MDS data were undertaken on all medical practitioners that had practice commencements at remote and very remote Queensland medical practices in 2003 and 2004. Four separate cohort analyses were undertaken: 2003 remote; 2003 very remote; 2004 remote, and; 2004 very remote. All MDS entries for each identified practitioner were extracted for analyses.

Results: There were 114 practice commencements which represented commencements by 93 medical practitioners. Preliminary results for the 2003 RA5 cohort indicated that 21 practitioners commenced work at 22 very remote practices. Average length of stay was 1.3 years. One-third of the practitioners did not have another rural remote commencement in the MDS, suggesting that this was their only rural/remote service. The remaining two-thirds had between 2-6 other MDS practice commencements listed. Overall, the 2003 RA5 cohort had 128 years of practice covered in the MDS database from their first entry until Aug 2014. Ninety-three per cent of those years (119 years) were spent serving in rural and remote Queensland.

Discussion: Implications and interpretation of high churn rates of medical practitioners in remote settings will be discussed. Results suggest that high rotation rates in remote settings may not be to the detriment of health in rural/remote communities generally. A short period in remote settings may form just one part of a career spent serving rural and remote communities. However, there is a concern for the impact of high churn for people in remote communities. Lack of long-term relationships with medical staff may interfere with the development of trusting health relationships and contribute to the generally poorer health outcomes for remote community members.

Family violence—primary prevention: a community involvement approach

Nerrida Mitchell^{1,2,3}, Carmel Mitchell^{1,4}

¹Country Women's Association, VIC; ²South Eastern Centre against Sexual Assault and Family Violence;

³Royal Melbourne Institute of Technology, VIC;

⁴MADCOW, Monbulk community organisation

Family violence has become a major issue of concern for many communities around the world and is recognised as constituting a violation of human rights. Family violence can have devastating consequences on individuals, families, and the communities in which they live. It is now recognised as a significant social problem within Australian society. In Victoria, there is a 10 year plan to prevent violence against women and children (2010-2020). This plan was devised due to; the human rights imperative; impact on women's and health; impact on children and young people and the impact on the economy.

There has been an increasing emphasis internationally on strengthening a justice response to family violence. In addition to its punitive effect,

the criminal justice system has a preventative effect by acting as a potential deterrent to men who use violence. However, in the application of this approach it was increasingly apparent that an effective family violence system would not be achieved through a justice response alone.

In 2002 the Victorian government developed an integrated model of response and prevention of family violence, which includes a justice and a community involvement response, it is termed 'whole government and community response'. This is a model which provides funding, training and resources to particular levels of the community e.g. people who use health care. It does not reach the community where people live and interact on a social level or for example a sports club level.

The community in which people live is an important place to have a conversation about primary prevention of family violence.

This project works with the Victorian Country Women's Association and the Monbulk community to:

- provide education to community members about family violence
- engage the community in a discussion about family violence
- invite community members and local family violence providers to give suggestions on the needs of the community regarding family violence
- develop recommendations for family violence prevention strategies
- develop recommendations to build resilience in the community.

The project started in January 2014 and has the support of the local services and community members. It is still continuing and making 'real' changes for individuals and families. These changes are clearly documented. One outcome is a DVD against family violence made by and including local members.

This community involvement model is transferable to other communities, particularly rural communities.

Rural remote generalist clinical requirements of allied health professions in northern Australia

Ilsa Neilsen¹, Renae Moore², Julie Hulcombe¹, Scott Davis³, Dianne Biacini⁴

¹Queensland Department of Health; ²NT Department of Health; ³Greater Northern Australia Regional Training Network; ⁴WA Department of Health

Introduction: The development of rural and remote generalist workforce and service models in the allied health professions has been identified as a priority by health services in northern Australia. Limited information on the profession-specific and inter-professional (skill sharing) clinical task requirements of rural and remote practice has hampered the progress of this work. In 2013/2014, the Greater Northern Australia Regional Training Network (GNARTN) undertook a two stage project to address this information gap.

Methods: In 2013, GNARTN funded five teams in northern Australia to undertake a comprehensive clinical task mapping and risk assessment process using the Calderdale Framework. Data from these sites was aggregated to produce a series of profession-specific clinical task list for physiotherapy, social work, speech pathology, occupational therapy, podiatry, and dietetics and nutrition. A list of tasks assessed by project site teams as potentially appropriate to skill share was also produced. Stage 2 of the project (2014) tested the skill share task list with experienced allied health professionals from other rural and remote services to examine validity and transferability of Stage 1 project findings. A modified nominal group technique method was employed.

Findings

- Multi-professional delivery of clinical tasks is common in existing rural and remote models of care
- 135 of 139 tasks identified in Stage 1 were confirmed in Stage 2 to be appropriate for skill sharing, assuming comprehensive training and clinical governance processes are implemented
- Proposed skill shared tasks generally represent a modest expansion of existing scope rather than substantial re-orientation of practitioners' skills sets
- Resources exist to support training and clinical governance, but further work is required to make resources broadly available in a coherent

workforce and service development package and to address gaps.

- Benefits proposed by stakeholders for increasing skill sharing were; improved access to care, better client outcomes, improved safety and quality of care, service efficiency and creation of more satisfying work roles

Conclusions: The project demonstrated that multi-professional delivery of clinical tasks, including skill sharing, is common in rural and remote teams and there is support for expansion. However, robust training and clinical governance processes are required to ensure maximisation of benefits for clients, health professionals and services. Development of sustainable, safe and effective rural and remote generalist models of care for the allied health professions will require translation of project outcomes into service redesign, supporting systems and training programs.

Telehealth to the home

Angela Morgan

Hunter New England Local Health District, NSW

Hunter New England Local Health District has developed, implemented and evaluated two telehealth models designed to improve the health outcomes of people isolated from health services. Both telehealth models developed presented innovative approaches to delivering a health care service. The models placed the consumer at the centre and have elements that are scalable across other service disciplines and disease processes.

The chronic disease *Telehealth to the Home* model and the *Working Together: Life Beyond Cancer* telehealth models were trialled in the New England region of NSW and achieved the following:

- multidisciplinary chronic disease and post-cancer care interventions delivered via telehealth that improved self-management skills and health behaviours
- in-home monitoring of biometric data combined with a coordinated care approach to managing changes in disease that demonstrated improved health outcomes
- in-home high definition videoconferencing for consultation, multiparty support group with guest speaker and individualised health behaviour change coaching

- application of a range of in-home and mobile technology devices over a variety of internet options
- embedded telehealth models into routine care and redesign of current services to accommodate the technology
- overall improvements in quality of life, health behaviours and achievement of health goals
- establishment of telehealth infrastructure including workforce, technology and clinical models
- scalable models with consumer and workforce engagement in the development.

The chronic disease and cancer care telehealth models demonstrated the essential key implementation domains necessary to conduct a successful telehealth service in rural communities. Domains include; technology, workforce skills, community participation, culturally appropriate care and governance.

Stronger eye care systems in Aboriginal primary health care

Anna Morse^{1,2}, **Colina Waddell**^{1,2}, **Jenny Hunt**³, **Fiona MacFarlane**⁴, **Daniel Jackman**⁵, **Christine Corby**⁶, **Tricia Keys**^{1,2}

¹Brien Holden Vision Institute; ²Vision Cooperative Research Centre; ³Aboriginal Health & Medical Research Council; ⁴Wurli-Wurlinjang Health Service; ⁵Coonamble Aboriginal Health Service; ⁶Walgett Aboriginal Medical Service

Background: Access to eye and vision care is important for rural and remote Australians, especially Aboriginal communities where rates of vision loss are higher than non-Indigenous populations. Primary health care (PHC) providers play a foundational role in the eye care system, by detecting, referring and following up patients needing comprehensive eye care or treatment.

Aims: To describe the process, methods, and preliminary outcomes of supporting eye care systems and services integrated with PHC services, in a collection of Aboriginal Community Controlled Health Services (ACCHS) in NT and NSW.

Methods: Priorities for improved organisation and delivery of Aboriginal eye care services were informed by: 1) focus group discussions with ACCHSs, 2) clinical file audit data about eye care access, 3) listening to patients and gaining community perspectives, 4) regional eye care

systems assessment and 5) mapping eye care services against projected population needs.

Guided by this situational analysis, several things were done to support eye care within these ACCHS. This included: 1) training PHC teams, 2) Continuous Quality Improvement (CQI) activities to assess and improve eye and vision care, 3) clarifying referral protocols, 4) advocating for eye care services to meet population needs, 5) developing shared regional eye care action plan. This integrated set of approaches were then refined and packaged as a user-friendly 'toolkit' that other Aboriginal or Torres Strait Islander health services may implement to strengthen their eye care systems.

Results: During the two-year phase: three training in-services were delivered, two rounds of CQI (clinical audits) were conducted, referral processes were documented, e-record templates were updated for primary eye care checks, and visiting optometry and ophthalmology services increased in some locations. Closer engagement with eye care services by ACCHSs was observed, and eye care became more integrated with PHC, especially in chronic disease programs.

Data show positive trends, with improved eye care access and coverage, particularly for patients with diabetes. Qualitatively; improved coordination and cohesiveness of eye care programs at the regional level has been noted. The post-line comprehensive file audit (early 2015) shall indicate the extent of these changes.

Relevance: Other visiting specialist services to remote health centres and ACCHSs may learn from this process of supporting PHC as the foundation for effective use of, and improved patient access to visiting services.

Conclusion and recommendations: This process of implementing an integrated set of approaches to strengthen eye care systems within ACCHSs has proven valuable and effective, and is therefore recommended to support eye care within other Aboriginal and Torres Strait Islander health services across Australia.

#Millennialsgorural

Greg Mundy, Anthony Wall, Jo-Anne Chapman
Rural Health Workforce Australia, VIC

Background: How do we encourage today's generation of health students to go rural?

What do we know about what motivates them to consider a career in rural communities, what has changed for them and what does this mean for future funding investments for medical and allied health professionals?

Despite increasing medical student numbers, data from the latest Medical Schools Outcome Database highlights that <1% of graduating medical students (or around 20 graduates per annum) state a preference to work as a GP in smaller communities (pop<25,000).

Rural maldistribution is even more marked for the allied health workforce, with the number of professionals falling from 22 per 100,000 people in capital cities to 12 in remote areas and 6 in very remote areas.

Quotas on students with rural backgrounds—even if expanded from current levels—are unlikely to be sufficient to meet workforce needs for an ageing population.

New strategies to persuade Australian-trained graduates to 'go rural' will be needed, but what will work and what needs to change to see "millennials go rural"?

Aims: A recent qualitative study found today's medical students and junior doctors ('millennials') value 'professionally advantageous' rural experiences that will benefit their longer term career goals. The research aims to quantify these findings amongst a large sample of medical and allied health students.

Specific research questions include:

- factors considered in undertaking rural placements (eg reputation of placement, mentor) and which are of greater relative importance?
- do students actively seek rural placements that are seen to offer professional advantages?
- are there differences in attitudes towards rural placements between medicine and allied health students or between students from rural and non-rural backgrounds?
- what would make them consider a career in rural Australia?

Methods: An online survey developed to quantify the findings from recent qualitative research will be emailed to over 10,000 multi-disciplinary health students at Australian universities.

Results: This will be the first survey of its kind and provide valuable information for future health workforce planners and policy-makers. The research hypothesises that millennial students see themselves in a competitive environment and are highly career-focused. When considering a rural placement or rural practice, they want answers to questions such as *'how will this benefit my career?'* and *'what is the reputation of this hospital/mentor/placement?'*

Conclusions: It is expected that when complete in March 2015 the research findings will provide recommendations of how best to develop and refine programs and initiatives to attract urban health students to rural practice.



The Imagine Me project. Awareness raising, skill-building, creative photographic project for people with disability in rural and regional Australia

Sue Murray

Imagine Me

Imagine Me is an innovative skill-building creative project empowering people with spinal cord injury living across Australia, to explore their imagination in an empowering creative process. The aim being to foster greater understanding towards people living with disability, and open up new creative opportunities by building skills and fostering community engagement.

Participants are invited to a series of workshops where they create self-portrait artworks using professional photographic equipment, specially adapted for people with spinal cord injury. This equipment enables someone with quadriplegia to control a digital camera and professional photographic studio using a mouth-stick with a mobile phone.

Peer support is a valuable part of community health and wellbeing and this workshop process encourages people to broaden and build new social networks, to share stories and to build resilience.

The specialised adaptive equipment for people with limited mobility is building capacity, while helping people with spinal cord injury to learn new skills while developing a sense of control over their circumstances. The workshops teach new skills through a creative process involving experimentation, expressing ideas, and forming

judgments. These critical thinking skills are primary to the creative process of making art.

Imagine Me is currently planning to run a series of workshops and exhibitions in Regional Art Centres concluding with a major exhibition at Casula Powerhouse Arts Centre on International Day for people with Disability December 3 2015.

The long-term vision for the Imagine Me project is to run creative workshops across Australia, along with touring exhibitions of the portraits created, linking each small community group into a network where individual stories can be heard and shared, offering support to others with spinal cord injury living across Australia.

Growing an optometry workforce for Aboriginal and Torres Strait Islander communities

Genevieve Napper¹, Luke Arkapaw², Mitchell Anjou³, Anna Morse², Michelle Pollard²

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Background: Optometry services provided in Aboriginal Health Services are critical for improving eye care access for Aboriginal and Torres Strait Islander Australians by providing comprehensive eye examinations in a culturally safe primary health setting. Indigenous communities' eye care needs are high and most vision loss is avoidable yet one third of adults have never had an eye examination. Optometry provides access to refraction and affordable glasses (addressing 50% of vision loss) and detect, monitor and refer the other main causes of vision loss (cataract, diabetic retinopathy). Key to sustained improvements in eye care access and equitable outcomes is an appropriately skilled and competent optometry workforce.

Aim: This presentation describes the strategies of two non-government, non-profit eye care organisations to develop an acceptable, appropriately trained and sustainable workforce for outreach optometry services within Aboriginal communities in Victoria and the Northern Territory.

Methods: Both eye care organisations employ a significant number of optometrists with a public health emphasis, who may be directly employed or engaged as locums, and work in close partnership with government and Aboriginal community controlled health clinics. Proactive strategies have been developed to ensure service sustainability and

continuity of care. In 2014, 133 weeks of optometry services were provided in the NT by 53 optometrists. Optometrists must comply with specific requirements in preparation for working in remote Aboriginal communities. Orientation resources and ongoing email support is also provided. The Victorian based organisation provides affordable eye care for people experiencing disadvantage and is a clinical site for optometry students. 45 staff and 30 casual optometrists provide clinical education and eye care in urban and rural Victoria, including 22 Aboriginal Health Services. In 2014, an additional 35 weeks of optometry services were provided in the NT program. This organisation provides a public health environment where optometrists gain experience in community eye care, specialist clinical skills and education. Mentoring, peer support and a requirement for cultural awareness training facilitate the development of optometrists able to provide optimum eye care in challenging environments.

Conclusion and recommendations: Optometrists working with Aboriginal and Torres Strait Islander clients require specific training and support to ensure good patient outcomes and sustained and effective service delivery. Two leading public health optometry organisations are working to develop and utilise a specialised optometry workforce in Victoria and NT. This experience and ongoing evolution to improve optometry workforce and service delivery may be applicable to other health practitioner groups.

Mental health support via video

Randal Newton-John

On The Line, VIC

Much has been said about the difficulty providing quality health services to people in rural and remote communities and tele-medicine is rapidly evolving to meet the need. As part of the tele-medicine revolution, video counselling (e.g. via Skype) is now emerging as the next important step in providing mental health support.

Over the past 50 years, remote mental health services have primarily been the domain of telephone 'helplines.' While the effectiveness of telephonic counselling has been demonstrated, there is a common perception amongst the public and health providers alike that telephone counselling services are a 'last resort' for people in extreme crisis. However, as a hybrid form of delivery with elements of both ongoing face-to-face and telephone services, video counselling is changing

the way in which we think about mental health support.

Video counselling offers a solution for people unable to access on the ground services due to geographical challenges or other access issues. Video counselling also attracts clients who may not otherwise use telephone or face to face services, such as younger people.

As a leader in remote service delivery, On the Line has introduced video counselling into two of its national professional counselling services: MensLine Australia and the Suicide Call Back Service. Both services now offer 24/7 high-level professional support via video to some of the most isolated in our community.

The presentation aims to improve participants' understanding of the implications of video counselling in supporting people in rural and remote areas. It will demonstrate how On the Line operates video services and responds to some of the practice, privacy and other concerns that have been raised. Case studies will be presented highlighting how the service supports people in rural and remote areas

The future holds many new forms of digital communications. It is expected that online communications will continue to grow, and that online therapies will form an important aspect of future service delivery. While video services still present a number of challenges, service providers need to embrace new communication channels.

☆ Rural telehomecare helping chronic disease and an ageing population

Shannon Nott

Future Health Leaders, NSW

Background: Chronic diseases in Australia form a large part of repeat hospitalisations every year. Patients with chronic disease are at high risk of multiple hospital admissions, poorer quality of life and as a result place greater burdens on overstretched health systems. Avoidable hospitalisations increase with remoteness in Australia, which in part is related to patients in such settings having less access to support when leaving hospital. Home monitoring through telehomecare has been developed to help support patients as they transition from acute services to the home. These services have also been developed to help monitor

geriatric populations at higher risk of re-hospitalisation following admission.

Objectives: This report will review current telehomecare programs run throughout Canada, the United States of America and Brazil. It will draw on lessons learnt and experiences from observing and participating in telehomecare programs as a part of a Churchill Fellowship focusing on telehealth in rural and remote communities. The report will provide first hand knowledge of successes and challenges associated with telehomecare and will form advice on best practice principles for developing telehomecare programs in rural communities. This report will also look at the results from international models, which have described decreased hospitalisation, GP visit, and walk-in clinic rates.

Key points

- Describe what telehomecare is, how it is run and patient outcomes achievable
- Describe telehomecare programs across Nunavut and Ontario in Canada, and Alaska in the United States of America
- Discuss key factors why telehomecare needs to be implemented
- Highlight challenges associated with the application of telehomecare
- Highlight common success factors for telehomecare

Conclusion: With an ageing population and a growing burden of chronic disease in Australia, health care systems need to be innovative to help support patients at home. This involves helping empower individuals to self-care through supported telehomecare models. These models have shown to decrease hospitalisation of these at-risk groups and have positive patient outcomes. Such models are more pertinent in rural and remote communities whereby access to support staff in communities are decreased comparatively to urban centres.

Integrated rural placements maximise medical student learning

Teresa O'Connor, Louise Young, Ruth Stewart, Peta-Ann Teague

College of Medicine and Dentistry, James Cook University

Preparing medical graduates with the ability to work in a variety of settings, particularly rural communities, is a key feature of the MBBS program

at James Cook University in Townsville. This program provides all students with 20 weeks of rural practice across their course comprised of four weeks in second year, eight weeks in fourth year and eight weeks in sixth year. In addition, some students in the sixth year are provided with the opportunity for an extended rural placement of 20 weeks.

A new venture in 2014 provided several students, with identified weaknesses after the final fifth year exams, with a rural integrated corrective. These students with identified clinical weaknesses were provided with the opportunity to undertake an integrated clinical corrective of eight weeks in a rural site during their sixth year. This meant that these students were completing 16 weeks or one-third of their placements in a rural site during their final year.

This presentation will report on an evaluation of the integrated rural corrective program undertaken in November 2014 which revealed enhanced skills and confidence among these students. "I learn more in one week on rural placement than I learn in eight weeks in [Regional] Hospital" said one student. Students commented positively on the variety of experience and the welcoming attitude of the multidisciplinary team at the rural sites in North Queensland to which they were allocated.

Staff involved in supervising these students also commented on changes in the students' confidence and competence as a result of this additional time in the rural context. One limiting factor in providing the integrated clinical corrective at a rural site is the pressure on rural placements and workload for the rural clinicians providing this additional support. The College of Medicine and Dentistry acknowledges the additional work required to support students with identified weaknesses in these settings. Whilst student numbers undertaking the rural clinical corrective in their final year was small, it is undeniable that transformation in clinical skills and confidence in these poorly performing students occurred as a consequence of the rural clinical context. This provides further evidence for rural clinical settings providing high quality learning opportunities for "at risk of failure" medical students and in preparing them for internship.

Our people, our places and unpredictability

Maree O'Hara, Danielle Withers

Anyinginyi Health Aboriginal Corporation

We are a community-controlled eye health service. This means that the community and especially our Board at our Aboriginal Medical Service has a say in the way they would like our service to be.

This is very exciting as our community are our patients and we are not short of feedback. This means that people get the service they want, not the one others, who don't live here, think they should have.

The 8 year journey of this particular model of delivery, has been one of discovery and adjustments.

A lot of assumptions were made by me (the Eye Coordinator) that were wrong, partially right and nearly right!

I have learnt that the model we have needs to be reliable but fluid. That sounds impossible but somehow that works.

Our clinicians (the optometrists and the Eye Specialist) are very gracious about usually working so hard I feel we are in a horse race sometimes, galloping towards the end.

This means that we never so "no" to anyone that wants to see an optometrists. Sounds easier than done because then we have to triple book for the one appointment sometimes. Somehow with the non attendees and patients that are very good about waiting (because they understand the crazy system and why we have it) it all works.

Our community members have taught me a lot about their lifestyles and what challenges there are for many of them.

This has changed my delivery of the service. It was always done with the right intent but with understanding it is even better.

Some of the wrong assumptions I made for the majority—people get sick of appointment letters (they don't), they get sick of you keep asking them to come in (they don't), people would not speak up if they wanted something else (they do) and many other assumptions.

I also learnt that it was best to have an assistant and driver that were Aboriginal but if I didn't—people

understood and we all worked it out. Lucky for us now we have both.

Most of our clients are from traditional Aboriginal backgrounds and continue to keep me (often via the Eye Health Assistant and driver, or directly) attuned to their needs

This is just part of my ongoing journey but I hope it continues with such unpredictability!

Comparing cerebral palsy in births to Australian Indigenous and non-Indigenous mothers

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¹NT Department of Health; ²Telethon Kids Institute; ³WA Department of Health; ⁴Menzies School of Health Research; ⁵Cerebral Palsy League

Aim: To explore the differences in proportion, risks and characteristics between Indigenous and non-Indigenous cases of CP in Australia for birth years 1996-2005.

Method: Numbers of cases of CP born in the decade 1996-2005 inclusive in QLD, WA and NT were collected then tabulated and stratified by Indigenous status and whether the CP was acquired pre/perinatally or postneonatally. All data were grouped by birth gestation, birth weight and the following characteristics of CP: Gross Motor Function Classification System level, vision impairment, hearing impairment, speech impairment, intellectual impairment and presence of epilepsy at age 5. For those with postneonatal CP, the distribution of causes was also estimated. Proportions were estimated and compared between Indigenous and non-Indigenous groups within each jurisdiction and in all jurisdictions combined. Relative risks associated with Indigenous status, and their 95% confidence intervals, were estimated for both postneonatal and pre/perinatal CP.

Relevance: This study has been able to draw on the largest population of CP in Indigenous Australian children ever used for epidemiological research.

Results: The proportion of Indigenous births subsequently described as CP was higher than that of non-Indigenous births. In all three states/territory the relative risk of postneonatal CP associated with Indigenous status was substantially higher than that for pre/perinatal CP. From combined data Indigenous births have almost 5 times the risk of

postneonataly acquired CP, but only a 42% increase in risk of pre/perinataly acquired CP. For Indigenous infants almost half acquired their brain damage as a result of infection and a further third as a result of head injury, whereas for non-Indigenous infants the most frequent cause was cerebrovascular accident, followed by infection (22%) with head injury accounting for only 15%. Within each ethnic group those with postneonataly acquired CP were more likely to be born at term and of normal birth weight than those with pre/perinatal CP. Indigenous children with CP were more likely to be non-ambulant and have more associated impairments than non-Indigenous children with CP. Within the group of Indigenous children, those with postneonatal CP were more likely to be non-ambulant and to have more associated impairments than Indigenous children with pre/perinatal CP.

Conclusions: It is important to continue to monitor CP in Australia's Indigenous and non-Indigenous populations to provide evidence of the health disparities between them and direct attention to areas requiring particular attention.

Policy recommendation: Monitoring CP in both populations may assist to increase prevention of CP for the different populations and direct services to where they are most needed.

Multidisciplinary rural training hubs—partnerships for sustainable rural training

Kathryn Kirkpatrick, Cameron Loy, Rod Omond, Karin Jodlowski-Tan, Morton Rawlin, Bronwyn Darmanin, Kelly Dargan

Royal Australian College of General Practitioners, National Rural Faculty

Background: The importance of primary care, and working as part of a primary care team, must be reinforced from the commencement of medical training and continued through training, with shifts in the current arrangements to enable interdisciplinary training. Jurisdictional barriers and a lack of flexibility in policy approach have led to an underutilisation of existing training networks, significantly impacting on rural workforce recruitment and retention.

Objective: To provide innovative and practical solutions to overcome barriers which currently limit training and workforce policy success.

Approach: The policy framework was formed during extensive consultation undertaken with the

Royal Australian College of General Practitioners (RACGP) rural membership, to identify the key issues, enablers and barriers to establishing streamlined medical education and training in rural and remote areas.

Findings: Investment in multi-disciplinary rural training hubs, in targeted locations, will address many of the current impediments to teaching and learning and create sustainable medical training communities by clustering funding and training effort. Reforms that include the use of locally available expertise and/or community partnerships, enabling tailored training relevant to the community setting, are needed.

The approach builds a strong teaching culture and facilitates a community connection for the learner, allowing for integrated and multidisciplinary team-based training to occur. The hubs are designed to enable a quality training experience, providing communities with the flexibility to design localised training solutions which:

- match their health care needs
- match their service construct, and
- accommodate the fluxes that occur over the duration of a doctor's career.

Strategically aligned partnerships at the regional level must be allowed to develop and not impeded by jurisdictional barriers where state and national policies intersect. This shift will provide the policy setting to establish the partnerships and infrastructure required to train across a broad scope to meet continuing comprehensive patient need.

Discussion: The integrated training hub model provides the supportive policy framework needed to facilitate medical and multidisciplinary training viability throughout rural Australia. This approach builds the connectedness and leadership required to facilitate a quality rural training experience, and instils a culture of teaching which supports workforce retention.

Dying at home is a choice

Fiona Onslow

The District Nurses, TAS

In 2013 the desire to die at home became a more realistic goal for Tasmanians as a project entitled hospice@HOME (h@H) commenced through Commonwealth funding to deliver "Better Access to Palliative Care". The project is a first in Australia and

aims to ensure all Tasmanians who wish to die in their own home are supported and resourced to do so.

Tasmania is ideally situated to provide evidence based results and systems based approaches that can be replicated in other States and Territories. Tasmania has a dispersed population, rural and remote communities, and a high rate of people living alone with limited after hours and weekend support systems.

The project to date has delivered 600 packages of care and is aiming to deliver 2000 over the three year funding period. The delivery of care is through established organisations and h@H is identifying the current gaps in services that impede people achieving their wish to die at home. h@H aims to deliver a quality of life change to the care that can be delivered in the home when meeting that gap.

To deliver this in an evidenced based approach that can be replicated in the future h@H are capturing the qualitative and quantitative data to deliver a systems based approach. Data is captured through the electronic based Client Management System, Mortality Reviews and Collaborative Practice outcomes.

The project team is working with 25 organisations across Tasmania to deliver the in home care approach with care coordination a strong link to the delivery of consistent practices across the State. The main aim has been to shift the method delivery of care away from a 'clinical approach' to 'individual client driven care' thus providing a unique wraparound model of care with a focus on meeting the gaps in care and provisions required for in home palliation at end of life. The gaps identified vary from equipment, support workers, gardening, walking pets, cooked meals and clinical support after hours.

h@H are implementing a system and partnership approach which requires collaboration across varying health and care providers aimed to maintain the focus on the individual who inevitably has complicated issues and challenges. The project is about how to overcome these challenges and break down the silos that currently exist to achieve what an individual wants and be responsive, flexible and adaptable. h@H is delivering this outcome and is striving for the rest of Australia to learn and adapt from the journey.

The health behaviours of rural SA men's shed participants

Chloe Oosterbroek, Gary Misan

UniSA, SA

Background: Australian men's shed participants are generally older, retired, blue collar, rural men often with low levels of educational attainment and suffering socioeconomic disadvantage, which are all characteristics which place them at higher risk of adverse health outcomes. Correspondingly the National Male Health Policy highlights men's sheds as potential vehicle for health promotion activities targeting this at risk group older men. However, for these programs to be effective it is important to better understand the health status, concerns, and health seeking behaviours of the men who attend men's sheds.

Aim: The aim of this project was to determine the health status, health concerns, health knowledge and health seeking behaviour of participants of rural SA men's sheds as a prelude to the design of health promotion activities for men in SA sheds.

Method: A cross sectional, quantitative, exploratory study design was used with data collected using a self-administered paper based survey across 11 of 25 rural South Australian men's sheds.

Results: 154 surveys were returned, identifying a mostly older, retired, lesser educated population. There was a high incidence of obesity and chronic disease, most commonly Type 2 diabetes, depression and cancer. Physical health was the category rated most highly as a concern with the prostate and the heart being the topics for which information was most commonly requested. A significant proportion of participants were interested in information about psychological health suggesting that incidence of mental health concerns was higher than reported. Participants were likely to have seen a GP or other health professional in the previous 12 months, mostly for preventative checks, pain or functional disability. There were knowledge deficits evident regarding the prostate, reproductive health and psychological health. The preferred method of health information delivery was through hands-on, practical approaches.

Conclusion: Men in rural SA sheds report a high incidence of chronic disease together with key knowledge deficits in areas of reproductive, prostate and psychological health. Health promotion programs that target men in sheds should take a

hands-on approach and incorporate the above topics as a priority.

Supporting rural ageing well: how important is the rural?

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¹University of Tasmania; ²Monash University

Background and objectives: Policies and programs to support ageing well form a key plank of government responses to population ageing. Such interventions need to be context sensitive because place matters in ageing and living rurally is likely to shape a particular, if not unique, ageing experience. Our project sought to examine the evidence base available to policy and practice developers seeking to support ageing well in rural contexts.

Method: A highly structured search of the literature to inform an understanding of the particularities of the rural ageing experience yielded a final sample of 163 papers.

Results: Large scale, statistical studies reveal a clear pattern of aggregate rural-versus-urban inequality across a range of measures likely to impact the rural ageing experience. However, a large, eclectic body of smaller-scale, qualitative and semi-quantitative studies reveal that these broad statistical generalisations gloss over huge diversity in rural context, condition and experience, as well as complex and changing distribution patterns of advantage and disadvantage. They reveal that the rural ageing experience will ultimately be a unique product of the interaction of an environment and the resources an individual or group bring to dealing with that environment.

Discussion: Robust but blunt statistical rural-urban comparisons provide strong support for claims for government resources to address rural, especially rural ageing, issues. However, because they gloss over diversity and difference, they are of limited help in understanding complex patterns of advantage and disadvantage and, therefore, in deciding how to most effectively and appropriately target those resources. The more nuanced evidence provided by more discriminating studies do support some broad general understandings of the likely nature of rural character, cultures conditions and issues but at the same time highlight the need to treat these simply as starting points and guides to the questions that need to be asked and answered with more detailed local evidence.

Conclusion: The rural context is too diverse and fast changing for definitive characterisations of rurality. The incomplete and ever-evolving picture emerging from a multitude of small studies provides some generalised understandings and a good starting point but without rigorous testing in the local context, these studies carry the risk of unhelpful stereotyping leading to inappropriate targeting of resources.

Policy recommendation: Government and services providers need to move beyond broad generalisations concerning rurality and ageing and devote more time and attention to unravelling and understanding the complex patterns of advantage and disadvantage in non-urban populations.

Planning integrated outreach: service patterns from the metropolitan and rural hubs

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¹School of Rural Health, Monash University; ²MABEL Survey; ³Department of Epidemiology and Preventive Medicine, Monash University

Background: In Australia, outreach is a key strategy to promote access to medical specialist services to residents in rural and remote areas. Around one in five Australian medical specialists participate in rural outreach work but we lack information about the patterns of outreach by metropolitan and rural-based specialists and how they vary. This information is important to plan accessible and integrated services.

Aim: Explore differences in the patterns of rural outreach by specialist doctors based in metropolitan versus rural locations.

Methods: This paper reports on specialist doctors who travelled to provide services in at least one rural location (ASGC-RA>1) as part of the MABEL (Medicine in Australia: Balancing Employment and Life) study, 2008. Each specialist could report up to three rural locations they travelled to. Firstly, five outreach models were defined (drive-in, drive-out; fly-in, fly-out; hub and spoke; multiple distant; and mixed) according to the distance travelled from the specialist's residence (<300km or >300km) and the number of rural locations visited (1 or 2+). Logistic regression examined the association between specialist base location and model of outreach. Cross-sectional weights were applied.

Results: Of 4,596 specialist doctors, 902 who provided a total of 1401 rural outreach services were included in this analysis. The most common model of service was drive-in, drive-out (n=379, 42%), followed by fly-in, fly-out (n=168, 20%), hub and spoke (n=183, 19%), mixed (n=94, 10%) and a multiple distant model (n=78, 9%). Compared with rural specialists (n=286), metropolitan specialists (n=616) were significantly more likely to provide fly-in, fly-out (OR 4.15, 2.32-7.42) or multiple distant (OR 3.60, 1.79-7.24) and less likely to provide outreach via hub and spoke models (OR 0.31, 0.21-0.46).

Conclusion and policy implications: Models of outreach differ between specialists based in metropolitan and rural areas. Metropolitan specialists are more likely to provide fly-in, fly-out models and less likely to provide hub and spoke services. Fly-in, fly-out models of service, overcome large distances and promote the national distribution of services given most specialists live in the city. However, the utility of this model depends on strong planning to integrate services from different locations and match them to regional priorities. This is easier where 1) regional outreach priorities and service gaps are clearly defined, 2) local health providers, hospital and health centre staff is aware of a predictable schedule of services coming and going and 3) specialists develop outreach services that are efficient, equitable and sustainable.

Help is never far away: the role of Angel Flight

Marjorie Pagani

Angel Flight

Angel Flight was launched as an Australian charity in April 2003 and is the initiative of successful businessman and experienced pilot Bill Bristow AM.

Angel Flight coordinates non-emergency flights to assist country people to access specialist medical treatment that would otherwise be unavailable to them because of vast distance and high travel costs. All flights are free and may involve patients travelling to or from medical facilities anywhere in Australia.

Marjorie Pagani was recently appointed as Angel Flight's Chief Executive Officer after serving as pro bono aviation lawyer for the charity since its inception, and being one of the founding volunteer pilots.

Marjorie will talk about what Angel Flight does; the scope and limitations of the service; who can access Angel Flight and the range of geographical locations; as well as highlight the difference between the transport options offered by Angel Flight and the services provided by the government travel assistance plans, the Royal Flying Doctor Service and the Air Ambulance.

Angel Flight receives no government assistance and is funded entirely by public donations, and the volunteer pilots and drivers who get disadvantaged rural people to medical appointments. Marjorie will explain the invaluable role played in this serviced by the remote area health professionals who refer their clients to Angel Flight for transport.

Learning from final year nursing student stories of rural practice

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Federation University Australia, VIC

This paper reports on a project that gathered final year nursing students' reflections on clinical events or situations that they experienced during rural clinical placements that they felt were memorable and meaningful for their future practice as Registered Nurses. Students from a rural university were invited to participate and describe and then reflect on 2 events they experienced during their clinical placements over the 3 years of their studies, which were predominantly undertaken in rural and regional health care settings. Data were gathered online in the form of de-identified stories uploaded as forum postings, with each participant providing a structured description of both events and then a reflection on how these events might contribute to their successful transition to practice. This project was underpinned by a storytelling pedagogy based on compelling evidence that stories provide an ideal vehicle to promote reflection and prompt deep learning. Humans are 'hard-wired' to learn from stories as both the teller and the listener, and so a storytelling learning framework was considered ideal to guide this project.

A total of 275 narratives about clinical events and student reflections on these were captured, and the data analysed thematically to identify emerging key themes such as 'Respect and Disrespect', 'Fitting In' 'Compassion and Caring', 'Administering Medications', 'Ethical Dilemmas', 'The Realities of Practice' and 'The Power of Role Models'.

These themes were identified by all members of the project team using an iterative process, with the aim of creating insights into future students' learning needs for clinical placements. The data will inform a series of articles for publication, with the primary aim of sharing these insights to contribute to a greater understanding of students' learning experiences during placements. This paper provides an overview of the processes involved in gathering, analysing and reporting on the data. Finally, some of the preliminary findings will be presented, as they provide a window into the experiences of nursing students in rural and regional health contexts.

Quality standards for emergency departments: a roadmap to excellence

Sam Denny, Didier Palmer

Australasian College of Emergency Medicine, VIC

It is widely acknowledged that emergency departments (EDs) in Australia and around the world face increasing pressure due to growing demand. With growing demand comes other challenges such as improving the patient experience and the continuing need to provide high quality and safe care to patients. The locality of an emergency medical service should not negatively impact on the quality and safety of care provided. This is a challenge in Australia given the spread of the population in rural and remote areas but this can be addressed with agreement on expected standards of care and improved resourcing for these requirements. These standards have been developed and tested with expertise from both metropolitan hospitals and rural settings.

The ED is a complex environment which requires the combined effort of clinical and administrative staff to ensure all patients receive timely and effective care. With this in mind, a collaborative project between the Australasian College for Emergency Medicine, the College of Emergency Nursing Australasia and consumers has been undertaken to develop the Quality Standards for Emergency Departments and hospital based urgent care services. These Quality Standards aim to provide guidance improve the quality of care offered to patients, their families and carers who present to a hospital for urgent care. A wide consultation process resulted in collaborative effort with other colleges and organisations with interest in rural health.

The implementation of quantitative targets in EDs has historically been associated with considerable

disadvantages such as difficulty in data collection, or more seriously, care being re-focused to a time target rather than the patient's care pathway. Consequently, in these quality standards a qualitative focus has been used. It was considered that this would enhance compliance for clinicians as it would promote the quality improvement process, rather than the standards being used to measure performance.

These Quality Standards for EDs will offer departments guidance through standards and defined criteria to aspire to without fear of penalties. In this way, it is anticipated that the standards will allow EDs to better engage in quality improvement activities, and influence change from within.

Lessons from the best to better the rest: quality improvement in Indigenous primary health care

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Background: There is a high degree of variability in the response of Indigenous primary health care services to continuous quality improvement (CQI) activity. Analysis of continuous quality improvement (CQI) audit data from over 130 services in the ABCD National Research partnership has identified six high-improving services (HIMPS) that show consistent improvement over three or more audit cycles in two or more audit tools. Multiple case studies are being used with these services to explore the secrets of their success.

This project aims to explore the strategies used to support quality improvement within these HIMPS, including engagement and support of a stable workforce, linkages with organisations in the broader health system, supportive funding and policy platforms and other factors

Methods: Multiple case study methodology and a mixed methods data collection approach have been adopted. Cases are defined as a primary care service and its staff, patients and community.

Case study profiles are developed initially using existing quantitative data encompassing governance, location, accreditation, use of recall and record systems and CQI (one21seventy) audits. Other sources include ABS demographic data, demographic data, human resources data and systems assessment tool reports where available.

Two comprehensive visits are scheduled to each site to obtain detailed qualitative data. Approximately twenty to thirty detailed interviews with local clinical staff, PHC clients and management are being performed.

Relevance: The six primary health care services (PHCs) located across the Top End of Australia chosen for in-depth analysis in this project are remote and rural and predominantly serve Aboriginal and Torres Strait Islander communities. There is a mixture of community controlled and government PHCs.

Results: Data collection is partially complete and initial results have begun to show common HIMP characteristics. Relevant factors examined so far include the historical context, policy and fiscal environment at macro-system level; regional health system, support networks, community factors and functioning and broader health workforce at meso-system level (all outside the case) and service leadership and governance, service processes, staff characteristics and patient factors at the micro-system (or within case) level.

Conclusions: Understanding variability in response to CQI initiatives is vital to comprehend how PHC services can operate successfully in remote and Indigenous communities. Lessons from these HIMPs may then be transferred and applied to other similar services.

Reporting by location—measuring health needs in NT rural and remote communities

Penny Parker
CareFlight Limited, NT

In 2014, the Top End's aero-medical retrieval service developed a series of reports that identify key diagnostic related groups and their associated sub groups for the Northern Territory (NT) Department of Health's Joint Aeromedical Services Operations Committee (JAMSOC). These 'by location' reports provide a unique insight into the nature and frequency of the clinical conditions being retrieved across the territories Top End.

A review of data captured in the retrieval database for the July–September 2014 quarter revealed the retrieval of more patients with a provisional diagnosis of bronchiolitis and bacterial pneumonia than any other respiratory condition, more abscess and cellulitis than any other musculoskeletal

condition, more missed dialysis than any other renal condition and more appendicitis than any other gastrointestinal condition. This data is broken down and reported by type and location to provide a regular clinical snapshot.

Reports identifying the time of aeromedical retrieval referrals have also been developed. We now know that the highest rate of referral from the Top End's regional hospitals occur between 1300 and 1500; and across all Top End remote communities, the majority of referrals are made at 1800. These referral times appear to be linked to the daily routines of individual health services. Having access to this information may assist these services when developing models of care.

The burden of disease in Indigenous communities coupled with the challenges arising from the vast geographic landscape that is the Top End ensures that measuring the health needs of rural and remote Territorians is both complex and challenging. Although rudimentary, these aero-medical retrieval reports have the potential to inform a targeted approach to health promotion and disease prevention in rural and remote communities that supports the national goal of 'closing the gap' in health outcomes.

Incidence, prevalence and challenges of managing CTEV in the Top End

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Congenital talipes equinovarus (CTEV) or clubfoot, is a largely idiopathic condition affecting 2.1:1000 Australian infants. The Ponseti method of treatment is the international gold standard for treating CTEV and is largely considered curative and cost-effective. It has been previously established that there is an increased incidence of CTEV in Indigenous populations in Australia, 3.5:1000 but there is no published data on incidence or prevalence of CTEV in the Northern Territory (NT), where 26% of the population identify as Indigenous.

We reviewed incidence and prevalence of CTEV in the Top End district of the NT from 2001 to 2006 birth cohorts. Initial data collection reveals a total 58 cases of CTEV across the Top End, with 49 identified as Indigenous. Incidence of CTEV in Indigenous population calculated at 6.15/1000 births whilst non-Indigenous incidence was 1.0/1000.

Genders were represented with 60.8% of Indigenous patients being male, 39.2% Indigenous cases were female, 66.6% of non-Indigenous were male and 33.4% non-Indigenous were female.

The authors are currently undertaking further data collection of years 2006-2012 and will be investigating the challenges of delivering treatment to a population largely residing in remote and rural communities. Delivering Ponseti treatment to rural and remote population dictates long stays at urban treatment centres with long travel times and total days away from home. This increases burden of care on the family and community and is costly to health service providers. The tropical climate also plays a challenging roll with compliance with full plastering, with temperatures often greater than 30degrees in humid conditions.

The authors aim to present full data collected from 2001-2012 covering the interesting epidemiology of CTEV in the Northern Territory and explore the unique challenges of Ponseti treatment delivery to remote Australians in the Top End. Analysis of this data will help to guide practice changes in order to deliver gold standard evidence based early intervention to rural and remote infants with CTEV in the Top End.

Outcomes of a population health program at Orange Aboriginal Medical Service

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Background: A population health approach seeks to address the health of the whole community rather than focusing solely on individual care. This approach is used internationally and is consistent with strategic plans in NSW to improve Aboriginal health outcomes through partnerships, consideration of the social determinants of health and outcomes monitoring. The Orange Aboriginal Medical Service (OAMS) is a regional Aboriginal Community Controlled Health Service (ACCHS) in NSW. There is currently little literature on the outcomes of the implementation of a population health program at an ACCHS.

Aims: The Population Health Program within OAMS aimed to develop a population health approach to improve the health outcomes of the Aboriginal

Community and to develop staff skills in population health and research.

Methods: The Program began in February 2013 as a collaborative initiative involving OAMS, the Universities of Sydney (USyd) and Western Sydney (UWS), the Western NSW Medicare Local and the Western NSW Local Health District. Organisation representatives form the Population Health Committee and provide direction and support to the Program. The Program has involved staff workshops to identify the health needs of the community served by OAMS, to identify the current services provided by OAMS, gaps in data collection and services, and improvements necessary to address these health needs and service gaps. This is an ongoing iterative process and monitoring outcomes is an important component of this approach.

Results: To date the outcomes from this Program have been: i) a Health of Our Community Report, ii) three research projects, iii) receipt of a tobacco control grant and employment of a tobacco control coordinator; iv) recognition of a deficit in clinical data with resultant improvements in data collection; v) quantified improvement in staff knowledge and confidence in population health; vii) growth in the number of partners and viii) recognition of gaps in service provision with resultant service improvements in patient follow up, primary health prevention and engagement with community organisations and service partners.

Conclusions: A Population Health Program delivered from within an AMS is effective in building partnerships, research and developing staff skills for improving the health of community. A program similar to that implemented at OAMS may assist rural, remote and regional AMS to address the health needs of their populations. This presentation will describe the Program and give insight into the lessons learned and the ideas and actions generated.

Challenging Conversations for Clinicians

Rodney Peadon, Natasha Alexander, Jessica Doland

Mid North Coast Local Health District

According to the Silence Kills study, every day many health care clinicians work next to colleagues and see them cut corners, make mistakes, demonstrate unacceptable behaviour or serious incompetence, however, less than one in ten of these clinicians

have fully discussed their concerns with their co-workers, even though they may be standing right next to them. Avoiding these crucial conversations endorses sub-standard work practices and can severely compromise patient safety and care.

The Challenging Conversations for Clinicians program is an interdisciplinary course focusing on teaching and developing communication skills directly related to challenging conversations faced by clinicians. This course was developed through funding from RHCE stream 2 grants and utilises simulation based learning centred around PLEASE© Conversation Framework. The PLEASE© Conversation Framework is a foundation from which a conversation is built on. It enables the individual to prepare for the conversation, understand the other person's behaviours, empower reflection on feedback and coach to take responsibility. Video based trigger scenarios are used to contextualise the conversation, then individuals are given the opportunity to practice the PLEASE© framework by delivering four challenging conversations throughout the day. Expert simulation facilitator's then provide structured observational feedback using simulation debriefing techniques. This provides the opportunity for the participant to experience four challenging conversations with the facilitator delivering four different personas and then receiving one on one direct feedback to enhance their learning opportunity

The Challenging Conversations for Clinicians is a new tool for their toolbox and is about empowering individuals to speak up and confidently address concerns with co-workers. The aim of this program is to influence cultural change to improve patient safety and quality of care, reduce clinical errors and promote a cohesive work environment.

Healthy lifestyles: active community collaboration between council, health providers and consumers

Dianne Penberthy, Jane Newman

Mid North Coast Local Health District, NSW

This program empowers rural populations to make informed choices and lifestyle changes to improve their health and reduce the risk of disease and complications from existing chronic disease.

Health professionals from the Mid North Coast Local Health District (MNCLHD) and Exercise Physiologists (EP) delivered Healthy Eating Activity and Lifestyle (HEAL™), and Losing It in the Bush

(LIITB) programs to 600 people. 26 programs, including 3 Aboriginal programs, were delivered. The program was in partnership with Port Macquarie Hastings and Kempsey Shire Councils utilising funding from the Healthy Communities Initiative.

People with risk factors and/or chronic disease associated with inactivity and poor nutrition were targeted.

The team included Healthy Communities coordinators, occupational therapist, exercise physiologists (EP), dietitian, women's health nurse consultant, health promotion coordinator and council staff. The 10-12 week programs consist of one hour each of exercise and education.

MNCLHD's contribution was via the following;

- LIITB, a locally developed healthy lifestyle program that targets small communities' specific needs delivered by health professionals.
- HEAL™ a prescriptive program that targets larger populations;
- MY HEAL™ program specifically for Aboriginal people

Participants received a manual and access to National and State resources with information relating to nutrition, exercise and motivation. This empowered participants to make lifestyle changes after completion of the program.

Pre and post program surveys relating to nutrition, lifestyle and medical history were completed. Physiological measurements completed the assessment. Openness in dialogue encouraged discussion of ill-health; after which participants were given realistic intervention strategies.

Many participants demonstrated significant improvements in weight, waist circumference, blood pressure and chair stands. Both Council areas demonstrated above average results compared to National data.

The program informed and encouraged communities to live life well, reduce the risk of complications from chronic disease through action and education, delivered in an environment of respect and collaboration.

The success of the program was due to it being delivered in local facilities so participants didn't have to leave their community.

Outcomes include: social connectedness, friendships, support networks, walking groups and the establishment of social groups, reported by participants as being a highlight of the programs, have been formed in even the most isolated areas.

This model encourages community engagement as the health workers are able to determine the communities' need for preventative health by meeting with community members prior to the program. It provides education on specific illness or risks via appropriate health professionals and adapts exercise programs to fit the communities' resources and environment.

☆ Improving outcomes in rural/remote communities through development of the gen Y workforce

Leigh Philpott

Hunter New England Local Health District, NSW

Consumer outcomes and experience of mental health care in rural and remote Australia is negatively impacted upon by significant challenges in the recruitment and retention of high performing staff. Furthermore as the workforce rapidly ages, particularly in rural and remote services, the need to recruit and retain staff from generation Y becomes key to not only providing a stable workforce, but also delivering high quality services. Over the course of three years the service undertook a journey of service redevelopment and generational change, which took it from a low performing service with critical recruitment issues, to a high performing service with full staffing and most importantly high levels of consumer satisfaction and outcomes. This journey was undertaken using a strategic plan which focused on the recruitment, development and retention of new staff, proving that rural disadvantage can be overcome in the recruitment and retention of quality staff.

By undertaking process redesign using CORE values as a framework, combined with developing processes aimed at a new generation of workers, new staff are engaged and supported from potential applicant through to high performing employee. The service was able to demonstrate increases in clinical performance and outcomes across a range of clinical quality domains and achieve a sustainable, full staffing profile.

This paper will not only discuss how over the space of three years a small rural and remote mental health service became a leader in recruitment,

retention and subsequently patient care, outperforming not only its rural counterparts but also its metropolitan ones across human resource and patient outcome measures, but it will also discuss the many learnings and insights gained in regards to building and developing the rapidly growing generation Y workforce. The learnings, whilst gained in the context of a small rural/remote mental health service, are readily transferable across all manner of health services, both rural and urban. The paper will also discuss recommendations based in this learning for future policy regarding developing and supporting the rural workforce. Most importantly, this paper will demonstrate very clear links and provide discussion and learnings regarding improving health outcomes through getting staff recruitment, retention and development right and makes a strong argument for increased focus on this area as a key strategy for improving health outcomes for rural and remote communities.

Participation of Indigenous children with disabilities in remote communities

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Top End Remote Disability Services Team, Department of Health Service, NT

Background: There is currently no literature or best practise guidelines around service provision for Indigenous children with disabilities living in remote communities. Despite there being a significantly higher rate of disability amongst Indigenous Australians¹, little has been documented about the day to day experiences of these children and their families. With the rollout of the National Disability Insurance Scheme, it will be mandated this population have better access to allied health service and likely that a number of new service providers will enter this area. Currently, there is no available evidence to guide allied health professionals providing services to this population.

Aim: To summarise past research about participation of Australian Aboriginal children with disabilities in remote Aboriginal communities.

Methods: Pubmed and Medline databases were searched using the following search terms: Oceanic Ancestry Group, Indig*, Aborig*, First Nations, Native American, Maori, Child*, youth, kids, pediatric*, paediatric*, participat*, disabilit*, Cerebral Palsy, Physical Ther*, Physiotherapy, Allied health, Occupational Ther*.

Relevance: One core purpose of allied health input for children with disabilities is to promote 'participation' in all areas of life, including in the home, school and the wider community. For allied health professionals working in disability, an understanding of what 'participation' means for different people is essential to guiding service provision.

Results: There is often no single word to describe disability in Indigenous languages and there is a strong focus on identifying the person in terms of what they are able to do^{2,3}. Unique barriers preventing participation of Indigenous people with disabilities in remote areas exist⁴. Some barriers are associated with the person's disability while others involve the broader environmental, cultural and social factors (i.e. infrastructure, attitudes towards education, shame)⁴. For Yolgnu people, major barriers to participation have been identified as access to assistive technology, transport, housing and access to public buildings⁵. No studies have looked explaining what participation is or means for Indigenous people with disabilities.

Conclusions: To provide culturally appropriate, client-centred allied health services, it is essential to understand the meaning, barriers and enablers of participation for children and families in order to achieve positive, functional outcomes. Moving towards the full implementation of an NDIS service delivery model in the Northern Territory, it is essential for allied health services to understand participation in a local context and use this knowledge to provide meaningful therapy for children, families and communities.

Policy recommendation: Further research to understand how participation is understood by Indigenous children with disabilities living in remote Aboriginal communities is needed to guide allied health service provision. A qualitative research project to investigate participation of children with disabilities in home and community life has been planned. A cultural narrative analysis using participatory action research will occur in a remote Aboriginal community in the Northern Territory. The results will be used to inform service providers about what is participation for this population, and hence, ensure services are culturally appropriate and relevant.

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Preparing rural health services for climate change

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Climate change threatens to have adverse health consequences for rural Australians. The pre-existing health disadvantage of those living in rural communities leads to an increased vulnerability to the health impacts of climate change. There have been calls for an integrated assessment of the impacts of climate change in rural Australia and community-based research involving rural stakeholders to develop adaptive strategies for climate change.

The World Health Organisation has emphasised the importance of regional assessment of the health impacts of climate change and has highlighted the need for research identifying knowledge gaps. Investigating the role of health services in the broader public health response to climate change is a research priority identified in the National Climate Change Adaptation Research Plan. This study examined rural Health Service Manager (HSM) attitudes and recommendations towards climate change and its impact on health by administering a survey to rural HSMs in the south west of NSW. HSMs play a crucial role in rural health service planning and management, and also hold a respected role within their local community; warranting an investigation of their knowledge and perceptions on climate change and extreme weather, and a summary of their recommendations. This study builds on a previous study in the region

examining the perceptions and recommendations of General Practitioners. This additional study enables comparison and the development of a comprehensive overview of the perceptions of local health leaders towards preparing rural health services for extreme weather and climate change.

The study will lead to an improved understanding of HSM perceptions of the impact of climate change on health in rural communities. The information gathered will assist in the development of adaptation plans for health services in rural Australia with particular regional relevance in the south west of NSW. An incidental benefit may be the raised awareness of rural health service managers of the interactions between climate change and health.

The health behaviours and attitudes of working men

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Introduction and objectives: Australian men have poorer health outcomes than women, with shorter life expectancies and higher mortality. In the North Queensland regional town of Mackay, the health status of men is below the national average. Help-seeking behaviour of men has been reported to contribute to poor health outcomes due to delay and inadequate utilisation of health care practitioners. The aim of this study was to investigate the general health and help-seeking behaviour of men in the wider Mackay area and explore motivations and barriers to undertaking regular health checks.

Methods: A cross-sectional survey of working men, including fly-in fly-out (FIFO) and drive-in drive-out (DIDO) workers, was undertaken in the wider Mackay region (Sarina, Dysart, Clermont, Moranbah, Collinsville, Bowen, Proserpine, Mackay and surrounding areas). Participants were recruited directly, as well as via communication with industries in the local community. The local print, radio and television media assisted with awareness and the recruitment process. The survey used electronic (Survey Monkey) and paper-based methods and took approximately 10 minutes to complete. Information regarding variables, including age, industry, FIFO/DIDO status, and health status (smoking, weight, alcohol, depression, GP visits) was collected. Participants were also able to provide responses regarding where they seek health-related

information and barriers to accessing health care, for qualitative analysis. Data will be analysed using SPSS. This study was approved by the Townsville Health Service Research Ethics Committee and funded by the Mackay Base Hospital Private Practice Trust Fund.

Results: To date, 250 surveys have been completed with recruitment continuing to the end of 2014. Data will be statistically analysed for associations with help-seeking behaviours and industries, marital status, age groups and FIFO/DIDO status. Thematic analyses of questions about motivations to have regular health checks will be conducted by the research team.

Conclusions: To be developed at the conclusion of the data analysis.

Changing and adapting: exploring an arts-health-environment interdisciplinary partnership

Christine Putland
Country Arts SA

The devastating effects of drought on the natural environment surrounding the mouth of the Murray River and Lower Lakes in South Australia during the last decade were well publicised, sparking controversial debates about water use and the respective responsibilities of governments and private interests. Less widely discussed were the impacts on the health and wellbeing of communities, the people who lived and worked, farmed and fished in this unique environment, including the traditional custodians of the land and waters. With the drought in its tenth year, an arts-based program was conceived in 2010 to support these communities' responses to the profound changes in their environmental, social, political and economic landscape by giving creative expression to their experiences, struggles, and resilience. As the environmental crisis subsided, the program evolved into an ambitious three year partnership between federal, state and local government agencies. Since that time health, environmental and arts organisations located in the Southern Fleurieu Peninsula, Murray Mallee, Kangaroo Island, Mt Gambier and the Coorong and Lakes communities have worked collaboratively to develop community-based arts initiatives exploring themes of 'change' and 'community wellbeing'. Local and visiting artists were engaged using diverse art forms including music, writing, cartoon, puppetry, sculpture, public

art, digital animation and film, to create both ephemeral and enduring works.

In recognition of the challenges associated with this complex interdisciplinary methodology delivered in geographically dispersed locations, an independent researcher was engaged to work closely with the team throughout. Incremental feedback from the perspectives of partners, organisational staff, artists and community participants has been analysed to document the program's development and inform continuous learning. As well as appraising program progress and outcomes, the research explores the broader potential for arts-based practice to enhance the capacity of local agencies to provide support to such communities. The key elements that enable artists and arts practice to work effectively within community health and environment sectors, in particular, are identified. These results are being reported in the form of a 'Model of Practice' for embedding arts partnerships in non-arts organisations.

The paper will present an overview of the program model of practice, demonstrating how community aspirations and organisational goals were integrated through close collaboration with health workers and community members. Significant outcomes for all of the communities involved, including the traditional custodians of the lands and waters, will be highlighted.

'Rural in Reach': delivering health and wellbeing services to regional Western Australia

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Often rural and remote communities are too small to support traditional models of health delivery locally, so residents must access care from larger urban centres. Unfortunately, access to health services provided in larger centres remains a problem for many residents of isolated settlements. In many cases, their inability to access health services when required results in health needs not being adequately met, lack of continuity of care and an absence of monitoring of the effectiveness of services in terms of health outcomes. It is clear that 'models of care in rural and remote areas must differ from those in metropolitan communities, incorporating strategies to account for these problems.

In 2011 a grant was made available by the Government of Western Australia's Department of Regional Development (funded by the Royalties for Regions program) and the West Australian Country Health Services for a four-year pilot project, now called Rural in Reach. The project aims to offer a range of services including one-to-one counselling support through video conferencing, community education/health promotion and professional development opportunities to women, their families and local agencies in rural and remote Western Australia.

In 2012 a West Australian University commenced a three year independent evaluation of the Rural in Reach project. The first year focused on process, the second year on impact and the third year on outcomes. The first major evaluation report (October 2013) indicated the project is a successful enterprise with a strong commitment from key stakeholders that it continues to increase rural and remote access to health and wellbeing services. The second report (March 2014) demonstrated conclusively that, over time, outputs are progressively greater in number and range and that outcomes for clients are very positive and far reaching benefiting the individual, their family and their community. The final report (January 2015) explored if and how the project is meeting the original objectives for the service. The three year evaluation demonstrated that the project is meeting these objectives in a principled, coherent manner. Outputs indicate that the project is an effective provider of counselling and allied health professional support services across rural and remote Western Australia. Concluding that this innovative, collaboratively designed and implemented project is probably the signpost to the future of allied health and wellbeing service delivery and community capacity building in rural and remote areas. This interactive presentation shares the evaluation findings and future recommendations.

A rural community seeks possibilities in addressing youth homelessness

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¹Flinders University Rural Clinical School; ²Riverland Innovative Community Action Network; ³Community Youth Justice

Introduction: Characteristics of youth (15-25 year olds) at increased risk of homelessness in Australia are being female, live in poverty, of Aboriginal and Torres Strait Islanders heritage, have a mental

illness, come from a non-English speaking background, live in state care or live in rural and remote Australia. Rural youth homelessness is described as hidden and often an unacknowledged issue for the general community. Homelessness can result in young people disengaging from educational, training and employment pathways and may impact significantly on their physical and mental wellbeing, and social behaviour. Rural homelessness has not been extensively researched, with studies tending to be localised to one region and recruiting small numbers of participants. The level of youth homelessness varies across rural areas depending on demographic shift, economic distress, labour patterns, the cultural makeup and social resources.

Aims: A working party of rural youth service providers in partnership with local university researchers developed a community project in early 2014 with the following aims:

- To understand the local issues influencing youth homelessness in the Riverland region of South Australia.
- To develop useful approaches to address youth homelessness in the Riverland region.
- Information sharing and networking between existing service providers.

Methods: Current literature was reviewed with a focus on youth homelessness in the rural context, and the effectiveness of strategies and models already implemented by communities.

A 'World Café on Youth Homelessness' was held to identify issues specific to Riverland communities, and to explore opportunities for possible accommodation solutions. Relevant service providers and community members with an interest in rural youth homelessness were invited to participate. Group discussions were facilitated, and centred on core focus questions. These questions were developed in partnership with local providers with expertise and knowledge within the local rural homeless youth context.

Results: The main themes emerging from the world café were:

- Riverland-specific issues
- raising awareness and literacy
- lack of youth specific accommodation
- connecting homeless youth to their community

- cultural and gender issues
- existing homeless supports and services
- challenges for youth under 16 years
- innovative strategies.

Conclusions: The Riverland service providers identified that research could assist in providing an evidence-based approach, informing the development of programs and policies to better support rural homeless youth. They also affirmed that while there were many challenges in trying to meet the needs of rural homeless youth in the Riverland, there was also a commitment to collaborate and identify possible solutions.

A settings approach: Healthy@Work— a model of a health promoting workplace

Kate Robertson

Department of Health, NT

Aims: To reduce the risk of staff for developing a preventable chronic condition by increasing fruit and vegetable intake, increasing participation in physical activity, reducing smoking and reducing the harmful consumption of alcohol.

Methods: The Healthy@Work program is a multi-strategy workplace health promotion project. The NT Health Promotion Framework was used as a guide to creating supportive policies and physical environments within the workplace and establishing a culture that encourages healthy lifestyles. Upon implementation in 2012 the program sought to bring about positive changes in individual healthy lifestyle behaviours.

Relevance: Healthy@Work was implemented across an organisation which includes staff based in urban, rural and remote locations across the Northern Territory. A Health Promoting Workplace integrates policies, systems and practices conducive to health at all levels of the organisation. The workplace is an important setting to be health promoting as the workplace environment can influence the physical, mental, social and economic wellbeing of its employees. This paper aims to share the successes and challenges of implementing a Health Promoting Workplace using the Healthy@Work model.

Results: Endorsement from the Chief Executive demonstrating the commitment of the organisation to provide a workplace that supports good health

and wellbeing for all staff. Increased access to health information, resources, health risk self-assessment tools, health promoting workplace related policies and a workplace health and wellbeing online forum staff via staff intranet page. Increased staff engagement and ownership over the development and implementation of workplace specific health and wellbeing activities. Healthy Lifestyle Sponsorship Fund program initiative participants reported improvements to fitness, nutrition, team cohesion and energy levels. System level integration of a health and wellbeing focus into the Workplace Health and Wellbeing Strategy and reporting procedures. Increased capacity to plan, implement and evaluate workplace health and wellbeing programs through the provision of Champion training and Network Catch-Ups. Annual Staff Health Survey conducted in 2013, one year after baseline data collection indicated modest improvements to some healthy lifestyle behaviours amongst staff surveyed.

Conclusions: Healthy@Work as a Health Promoting Workplace model has succeeded in increasing awareness, engagement and capacity amongst staff with regard to healthy lifestyle behaviours in the workplace. Furthermore, a sustainable Health Promoting Workplace model has been developed which in the long term could contribute to decreasing the risk profile of staff for developing a preventable chronic condition.

Overview of CRC research and education programs

Sylvia Rodger

Cooperative Research Centre for Living with Autism Spectrum Disorder, QLD

In this paper I will provide an overview of the research programs being undertaken by Autism CRC (Cooperative Research Centre for Living with Autism Spectrum Disorders) established in July 2013. These three programs are:

- A better start—diagnosis and early intervention practices
- Enhancing teaching and learning during the school years
- Finding a place in society during post school and adult years.

The projects invested in to date, with particular emphasis on those that have immediate relevance to regional, rural and remote health and educational

practitioners will be outlined. Specifically the following will be discussed:

- developmental surveillance and proposed national diagnostic protocol
- survey of diagnostic procedures across Australia (co-investment Department of Social Services)
- graduate certificate in autism diagnosis and assessment and scholarship
- early years behaviour support project with tele-classroom consultation in rural/remote schools
- School Connectedness Project with rural as well as urban focus
- adult longitudinal and transition studies (national recruitment)
- health and wellbeing tools/resources for health professionals and adults with ASC.

Methods of engaging with the research work of the Autism CRC as research participants as well as research applicants will be discussed. In addition the important role of the National Rural Health Alliance in shaping research outcomes that are useful for rural practitioners and engaging with dissemination and knowledge translation activities will be highlighted.

Maternity services in remote Australia

Margaret Rolfe, Jo Longman, Lesley Barclay, Deborah Donoghue, Geoff Morgan

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Introduction: Of the nearly 300,000 babies born in Australia each year, 2.8% are born in remote and very remote areas, and accounts for over 9% of rural births.

Aims: To explore the distribution of maternity services in remote and very remote Australia, and to identify factors associated with that distribution.

Methods: The first step of our study, the Australian Rural Birth Index was to identify public health facilities which serviced community catchment populations of 1,000 to 25,000. These community catchments were identified as being within 1 hour travel time (driving) in any direction from the facility. Catchment was calculated using the geographic location, road network calculations (based on driving speeds and type of road), and Geographical

Information Systems. Small geographical areas with known estimated populations and birth numbers (over 5 years) were overlaid onto the catchment area and area-weighted population and birth numbers calculated. Similarly parameters were determined such as percentage of Aboriginal and Torres Strait Islander peoples and of women of child bearing age, social economic status of the population, population density, birth rate and travel time to the closest maternity service with emergency surgical capabilities.

Services in remote and very remote areas were identified and their distribution, characteristics and level of maternity services were assessed using Chi-square tests and logistic regression. Sensitivity analyses investigated the impact of increasing the catchment area.

Results: We identified 260 facilities for rural and remote populations between 1000 and 25000, of which 109 offer birthing services. Of these 82 were located in remote and very remote Australia, with 65 having no local birthing services.

The 17 facilities with birthing services all had at least emergency Caesarean section capability and were located in Western Australia (7), Queensland (5), South Australia (3) and Northern Territory (2). Only 5 of these were in very remote Australia. The majority (n=16) were over 3 hours road travel time to the next nearest birthing service with surgical capabilities.

The catchment population size, birth numbers, birth rate, and population density were significantly lower for remote/very remote maternity services with no local birthing capabilities. The distribution of birthing services more likely to be in areas where the proportion of Aboriginal population ranged between 10% to 30%, and the catchment socio-economic status was relatively low and travel time to the next nearest CS service was between 3-4 hours, however none of these attributes retained significance in a model inclusive of catchment birthing numbers.

Conclusions: Although the proportion of the Aboriginal population, socio-economic status, and travel time to alternative birthing services are implicated in the distribution of birthing services in remote Australia, these are far outweighed by the size of the catchment birthing population.

ANZAHPE ... highlighting possibilities for rural health professional educators

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The Australian and New Zealand Association for Health Professional Educators (ANZAHPE) is the peak professional body for all those involved in health professional education—educators and students. It aims to promote, support and advance education in the health professions, and to facilitate communication between educators.

One of the association's stated objectives is:

To ensure, for the benefit of the community in general, that medical and health professional education is fostered and developed to maintain the highest possible standard, to the end that medical and health professionals are better trained, equipped and educated to provide medical and health assistance to the community.

ANZAHPE will present the range of opportunities it offers across all health professions and locations which includes:

- Meetings: The ANZAHPE Annual Conference, centred each year around a specific theme, offers an opportunity for sharing ideas and information, networking and professional development.
- A refereed journal: *Focus on Health Professional Education* is published three times a year. The journal includes original papers and other contributions on all aspects of health professional education, including undergraduate, postgraduate and continuing education.
- Awards: The association sponsors a number of awards aimed at providing recognition and encouragement for educators, researchers and students.
- Networks: *The ANZAHPE Bulletin* is published four times a year and includes current events, personal viewpoints and Association news.

ANZAHPE's presentation will highlight:

- the benefits to individuals and organisations in academic or clinical settings of engagement with a representational body for those involved in health professions education

- ANZAHPE's ability to facilitate the coming together of educators from all health professions
- the membership structure which provides a pathway from student member to full membership to encourage early career educators to continue their professional development with ANZAHPE

ANZAHPE is a collegial body that can provide meaningful interaction for rurally based academics, clinical supervisors, researchers in health professional education and staff of health education units together with students of health professional courses and students of higher degrees.

In highlighting ANZAHPE to rural educators we aim to increase awareness with those who could benefit from the various opportunities ANZAHPE offers, and for ANZAHPE to acknowledge the importance of engagement with rural educators to ANZAHPE'S overall mission to represent the health professional education workforce.

Clinical pharmacists connecting with patients in rural and remote towns via telehealth

Michelle Rothwell, Adam Hogan
Queensland Health, QLD

Aim: A successful funding application for rural and remote revitalisation is allowing for delivery of a professional pharmacy service to patients in a large rural and remote area of Queensland. The clinical pharmacy service is delivered via telehealth, from a medium sized rural hospital to seven rural and remote health care facilities, covering an area of approximately 160,000 kilometres. The main aim of the new service is to provide equitable access to a pharmacist for rural and remote patients and clinicians. Patient medication reviews are now taking place and future support for visiting medical officer's and staff medication in-services are being developed as part of the new pharmacy service.

Methods: Clinical Pharmacist Medication Review

Infrastructure for videoconferencing was already in place at the rural and remote facilities. A clinical pharmacist outpatient clinic was set up using the Hospital Based Corporate Information System (HBCIS) for appointment booking and activity data collection. Nurses identify patients from their communities, thought at risk from medication misadventure, using referral criteria adapted from the Australian Pharmaceutical Formulary and

Handbook.^{1,2} An appointment letter and explanation brochure is emailed either direct to the patient or to the patient via the nurse; the patient is advised to bring all their medicines with them to the consult. The nurse attends the consult with the patient in their community and the pharmacist conducts the medication review via telehealth. An electronic medication list is compiled for the patient and any pharmacist recommendations are then communicated to the general practitioner/Royal Flying Doctor Service. Data collection includes telehealth activity from HBISC to measure patient uptake; patient and nursing staff surveys to measure service satisfaction and pharmacist interventions and their outcomes.

Relevance: The consequences of 'medication misadventure' have been highlighted, prompting the development of cognitive services to enhance the management of medication use³. It is well established that in rural communities timely and quality access to medication services remains a significant and growing problem⁴ and previous pharmacy services to the seven rural and remote facilities consisted of supply and occasional phone information for nursing staff.

Results: Nursing staff at the seven health care facilities are actively engaged with the pharmacist outpatient clinic and are fully supportive. Nursing staff immediately identified patients at risk of medication misadventure in their communities and patient consults are now underway. Preliminary results show good patient uptake of the service.

Conclusions: It is expected that data collected from this new service will serve to highlight telehealth as an appropriate and accepted service delivery model for professional pharmacy services in rural and remote communities. Telehealth can enhance the provision of pharmacy consultation to rural areas improving patient access to a pharmacist and decreasing patient risk of medication misadventure.

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Practising ethically as a rural psychologist

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As an undergraduate [psychology] student, I sat through my university ethics lectures in a state of rising anxiety ... The lecturer stated that under no circumstances, should psychologists engage in multiple relationships ... Then another academic, a practicing psychologist in a regional town joined the lecture. He revealed how, under some circumstances, he engaged in multiple relationships. I felt confused. When I become a psychologist, I wondered how I might determine ethical from unethical practice in a rural community. I questioned whether I could serve the needs of clients known to me and still practice ethically (Student, 2013).

All psychologists in Australia are required to adhere to the Australian Psychological Society (APS) Code of Ethics. Psychologists working outside major centres have described a range of rewards associated with rural and remote practice but also several aspects of their work that pose challenges to ethical practice. These include: being presented with situations beyond the limits of competence, boundary management, maintaining confidentiality in small communities, and professional isolation. These challenges are well described in the literature and often referred to as barriers to recruitment and retention of the workforce. In response to this feedback, the APS developed Guidelines for Psychological Practice in Rural and Remote Settings.

This paper focuses on the issue of managing professional boundaries and multiple relationships in rural practice. It provides an overview of the Code of Ethics that requires psychologists to refrain from engaging in multiple relationships and how the Guidelines assist psychologists to apply the principles of the Code to the context of rural and remote practice. To illustrate the types of strategies used by psychologists to manage multiple relationships, examples will be drawn from a series of interviews undertaken with 12 practicing

psychologists across rural Australia. The data suggests that it is possible for rural psychologists to practice in a safe and culturally sensitive manner that mostly aligns with professional ethical frameworks.

The paper will conclude by drawing attention to the need for professional ethical frameworks to shift from an assumed urban-centric model of practice to one that is values-based and independent of location. Recommendations for the training of psychologists and other health professionals to enable them to actively navigate ethical situations in situ will be discussed.

Seeking health information online among young, rural women: association with physical, mental and reproductive health

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Background: Going online for health information may be particularly useful for women living in rural and remote areas of Australia where access to health services is often limited. However, relatively little is known about the extent to which young women use the Internet as a health information resource and whether use differs by health status and among women living in rural and urban areas.

Methods: We aimed to identify the physical, mental and reproductive health factors associated with Internet use for health information, and whether this differed by area of residence. We use data from 17,069 young women aged 18-23 years who participated in the Australian Longitudinal Study on Women's Health. Multivariable logistic regression was used to estimate the association between physical, mental and reproductive health factors and Internet use for health information among young women residing in urban, regional and rural areas.

Results: Overall, women accessed around three sources of information for their health. Doctors (77%) followed by family members (62%) and the Internet (44%) were the top three sources of health information. Women from urban and regional areas who used the Internet for health information were more likely to report psychological distress, self-reported mental health diagnoses, urinary or bowel symptoms, and menstrual symptoms than women who did not use the Internet. However, urban and

regional women with children were less likely to use the internet for health information. In contrast, women from rural areas who had children were more likely use the internet as were those who had high levels of psychological distress.

Conclusions: Young women from regional and rural areas do rely on the Internet for their health information. Internet use is particularly common among regional and rural women experiencing psychological distress and among mothers living in rural areas. While the Internet offers anonymised information and support, it is important to develop strategies to assist, and direct, women to credible online health resources. Professionally supported, online self-care programs tailored to young women living in regional and rural areas may be important.

☆ Integrated mental health inpatient units: reducing the burden of mental health for rural communities

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Background: The burden of mental health upon rural Australian communities is well known. Historically hospitalisation for episodes of acute mental ill-health has involved transfers to metropolitan hospitals. In 2014, Country Health SA (CHSA) opened Integrated Mental Health Inpatient Units (IMHIU) in Berri and Whyalla. These six bed open units allow people to remain in or near their local rural community. This study will evaluate the impact of the IMHIU from a client, carer, staff and management perspective.

Methods: The University of Adelaide academics were appointed by CHSA to independently evaluate the IMHIU service. Interviews were conducted with 40 participants including clients' post-discharge, carers, IMHIU staff, rural GP's and community service stakeholders. Thematic analysis of interview transcripts was conducted using Nvivo 10 software. Public hospital separations data for the period three months prior and six months after IMHIU operation were analysed to explore referral patterns and whether the IMHIU is reducing hospital costs.

Results: Most participants had experience of transfer and hospitalisation in a metropolitan facility to compare with their IMHIU experience. There was a consistent positive appreciation for the opportunity to remain in a rural community. Clients reported

reduced trauma, improved rapport with other rural clients in group therapy, opportunities to re-enter their community for social outings with support workers and meetings with NGO and community mental health clinician working in collaboration with IMHIU staff. Carers reported reduced stress, isolation and financial strain and greater capacity to maintain their home, family and employment while supporting their hospitalised loved one. Personalised client-staff relationships, unique interprofessional team operations and opportunities to interact with the community for discharge planning promoted job satisfaction for staff. Hospital stay data and cost savings were inconclusive but admission data indicated that less than half of IMHIU referrals were from within the local catchment area.

Conclusion: Initial findings indicate that the IMHIU are promoting improved quality of life for families and health professionals managing mental illness. A continuum of care is evident when compared with upheaval experienced as result of transfers to Adelaide. More admissions and discharge data over a longer period of time is needed to infer the financial cost effectiveness of IMHIU and whether that resonates with the reduced social costs demonstrated in this research.

☆ Important new empirical evidence to guide rural health workforce retention policies

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Background: Tudor-Hart's 'Inverse Care Law' states that 'the availability of good medical care tends to vary inversely with the need for it in the population served.' Not only is this inequitable and unfair, it also costs rural and remote Australians good health and longevity!

Over the past 25 years the Australian government has responded to the geographical mal-distribution of health workers by instituting a broad range of policies aiming to improve the overall supply of health workers, as well as boost recruitment and retention of health workers in rural and remote Australia. However, these reforms have not always been informed by evidence, and have not invariably led to improvements in health workforce distribution.

Aim: To synthesise new empirical knowledge of the factors associated with the retention of rural and remote primary health care workers, and analyse their implications for strengthening Australian rural workforce retention policies.

Method: The findings from four separate but related quantitative retention studies published since 2011 are synthesised. These studies comprised analyses of longitudinal and cross-sectional data from both national and State/Territory, primary and secondary, rural and remote health workforce datasets. Kaplan Meier survival analyses and multiple linear regression analyses were undertaken across a range of health worker disciplines: GPs, nurses, Aboriginal health workers, and seven different allied health professions.

Results: These studies reveal important new empirical evidence:

- Primary health care worker retention varies significantly with both remoteness and population size.
- Length of service of Allied Health Professionals in small rural and remote locations is as short as doctors, and career grade is a significant factor.
- For GPs, procedural work and hospital work are associated with longer retention.
- Increased taking of annual leave contributes to longer GP retention.
- International medical graduate rural retention is less than for Australian graduates once periods of obligated service are taken into account.

Discussion and conclusion: These findings suggest that rural health policies be modified, including:

- Federal government GP retention incentives take community population size into account.
- Improved rural career pathways for Allied Health Professionals are needed.
- Contrary to current policies, GP up-skilling, scaling up rural generalist training pathways and maintaining rural hospital infrastructure may strengthen health worker retention.
- Strengthening GP locum support programs may improve GP retention.
- Retention strategies should specifically target internationally trained health workers, for

example through training and support, to promote professional and community integration.

Building a medical workforce for your community: a success story

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Kingaroy in 2010, had three permanently employed medical officers, two GP VMOs supporting the obstetric service, and a range of either temporary appointments or locums. The permanent establishment was 6 full time equivalents.

Kingaroy Hospital is the hub hospital in the South Burnett region of Queensland servicing a community of approximately 35,000 people. It is also the busiest non specialist birthing service in Queensland with over 400 births each year. The community it services is of a low socio economic demographic with 60% in the lowest quintile, with Cherbourg only 40 minutes by road and a close relationship, delivering services which are culturally sensitive is also critical to the design of the service and workforce. At this time Kingaroy Hospital there was the Flying Obstetrician and Gynaecologist, a small amount of oral surgery and caesarean sections. The operating theatre was being utilised approximately 3 days per month.

Today, Kingaroy has a medical establishment of 9.3 FTE all permanently recruited to, there are long term temporary contracted staff who are now supporting backfill arrangements for maternity leave. Kingaroy Hospital is now a place medical officers now want to work. So how did we turn it around?

- The recruitment of a high profile medical leader.
- Link into the Rural Generalist Pathway
- Recruit an upcoming young enthusiastic Medical Superintendent with a passion for training and education.
- A medical workforce plan to support targeted recruitment and building a service. In producing this plan it supported the following:
 - increased service capability
 - engagement with GPs about service needs
 - joint appointments with GPs
 - training collaboration for registrars between Hospital and GPs

- funding allocations
- junior doctor training accreditation.

What has this meant for community? Four days of operating theatre per week (could be five by the time of conference).

From the plan Kingaroy Hospital has partnered with Private Hospital for intern rotations, and intern accreditation. Griffith University through Long Look program has six third year medical students on year long placement; in 2015 two of the students will remain for their fourth year placement.

Rural Generalist trainees who rotated in Kingaroy as junior medical officers are contacting the hospital to return once they have completed their advance skill. Three from the last two years.

Now we move onto the challenge of the rural nursing workforce and the advanced skills they require in areas such as midwifery, operating theatre and mental health.

Reducing the impact of cyclone, flood and storm-related disasters in rural areas on non-communicable diseases through public health infrastructure resilience

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Aim: To explore how the impact of cyclone, flood and storm related disasters, in rural areas of Queensland, on non-communicable diseases can be reduced through public health infrastructure resilience.

Objectives: The objectives were to:

- discover knowledge-levels of non-communicable diseases (NCD)
- identify awareness of public health infrastructure (PHI)
- discover how public health risks and NCDs are influenced by disasters
- identify resilience concepts for mitigating the impact of disasters on NCDs.

Background: Rural areas of Queensland have recently experienced a number of large scale and devastating natural disasters, including far reaching floods and damaging storms. This is a feature of the climate and this threat is expected to continue, if not increase.

The relationship between disasters and NCDs is a risk for people living in rural areas. This is due to a 'disease transition' from communicable diseases to NCDs, creating a range of challenges for governments, health care and service providers. Prominent among the NCDs are cardiovascular diseases, cancers, diabetes, asthma, arthritis and kidney diseases. NCDs are reliant on PHI such as medications, equipment, services, housing, water, food, waste and sanitation. Damage to this infrastructure places vulnerable populations with NCDs at a greater risk of mortality due to disasters.

The research aims to address this risk by exploring how the impact of cyclone, storm and flood related disasters on NCDs can be reduced through PHI resilience.

Methods: Focus groups and interviews were completed with people who have NCDs, disaster responders and health specialists in the Cairns, Toowoomba and Townsville regions. Government officials in Brisbane were also interviewed. The data was analysed following the process for a qualitative study. This included data collection and organisation, description, classification and interpretation.

Results: The research found disasters and the subsequent management of NCDs is a challenge for rural communities. This included 30 descriptions of how disasters can impact on NCDs; 123 descriptions of PHI, which were categorised into 16 themes; and identified 24 resilience concepts. The findings have informed the development of a conceptual framework for mitigating the impact of disasters on people in rural areas with NCDs.

Conclusion: Disasters are a challenge for rural communities. To minimise the impact there is a need to have resilient PHI. This means disaster preparedness needs to focus on strengthening PHI, which will also help address modern disease priorities.

Nutritionists where there is no nutrition

Richard Sager

Darwin Dietitians, NT

The involvement of a dietitian as a part of the primary health care team is essential to the health outcomes in urban and remote settings. Previously, individual nutritional care was provided by the remote health clinics, using their own interpretation of public health promotions or the advocacy of local clinic staff that have no training in nutrition and dietetics. This leads to basic recommendations and counselling services being provided from resources electronically distributed from a central NGO office or a supportive government department.

This approach has significant limitations. Achieving appropriate and adequate nutrition services is by far the most significant barrier towards improving the health status of residents in a remote setting.

Clinical dietitians are trained to provide intensive individual dietary advice, however for remote health clinics this service has traditionally only been able to be provided on an irregular basis. The needs of the remote community setting are far greater. This model of service is impractical for a relatively small population spread out over a vast area. Therefore if remote residents are to receive equitable access to services that promote quality nutrition advice to improve and to permanently support lifestyle changes, it is important to develop a service delivery model that meets the clinical demand of the population.

In recent years a Federal Government initiative managed through the Northern Territory Medicare Local known as MOICD, has improved access to clinical Dietetic services within remote clinics. The funding has increased access to the necessary individual dietary advice for sufferers of chronic disease. This paper describes the current model used to provide the increased clinical dietetic services necessary for remote Aboriginal communities. Each community that is serviced has uniquely different needs in attempting to improve the quality of nutrition knowledge and capacity for Indigenous Australians, therefore the model of service is adapted accordingly.

To date this clinical dietetic service has provided more than 800 patient encounters over the past twelve months. This paper will review this model of service delivery, discussing the strengths, including clinical benefits, and limitations of the model. It will also encapsulate the views and experiences of

clinical dietitians currently working to provide this service, and their recommendations on how the service can be more cost effective and achieve improved clinical outcomes.

Youth migration and wellbeing in rural communities

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The migration of young people out of rural communities is an ongoing source of concern in many parts of Australia. This concern often focuses on the implications for rural communities: if youth are leaving, will a community survive? In this paper we argue for a wellbeing-centric way of thinking about youth migration. We examine the interrelationships between the place a young person lives in, their desire to migrate or to stay in a community, and their wellbeing, drawing on data from the Regional Wellbeing Survey, a nationwide survey of more than 10,000 people living in rural and regional Australia. Based on this, we begin to articulate when and why migrating or not migrating is associated with better or poorer wellbeing, and the wellbeing-related factors that may be driving the decision to migrate or stay. When added to the already well understood drivers of youth migration, such as the need to migrate for study or employment, this provides a more holistic understanding of youth migration and wellbeing in rural areas.

Heart Foundation Walking—a series of rural case studies

Kyle Schofield

Heart Foundation Walking, SA

Background: About 7 million Australian's (32%) live and work in widespread, rural and remote places. Rural and remote areas share common traits such as generally older populations, higher levels of health risks and higher rates of chronic disease. Additionally, people living in rural and remote areas have lower rates of physical activity than those in major cities. Research conducted in rural and remote Australia has identified various barriers faced by residents in undertaking physical activity, including lack of time, limited transportation to sporting facilities, social and cultural barriers, and affordability.

Walking is a popular, low cost form of physical activity which is easily accessible to most people,

including those in rural and remote areas. Heart Foundation Walking (HFW) is Australia's largest free national network of community based walking groups. HFW engages those least likely to be active including older Australians, people who are socially isolated, and those with a low house-hold income. Walking in groups has the added benefit of social interaction. Our walkers make friends and report increased mental health and wellbeing.

Methods: HFW provides a national framework based on a train-the-trainer model. HFW forms partnerships with local governments, health and community services who become Host Organisations. Each organisation appoints a Local Coordinator who recruits volunteer Walk Organisers and trains them to engage with walkers and lead the groups. The Heart Foundation provides a range of resource and merchandise supporting Local Coordinators and Walk Organisers to establish and maintain groups, while also motivating participants through recognition schemes and regular communications. Quantitative data is collected through a national database (n=20,069) and qualitative data collected via participation surveys.

Results: HFW currently engages over 20,000 active participants who walk in 1385 groups across the country. The average group is active with the program for 3.4 years, with HFW total retention rates of 98% at 3 months and over 75% after 3 years. This included numerous groups in rural and remote settings across all states and territories. Group specialities include over 50s, groups for culturally and linguistically diverse people, Aboriginal and Torres Strait Islanders, and groups in aged care facilities. This presentation will include case studies of HFW groups in various rural and remote settings including Alice Springs (NT), Mallee Region (VIC), Flinders Ranges (SA), Toowoomba (QLD) and the West Coast of Tasmania.

Discussion: HFW provides a sustainable and affordable national framework that engages and supports a range of regional and rural communities to participate in physical activity through establishing and maintaining walking groups. HFW develops long term walking behaviours, and provides social inclusion for isolated individuals and populations.

Occupational and spatial mobility of rural physiotherapists: insights for workforce development

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While 25% of the Australian population lived in a rural or remote area according to the 2011 Census, just 15% of physiotherapists worked in rural or remote areas. Furthermore, rural and remote physiotherapists tended to be much younger and therefore less experienced than their urban counterparts. Addressing undersupply and lack of experience in the workforce requires both attracting more people to the profession (occupational mobility) and attracting professionals to live and work in rural and remote areas (spatial mobility). The purpose of this paper is to examine the extent to which contemporary and historical occupational and spatial mobility of physiotherapists contributes to, or alleviates, rural and remote undersupply of the profession. Data are drawn from each Australian Census between 1986 and 2011, with a focus on detailed analysis of data from the 2006 and 2011 Census. Despite some limitations, the Census provides a useful source of information because it is historically consistent, and it provides details about the demographic, economic and educational characteristics of physiotherapists that are not available in other national data sets. Specifically, the research describes the flow of practising physiotherapists in to and out of rural and remote areas in each State and Territory, the occupations of people who have physiotherapy qualifications, and the impact of migration and education-occupation match on the number and demographic characteristics (particularly age) of physiotherapists who work in rural and remote areas. The research suggests that migration streams favour young physiotherapists moving to rural and remote areas from urban areas, and older physiotherapists moving from rural and remote areas to urban areas. There are also substantial numbers of qualified physiotherapists living in rural and remote areas and who work in other occupations, suggesting that occupational mobility may be as important as spatial mobility in its contribution to workforce undersupply. The paper is innovative in the context of health workforce research because it specifically considers workforce shortages as a migration issue, and because it examines migration over a 25-year period. This research is valuable to workforce planning since it reveals a potential underutilised capacity in rural and remote areas that may be targeted to return to rural professional practice, as

well as revealing inefficiencies in the current physiotherapist migration system that could be addressed through location specific initiatives.

Queensland Rural Generalist Pathway: impacts on rural medical workforce

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Aims: In the seven years since the establishment of the Queensland Rural Generalist Pathway (QRGP), more than 200 doctors have commenced training under the auspices of the program with 45 having achieved Fellowship of the Australian College of Rural and Remote Medicine and/or The Royal Australian College of General Practitioners. This paper outlines development of the pathway and its early workforce impacts.

Methods: Internal QRGP records and an externally commissioned review provided data on trainee activity and practice location.

Relevance: The QRGP concept was established to provide medical graduates with a supported training pathway to a career in Rural Generalist Medicine and provide rural and remote communities with an appropriately skilled medical workforce. Similar approaches are being adopted in other jurisdictions both nationally and internationally, with World Summits on Rural Generalism being held in 2013 and 2015.

Results: Advanced Skills Training (AST) forms a prominent training and preparatory element of the program. 107 Rural Generalist trainees have completed ASTs, predominantly in the procedural disciplines of Anaesthetics, Obstetrics and Emergency Medicine. 15 trainees have completed two ASTs. In direct response to the Pathway's demonstrated success in decreasing rural medical workforce shortages whilst increasing the capacity to train safe and appropriately skilled rural medical practitioners for the bush (Ernst and Young, 2013), the Queensland Minister for Health announced in 2013 the State's commitment to double the intake of the program to 80 by 2016.

Future challenges of expanding the program over forthcoming years include securing additional Intern and Junior Medical Officer training positions and

expanding AST training capacity. Innovative training solutions continue to be explored, including the establishment of the 'Prevocational Integrated Extended Rural Clinical Experience (PIERCE)', for which three Queensland pilot sites have been chosen to trial the education model in 2015. PIERCE aims to increase prevocational training capacity and strengthen Rural Generalist trainee commitment to rural practice by providing an extended experience in suitably accredited rural hospitals that meet the program's prevocational training requirements.

Conclusions: The resounding success of the program is demonstrated through the striking rural medical workforce outcomes of communities such as Longreach, Emerald and Stanthorpe where self-sustaining, medical workforce models have provided rural and remote communities with broad, safe and stable services. Greater than 100 trainees to date contribute to the public and private rural medical workforce across Queensland. Such models may well be applicable in other jurisdictions given the global resurgence of interest in rural generalism.

How can metropolitan rehabilitation services support remote area people with an ABI best?

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Aims

- To investigate how a specialised multidisciplinary brain injury rehabilitation service in Perth can improve the process for referrals, treatment and support for people with an acquired brain injury (ABI) and their care givers in remote areas.
- To engage with remote area service providers to understand how best to support them and caregivers of people with ABI.

Methods: Information sessions regarding ABI services in Perth were held with various service providers (disability service providers, allied health, nurses, teachers, legal aid lawyers, support workers) in three remote northern West Australian towns. 30 participants completed surveys investigating needs and required service assistance and considerations. This was followed by a focus group with a remote area ABI service provider which was transcribed and thematically analysed. This project was funded by a Brightwater Peter Lane Scholarship.

Relevance: High rates of brain injury, resulting from stroke or trauma, are evident in rural and remote communities however there is limited access to specialised ABI services.

People from remote areas are underrepresented in metropolitan services due to geographical distance involved, wanting to return home, a lack of understanding of cultural needs and resource limitations. In order to provide best rehabilitation services this needs to support remote area living environments.

Results: There are large numbers of service providers visiting communities who have existing relationships with clients and families and thus effective service models must support these service providers. Specialised ABI services must demonstrate cultural understanding of the people and region to enable effective service provision. There are large numbers of unidentified people with ABI in remote areas and further research is required to identify and support these people.

Key outcomes for specialised ABI services to effectively support regional service providers, clients and families are:

- mentorship programs between specialist health professionals and local therapists (through phone, video or email consultations)
- culturally and linguistically specific resources, in a range of literacy levels
- accessible training and education (via various media including videoconferencing and face-to-face)
- raising community awareness of ABI
- liaison between metropolitan and remote services for discharge support and follow-up
- advocacy services
- collaboration with families, health provision and communities
- remote community visits.

Conclusions: To provide effective support to people with an ABI in remote areas, service models must recognise cultural and geographical differences. Support can be provided via various communication, education and resource development. Metropolitan services providing statewide rehabilitation services need to consider appropriate alternatives to overcome barriers.



A new model of clinical placement in the Solomon Islands

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Background: Makira Island in the Solomon Islands has a population of over 41,000 people, which in 2013 was serviced by one doctor, who worked in the hospital and travelled to remote sites, supported by highly skilled nursing staff. The capital Kira Kira is a very impoverished community with no formal governance structure, poor infrastructure and a large variety of public health issues that lead to fascinating medicine.

During 2013 Bond University on the Gold Coast in Australia piloted final year undergraduate medical student placements at Kira Kira Hospital, with 33 students participating. By the end of 2014 over 50 final year medical students will have undertaken a placement at Kirakira Hospital. It is now a university wide experience with students from other faculties including 12 students from the Physiotherapy, Public Health Nutrition, Sustainable Development, Film and Television and Project Management who work together to support the local community.

Methodology: The placement was evaluated over both years using electronic surveys, focus groups and semi-structured interviews with staff, students and community members.

Results: The evaluation found that this was an extremely valuable, personally safe, clinically fascinating, and professionally life changing student experience, which was greatly appreciated by, and contributes to, the local Kira Kira community. The greatest strength of the program was the peer mentoring and supervisor model—whereby four students worked in pairs supported by nurses, the doctor and local community. The main challenges were the supervision arrangements and available resources.

Conclusion: Placements in developing countries can be career highlights for all students. This paper will present the findings from the evaluation and the innovative peer supervision model that was developed in a third world country that others could learn from.

Challenging the status quo in rural health workforce roles: risks versus benefits

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In spite of the challenges of providing high quality health care to the rural and remote population, it seems that widely applicable, innovative workforce strategies are not as high priority as they could be. More needs to be done to support horizontal and vertical integration and 'task transfer' in rural and remote health care.

Examples already exist of how such innovations can be effective, such as rural nurse practitioner roles. However, there are sound arguments that updated policies and procedures are needed to address the legal capabilities of nurse practitioners, including referral pathways, admitting rights, prescribing rights, ordering and interpreting of diagnostic tests, and Medicare provider numbers.

Another example is that of limited license radiography performed by nurses and GPs in locations where radiographers are not available. In that case, however, the licence conditions, as well as pre-requisite and continuing education requirements, vary from State to State, causing ongoing confusion among practitioners.

Other opportunities for innovation also exist. Advanced practitioner roles for allied health professionals have existed in other developed countries for decades; however, they have not yet been developed in Australia, let alone in rural and remote Australia where the benefits could be substantial.

This paper considers the barriers to implementing innovative practice roles in the context of rural and remote health care, making use of two interrelated themes. Firstly, the legislative, regulatory and policy barriers (real and perceived) to expanded scopes of practice are considered. Secondly, drawing on literature from the sociology of professions and social identity theory, there are arguments around professional identity and socialisation that can drive another potential barrier—the perceived threat to professionalism, particularly to distinctiveness and value.

At the same time, there are legitimate concerns about service quality and safety when the

boundaries between health professions are challenged. Some interprofessional boundaries exist for sound reasons and there is a need to ensure that those who are legally permitted to cross interprofessional boundaries do so with due care and do not place the health and wellbeing of the already vulnerable rural and remote population at greater risk because of poor quality clinical practice. Consequently, this paper attempts to balance the arguments and put forward a risk-benefit framework for the implementation of innovative rural and remote health workforce strategies.

Improving quality use of medicines in the bush

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Australians in rural and remote areas have shorter lives and higher rates of disease and injury than people in urban centres. In addition to having a greater burden of disease, populations in rural and remote areas face increased challenges in accessing appropriate health care, including issues related to geography, availability of health professionals, and rural culture.

Workforce issues are a significant barrier to access to health care in remote areas, with rural and remote health services often struggling to secure resources and recruit and retain staff. One of the strategies employed to improve access to health care services in remote areas is the recruitment and training of remote area nurses (RANs). RANs practise at an advanced level often with limited or distant medical support. The extended scope of practice requires RANs to have a broad knowledge base in relation to disease management, including the administration, monitoring, supply and storage of medications.

Recognising the extended scope of practice of RANs and the additional challenges this presents in ensuring quality use of medicines (QUM), highlights the need for advanced knowledge and skills management. The Centre for Remote Health (CRH) provides a course in the practical use of medicines in disease management aimed at ensuring medicines are used appropriately, effectively, judiciously and safely, called Pharmacotherapeutics for RANs. The pharmacotherapeutics program is designed to assist RANs in developing knowledge and skills in the use of medications, the risks associated with them, and strategies to increase the benefits and minimise the risks of treatments. The

course covers conditions, both chronic and acute, that are common to remote practice and challenges participants to think beyond the usual scope of being a nurse. A practical approach to disease management is promoted, underpinned by principles of drug therapy, such as adverse reactions, interactions, pharmacology, adherence and professional and legislative issues.

In 2014 CRH conducted a survey of participants who had completed pharmacotherapeutics for RANs. Respondents stated that the training had increased their awareness of drug interactions and side effects of medications, and had given them strategies to enhance adherence. It had also increased their understanding of legal and legislative requirements, prescribing process, medication review process, risks of medications, and increased competence in utilising recommended reference material.

Policy recommendation: Funding for educational programs to prepare and upskill the remote health workforce needs to be maintained at appropriate levels.

Medical–legal partnerships: connecting services for people living with mental health concerns

Chris Speldewinde, Ian Parsons

Centre for Rural Regional Law and Justice, VIC

Our paper will discuss an action research project currently underway in regional and rural Victoria which seeks to build a dual site Medical-Legal partnership (MLP). MLPs bring together medical practitioners and legal practitioners to provide an integrated service aimed at supporting the health and wellbeing of individuals. MLPs, conceptually, are in their infancy in the Australian context having been successfully operating in the United States since the early 1990s. Our research project focuses upon an MLP model which diverts from the norm focusing upon holistic health rather, is specifically directed towards supporting individuals living with mental health concerns in rural and regional Victoria. Empirical evidence will be drawn upon to demonstrate how a project such as ours can be commenced and it will deliver early findings into the success of integrated services and notions of co-locating services in the rural context. We aim to demonstrate the benefits of the MLP model in supporting the mental health needs of individuals living the rural Australian context.

Tasmanian HealthPathways—clinical leadership in action

Catherine Spiller

Tasmedicare Local, TAS

Background: Tasmanian HealthPathways (THP) is being implemented in Tasmania, as collaboration between Tasmania Medicare Local, Department of Health and Human Service and Tasmanian Health Organisations funded under the Tasmanian health assistance package. The THP methodology is based on a successful NZ model, and innovation in health care delivery, the Canterbury Initiative. In this context, HealthPathways are an agreed team approach between primary, secondary and tertiary care providers in managing a patient in the Tasmanian Health system.

Methods: Since March, 19 clinical work groups (CWG) have been convened across the state with the purpose to develop localised Tasmanian HealthPathways in key clinical areas. This is a clinician lead approach with a total of 16 hospital specialists, 48 General Practitioners and a number of allied health practitioners attending CWGs.

Google analytics has been used to collect usage data for website uptake, since its official launch in October 2014.

In November, the promulgation phase commenced which includes General practice visits, presentations, website demonstrations and integration with the current TML education program.

Findings: Since March 2014, 87 pathways have been localised for the Tasmanian context and are available to health professionals via the live website. Pathways are currently being finalised in a range of neurodegenerative and respiratory conditions.

Other than pathway development, outcomes from CWGs have included options for capability and capacity building for health care improvement.

An initial, Google Analytics report (Table 1) recorded an increase in both page view and unique pages view over the first 2 month period, by 42.62% and 69.78% respectively. This data will be tracked regularly to monitor usage and uptake.

The feedback received from stakeholders has been generally positive, and focuses on the potential benefits to General practice teams and functionality of the website.

Conclusions: Initial findings indicate that the implementation of Tasmanian HealthPathways has been successful with a potential to support clinical practice, especially in rural regions of Tasmania, where access to services is limited. The development of a greater number of localised Tasmanian pathways and a comprehensive promulgation phase, over time will further enhance uptake and engagement with Tasmanian Health Practitioners and encourage a community of practice.

Integrating and consolidating health promotion efforts in rural Victoria

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¹Goulburn Valley Primary Care Partnership; ²Lower Hume Primary Care Partnership; ³Central Hume Primary Care Partnership

Background: Primary Care Partnerships, a Victorian State funded framework, support agencies to deliver the Integrated Health Promotion program. A 2009 audit of 62 health promotion plans across Hume Region, encompassing four Primary Care Partnerships, identified 13 different health promotion priorities. Findings reported a lack of integrated planning between agencies and limited use of evidence, evaluation and strategic targeting of interventions.

Methods: The Regional Health Promotion Strategy was developed in 2012 to maximise health promotion outcomes in rural communities through a focused and integrated approach. The main objective of the strategy was to consolidate resources through the identification of a single priority for the Hume region. The Regional Health Promotion Strategy supports the sharing of resources and knowledge across a large rural area, reducing duplication of activities. Primary Care Partnership staff display leadership in integrated planning and implementation by working together to provide capacity building opportunities for the geographically isolated workforce.

Results: Introduction of Regional Health Promotion Strategy reduced the number of health promotion plans from 62 to four, reflecting a single health promotion priority across four Primary Care Partnerships (12 local government areas). Working together using a coordinated planning process has seen agencies increase the use of evidence based interventions and plan comprehensive evaluation measures. An integrated approach across the four Primary Care Partnerships strengthens ability of

agencies to adopt a 'big picture' understanding of health promotion sector. Resources have been consolidated under one health promotion priority reflecting a commitment from agencies to work together in delivering integrated health promotion across a large rural region.

Conclusion: This strategic approach to health promotion has been a strong catalyst for regional consolidation of resources, improved planning process, and greater focus on evidence based practice. This presentation identifies the leadership capacity of Primary Care Partnerships in working together to strengthen and facilitate a consolidated approach to best practice health promotion in a rural context.

A rural AOD pharmacotherapy model

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¹Great South Coast Medicare Local; ²Southwest Healthcare; ³Western Hospital; ⁴Deakin University

Aim: To develop and deliver a pharmacotherapy program in regional/rural Victoria that meets the needs of clinicians and clients. Traditionally, general practitioners (GPs) and pharmacists have been reluctant to engage with AOD clients, due to a minority who demonstrate behaviours which impact on other customers negatively. There has been poor clinician take-up for the pharmacotherapy program as funding and workforce issues provide few incentives for participation. Despite recent sector reforms, lack of strategies addressing these fundamental issues means minimal progress has been made to date.

Additionally, current experts in addiction medicine are rapidly nearing retirement age. The system is currently unsustainable. Clients in rural and regional parts of the state are most immediately affected as there are entire areas with no prescriber or dispenser available and public transport options to services are limited or non-existent.

This program has been established as a pilot to address the needs of rural and regional clients who require an opioid-replacement pharmacotherapy program. Using clinicians who understand rurality factors in the delivery of health services, it has been designed to engage local clinicians in working with their patients through a state-wide mentoring and training program which provides secondary and joint consultations to develop confidence and skills. Working with the whole of the practice, it recognises the difficulties that can arise from working with the

client group and aims to provide strategies and solutions to those issues through building workforce capacity.

Methods: This pilot operates across the rural areas of Victoria, collecting a few key measures to define the 'success' of the pharmacotherapy program. These include: % increase in clinicians engaged into the full program; % increase in clients receiving care closer to home; % increase in clients in pharmacotherapy; % increase in clinicians trained to prescribe/dispense. Also as part of the project, patient flows will be mapped to identify gaps in service availability across the state. Reports will be published each year for the 3-year pilot period. Methods include participatory action research through PDSA cycles.

Relevance: This pilot is replicable for other parts of Australia, demonstrating how to efficiently use limited specialist workforce and enhance workforce capacity. While this model addresses pharmacotherapy, the model remains applicable to any chronic disease requiring specialist care in rural areas.

Conclusions: The model potentially shows how collaboration across sectors can support better access to specialist care, using a combination of local clinics, telehealth, mentoring, and practice visits. It also demonstrates the necessity of looking at what levers there are for engagement across the continuum of care for chronic disease.

Development of regional dementia services pathways

Evan Stanyer
Bendigo Health, VIC

Background: The purpose of this project presentation is to provide an outline of the development of regional dementia services pathways. Pathway development was based upon the KPMG document 'Dementia services pathways—an essential guide to effective service planning', developed for the Department of Health and Ageing.

Aim and objectives: The aim of this project was to develop dementia pathways that are applicable across the Loddon Mallee region. The overall project objectives included:

- the development of local pathways for three of the management stages of dementia as

identified in the KPMG Dementia Services Pathways Framework:

- awareness, recognition and referral
 - initial assessment, diagnosis and post-diagnosis support
 - management, care, support and review
- develop user-guide for pathway implementation.

(Note: The end of life pathway was excluded as it was being managed by Palliative Care Services)

Methods: The KPMG Framework recommends the development of service pathways be conducted at workshops that include a broad spectrum of key service providers across the continuum of care and consumer representatives.

The Framework also includes a self-assessment tool which was used to identify current dementia services. Two rounds of service provider workshops were conducted: the first round of workshops aimed to gather relevant information to develop the Pathways; the second round of workshops reviewed the final draft of the Pathways.

Focus groups were also conducted with people with dementia and their carers across the region to gain their input into the development of the Pathways.

Results: Initially it was envisaged that three Dementia Services Pathways would be developed, one for each key management stage, however it soon became apparent from the Advisory Panel, service provider workshops, and consumer/carers focus groups that each of the three pathways needed to be further refined if they were to meet the needs of both service providers and consumers/carers. The outcome was that six different Dementia Services Pathways were produced. The Dementia Services Pathways have been designed to provide one page of content in a practical and user friendly format.

Recommendations for policy

- The Dementia Service Pathways were developed for use in the Loddon Mallee region of Victoria, however they are transferable and applicable at a national level.
- A business model should be developed to support the use of Dementia Service Pathways in General Practice.

Early intervention for children with an autism spectrum disorder: a rural hub-and-spokes model and the NDIS

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¹University of Tasmania Rural Clinical School; ²Burnie Autism Specific Early Learning and Care Centre

Introduction: Parents and carers from regional and remote communities experience unique circumstances that make parenting a child with an autism spectrum disorder (ASD) challenging. In 2008, six Autism Specific Early Learning and Care Centres (ASELCCs) were established in Australia. The North West Tasmania (NW Tas) ASELCC is the only rural/regional ASELCC and operates as the only 'hub and spokes' model. Transition to the National Disability Insurance Scheme (NDIS) will represent a significant change to the way in which the ASELCCs conduct business and how they will source their funding.

Aim: We sought to provide evidence of effectiveness of the NWTas ASELCC hub and spokes model, and gain parental perspective of the service to inform transition to the NDIS.

Methods: Routine assessments collected by the ASELCC of all children and parents over the period 2009-2014 at entry and follow up were analysed to determine differences between the hub and spokes centres. A cohort of current parents participated in qualitative interviews.

Results: 125 children (33 girls and 93 boys) were included in the analysis. Mean age at entry to ASELCC was 43 months (SD 10). Baseline, follow-up and centre attended information was available for 116 children (93 hub, 23 spokes and 3 both). Due to the small sample size of spokes children, there were no statistically significant differences between the groups. However, further investigation of possible differences in the Vineland Fine Motor Skills sub-scale, and the Mullen Receptive Language and Visual Reception sub-scales is warranted in a larger study. Parents valued aspects of the ASELCC such as expertise, non-judgment and understanding, information and education, as well as reliability and consistency of services, may be factors related to future decision-making by parents under the NDIS.

Discussion: Autism-specific early intervention can be delivered in mainstream child care centres in rural areas when it is supported by a multidisciplinary team located in a nearby regional town. As Australia transitions to the NDIS the

ASELCCs will need to evolve to meet the diverse needs of families. The challenges in providing effective early intervention for children with ASD and their families in rural Australia are many, however the model currently utilised by the NWTas ASELCC may provide an early view of the way forward.

Developing locally specific 'wellbeing models' for Aboriginal and Torres Strait Islander peoples living with chronic disease

Carol Davy¹, Maida Stewart², Margaret O'Brien²

¹Sahmri; ²Danila Dilba Health Services

The Wellbeing Study Team (in alphabetical order): Timena Ahmat, Gary Brahim, Alex Brown, Carol Davy, Anna Dowling, Shaun Jacobson, Tania Kelly, Kaylene Kemp, Elaine Kite, Fiona Mitchell, Tina Newman, Margaret O'Brien, Jason Pitt, Bernadette Rickards, Kesha Roesch, Christine Saddler, Leda Sivak, Maida Stewart, Tiana Thomas

Access to appropriate, affordable and acceptable comprehensive primary health care is critical for preventing and managing chronic disease. Yet the obstacles faced by Aboriginal and Torres Strait Islander peoples attempting to access primary health care services are many. While appropriate infrastructure, sufficient funding and knowledgeable health care professionals are crucial, these elements alone will not lead to accessible primary health care services for all Aboriginal and Torres Strait Islander peoples.

Re-defining the way in which care is delivered in order to reflect Aboriginal and Torres Strait Islander peoples' needs and values is essential for improving the accessibility and acceptability of primary health care services. Chronic care models that are currently in use within primary health care settings, however, do not generally focus on important roles of culture, spirituality, Country and family in maintaining health and wellbeing.

Developed by and for Aboriginal and Torres Strait Islander peoples, the Wellbeing Framework aims to assist primary health care services to improve the quality of life and quality of care, as well as the health outcomes, for Aboriginal and Torres Strait Islander peoples living with chronic conditions. The Wellbeing Framework consists of two *core values* that are fundamental to the provision of care for Aboriginal and Torres Strait Islander peoples. It also sets out four *essential elements* that can assist primary health care services to support the

wellbeing of Aboriginal and Torres Strait Islander peoples living with chronic disease. Every element is supported by *four principles*. Underpinning each principle is a number of practical and measurable *applications* that suggest ways in which the principle could be applied.

This presentation will provide unique insights into how the Wellbeing Framework was developed and will reflect on the value of two-way learning within collaborative research projects. It will also discuss how primary health care services will, in collaboration with their own communities and clients, be able to adapt the core values, elements, principles and applications of the Wellbeing Framework into locally relevant Wellbeing Models to support the wellbeing of individuals, families and communities in the context of chronic disease. The presentation will conclude with a discussion of ways in which the Wellbeing Framework can already be applied to chronic disease policy and practice.

Emerging issues in rural youth health: a practitioner's perspective

Nigel Stewart

Port August Hospital, SA

In all of the policy discussion and confusion about health care reform, we sometimes forget that children's voices have to be heard as well as everybody else's. Children in rural and remote areas experience all of the extra difficulties and challenges of their parents, as well as the fact that advocates for them are few and far between. This makes the task of a rural paediatrician all the more important. As well as doing everything in our power to provide good paediatric services, we also need to highlight the place of children in a health system, which is characterised by constant change and 'to and fro' between state and Commonwealth governments. Children in rural South Australia living with a disability are just one example. Currently they are being served more or less effectively by a patchwork of local, state and national initiatives—and through the devotion of carers and clinicians. The National Disability Insurance Scheme is being rolled out to babies and children in South Australia and despite the best intentions in the world, considerable anxiety and uncertainty have been created for the kids themselves and their families and their clinicians. Transitioning to the new scheme is creating real challenges. In South Australia there is now the statewide health plan, *Transforming Health*, with a fair bit of extra uncertainty about what exactly it will mean for health services and staffing in rural and

remote areas of the state. Children are our future and those who care for them do not intend to go away or give up!

☆ Are Queensland's new GP obstetricians going where they are needed?

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Aims: To report on a comparison of the workforce distribution of obstetric skilled graduates of the Queensland Rural Generalist Pathway (QRGP) and the birthing numbers in rural and remote Queensland

Methods, The graduate destination from the Queensland Rural Generalist Pathway in 2013 were mapped against Statistical Area Level 2 birth numbers and birth rates for 2013 and with District of Workforce Shortage as defined by the Australian Government. Analysis was performed to determine if the newly qualified rural generalist obstetricians (i.e. those who had completed 12 months of advanced specialised training in obstetrics) were commencing work where they were needed as determined by these parameters.

Relevance, The QRGP aims to provide medical graduates with a supported training pathway to a career in rural medicine; which in turn provides and rural and remote communities with a skilled medical workforce. It is important to evaluate whether this skilled medical workforce is working in the areas where there is greatest need for their skills.

Results Early indications are that newly qualified rural generalist obstetricians are working in areas of need with some regional variation

Conclusions: The QRGP is providing rural generalist obstetricians to areas of need. Further work is needed to refine incentives and supports to direct new rural generalist obstetricians to the areas where they are most needed.

Inspirational stories from rural and remote Aboriginal communities

Melissa Stoneham, Sunni Wilson

Public Health Advocacy Institute, WA

Many excellent projects occurring in rural and remote Indigenous communities do not get exposure and are rarely published in traditional academic journals. Reasons for this include lack of experience and skills, resources and time. The WA Indigenous Storybooks aim to address this issue by providing an easy and non-threatening way for Indigenous people to record and share their positive stories within their own networks and with the broader West Australian (WA), and Australian community. PHAIWA aims to publish two books per year.

A Steering Committee of key Indigenous practitioners oversee this project. A framework which ensures all stories are structured under five headings has been developed to guide authors. Consultation with Indigenous people and communities takes place face to face to collaborate on the writing and storytelling process and relevant photos are taken of both the project and storytellers involved. A local launch of each book in the relevant region is conducted followed by post evaluation to determine reach and effectiveness.

The Storybooks provide Indigenous people with an opportunity to share their positive stories and express the value and benefits of their projects for public consumption. These innovative Storybooks encourage improved dissemination of written Indigenous stories in a culturally appropriate and sensitive manner. They recognise and celebrate the achievements of Indigenous people and their communities by embracing a holistic view of health and sectors outside of health including education, employment, housing, environment, the arts, animal management, sport, alcohol and drugs and others.

The five Storybooks that feature only rural and remote Aboriginal stories will be featured in this presentation. The paper will outline how the stories portray positive outcomes in communities which have resulted from sharing and disseminating these stories.

Improving medication outcomes for Aboriginal and Torres Strait Islander people

Lindy Swain, Lesley Barclay

University Centre for Rural Health, NSW

Background: Home Medicine Review (HMR) has been found to be an important tool to raise patient awareness of medication safety, reduce adverse events and improve medication adherence. Aboriginal and Torres Strait Islander people are the most likely of all Australians to miss out on HMRs despite their high burden of chronic disease and high rates of hospitalisation due to medication misadventure.

Aims: This study explores barriers and facilitators to delivery of medication review to Aboriginal and Torres Strait islander patients from both patient and health professional perspectives.

Methods: This was a mixed methods exploratory study of 18 semi-structured focus groups with 102 Aboriginal and Torres Strait Islander patients at 11 Aboriginal Health Services (AHSs). Thirty-one semi-structured interviews were conducted with AHS staff and a cross sectional survey was used to gather data from 945 Australian pharmacists accredited to undertake HMR.

Relevance: Findings from this study are currently being used to inform Sixth Community Pharmacy agreement decisions around medication review program rules. The Australian Government should invest in medication review programs to assist Aboriginal people to manage their medicines and so assist in reducing the burden of chronic disease and Closing the Gap.

Results: Most of the Aboriginal and Torres Strait Islander participants found the HMR process confusing and confronting. Participants felt HMRs for Aboriginal patients should be organised by Aboriginal Health Service staff, with patients being offered a choice of location for the HMR interview, and the choice of a group consultations. These participants identified that Aboriginal Health Workers should play a key role in communication, knowledge translation, referral and follow up.

Aboriginal health staff interviewees felt that the low number of HMRs for Aboriginal patients was mainly due to their lack of awareness and understanding of the HMR process, the complexity of the HMR model and the GPs' time constraints. Pharmacists reported that barriers included lack of understanding of

cultural issues by pharmacists, burdensome program rules, the lack of patient–pharmacist relationship, and the lack of pharmacist–AHS relationship.

Conclusion: Increasing HMRs for Aboriginal and Torres Strait Islander people has the potential to increase medication knowledge, medication adherence and therefore improve chronic disease management, however more culturally appropriate and acceptable medication review programs need to be established with increased pharmacist and health staff training. This presentation will explore potential new medication review models informed by the study's findings. There are great possibilities if the right people can conduct medication reviews in the appropriate places.

Prostate cancer education

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¹The Prostate Cancer Foundation of Australia; ²Health Consult; ³Consultant urological surgeon; ⁴WA Cancer and Palliative Care Network

Prostate Cancer Foundation Australia (PCFA) launched its Rural Education Roadshow program in 2013. Funded through the Commonwealth Government, and modelled on the Western Australia Cancer and Palliative Care Network framework, the program brought a structured prostate cancer education program to regional, rural and remote communities across Australia.

The roadshow aimed to:

- improve local knowledge and skills of local health care providers from all disciplines who come into contact with prostate cancer patients
- deliver education directly to those affected by prostate cancer to engage with them on how to improve quality of life with prostate cancer diagnosis, while addressing issues around survivorship.

The roadshow provided the opportunity for local health professionals to explore the complexities of treatment and increase expertise in regional areas to support patients through their cancer journey. The roadshow was delivered by a multidisciplinary team including a urologist, oncologist and a prostate care nurse. Local clinicians or Visiting Medical Officers (VMO) were utilised to ensure content reflected local pathways and promoted interdisciplinary networking.

Two sessions were delivered at each roadshow event; one targeting health professionals, the other, community members affected by prostate cancer. Content for the health professional session included information on diagnosis, treatment and side effect management of both localised and advanced prostate cancer. The community session focused on coping with treatment and side effects, survivorship and support.

Program evaluation was undertaken to determine if the roadshow met objectives. Data were collected from multiple sources using surveys and interviews with PCFA personnel and those participating in the education sessions. Ethics approval was obtained from the Australian Department of Health Ethics Committee.

Key evaluation findings demonstrated a positive impact on health professionals. Overall the majority of health professionals reported an increase in their knowledge of both diagnostics and treatment of prostate cancer. 89% of respondents agreed that sessions increased confidence in supporting and managing patients with prostate cancer, and a high proportion retained this view at least three months post event. Consumers reported an increase in knowledge of effects from treatment and when to seek further help in relation to the effects of their disease and treatment. 86% of consumer attendees agreed that attending the session increased empowerment in managing issues relating to prostate cancer.

The roadshow has been an effective program for delivering education through an outreach model to both health professionals and community groups with potential to apply this model to other disease types.

ASD diagnostic practices in Australia

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In the absence of an established biological marker for autism spectrum disorder (ASD), 'gold standard' diagnosis is currently a 'best estimate' clinical judgment based on the behavioural presentation of the individual. However, the variability in ASD symptoms and the considerable overlap between behavioural characteristics of ASD and other developmental disorders means that ASD diagnosis is difficult. The task of providing ASD diagnosis in Australia is further complicated by the variability in the level of skill and experience required by

diagnosing clinicians. In addition, diagnostic practices for ASD differ between states, with some requiring a comprehensive multidisciplinary team assessment, and others with far less stringent criteria.

In this presentation, I will describe two studies in which we are investigating diagnostic processes for ASD across Australia. The first study is a comprehensive survey of diagnostic practices across Australia. In the second, we are conducting an empirical study to examine diagnostic accuracy among clinicians in Australia. The results of these two studies will contribute to the development of a Graduate Certificate in Autism Diagnosis, Australia's first tertiary qualification for ASD diagnosis. This body of work will assist with the standardisation of diagnostic practices for ASD across the nation.

☆ **Outback Intern Pharmacist Training Program: a future in rural and remote practice**

Selina Taylor

Mount Isa Centre for Rural and Remote Health, QLD

Mount Isa Centre for Rural and Remote Health (MICRRH) has designed and implemented an innovative response to the pharmacist maldistribution issue by developing the first rural and remote Intern Pharmacist program in Australia.

Building a pharmacy workforce in the bush necessitates addressing the impact of the high cost of living, education and support and the perceived lack of professional opportunities.

The MICRRH Intern Program aims to address barriers and prepare intern pharmacists for a successful career as a 'rural generalist pharmacist' in the remote workforce. The MICRRH program provides interns with a rurally focused approach that supplements the mandatory prescribed intern training program.

The program consists of three major areas; accommodation assistance, focused education and preparation for intern examinations and integration in multidisciplinary teams.

Intern pharmacists meet fortnightly with the Pharmacy Academic and a member from an allied health setting for an interactive, participatory teaching and learning opportunity. Allied health practitioners discuss their discipline with the interns and how their field relates to pharmacy practice. Interns share pharmacy-specific information with the

allied health practitioners tailored to their discipline. Sessions are designed to promote open discussion and practical information sharing with the aim to better prepare pharmacists to work within rural multidisciplinary team. An additional benefit of this program is that allied health practitioners are upskilled on medications and the pharmacist role.

Five intern pharmacists have successfully completed the program over two years. Their practice demonstrates the importance of networking with allied health teams. Feedback indicates the program fills a gap in undergraduate training resulting in an enhanced understanding of the roles, function and capacity of allied health professionals and the importance of interprofessional approaches for optimal patient care. Further, they develop the skills and confidence as a pharmacist to integrate into multidisciplinary teams to improve patient outcomes in a rural and remote context. Of the five pharmacists who completed the program, all five have been retained as practicing pharmacists in outback Queensland, in an area equally or more remote than Mount Isa.

The MICRRH intern program highlights the importance of interprofessional teaching and learning models, structured examination preparation, and accommodation support. The intern pharmacist year is an ideal time for pharmacists to create networks and enhance their knowledge of multidisciplinary care. The intern program better equips pharmacists to work as a 'rural generalist pharmacist' and provides an important component of the pharmacy workforce pipeline.

Lessons learnt from capacity building community projects in remote Central Australia

Karen Thomas, Jill Naylor

Northern Territory Medicare Local, NT

This abstract highlights the outcomes of a completed evaluation of two remote preventative health initiatives in Aboriginal communities in the NT.

The aim of the preventative health initiatives has been to build community capacity in preventative and health promotion activities. The initiatives have increased the knowledge of community members on improved health and wellbeing. This has progressed through a collaborative and coordinated approach to health promotion and prevention, informed by

community health needs, focusing particularly on physical activity and healthy eating. Project activities within the communities have included supporting the building of a community laundry, classroom nutrition education, implementation of a healthy snacking fridge at the store and community gardens to enable increased access to affordable fresh fruit and vegetables.

Both projects have been implemented over four years and, as part of the funded organisations commitment to evidence based practice, a comprehensive evaluation was completed in 2014.

Preventive health projects and the intended health outcomes take time. In a remote context these projects are at the liberty of limited funding timeframes, workforce shortages, organisational change and complex health conditions. This evaluation has provided information to further shape these projects into a sustainable model through community capacity building to improve health.

It is hoped that two local Aboriginal women will co-present with the project officer on the impact and lessons learnt on the project delivered in their community.

★ Pulling people, places, pages and pathologies together through farm health

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Background: Social isolation, lack of connectivity, connectedness and poor quality information have been cited as influencing health, wellbeing and safety outcomes for rural and remote populations. Of particular concern has been the dearth of rural topics on the highly accessed Better Health Channel (BHC) with previously nil resources focusing on farmers' health.

This paper outlines the union of people, places, pages and pathologies by collaboratively developing an online presence to engage, improve access and make a real difference to farmer's lives.

Method: A search examined all sites providing farmer health information to identify gaps. A skills-based, consumer-focused advisory committee was established comprising farmers, (with varied levels of computer literacy) industry representatives, health professionals and IT specialists. Quarterly meetings over 3.5 years functioned to design, develop,

implement and evaluate the website. A partnership was established with the BHC to increase agricultural specific content. To ensure credible and up-to-date health information, Health on the Net Foundation (HONcode) accreditation was sought. The HON Foundation is a non-government organisation ensuring adherence to a basic set of principals and certifying websites publishing reliable health information.

Results: In April 2010 the HONcode accredited www.farmerhealth.org.au website was launched with over 80 fully referenced farmer health, wellbeing and safety fact sheets, shared through RSS feeds with BHC. Weather, videos, discussion forums, education and interactive learning tools were provided. Since 2010, www.farmerhealth.org.au has had over 90,000 unique Australian and international visitors and over 350,000 page views.

The most accessed pages have consistently been the zoonotic disease Scabby mouth (Orf), eye injuries, succession planning, crush injuries and depression. This reflects both the nature of the farming population's need for information and the health and wellbeing issues experienced by farmers.

The website has also been used to communicate with rural people generally. One successful example was through the 'farming in focus' photography competition, attracting over 1100 digital submissions available for viewing on the website and via a touring public exhibition.

Discussion: Building on the original website, we now disseminate information and encourage engagement through a variety of platforms including Facebook, Twitter, YouTube, BHC, university webpage and a mobile-ready website.

Given the continuance of poor digital access in rural communities, the possibilities are endless as to who, where and how we send the message and quality information to improve farmer health.

Recommendation: We recommend fast, reliable digital access be an urgent priority for rural communities.

Workplace based assessment pilot in General Practice for AMC Part 2 certificate

John Togno, Di Wyatt, James Hughes
ACRRM, VIC

Aim: To present a report of the outcomes of the ACRRM pilot of Workplace Based Assessment (WBA) of overseas trained doctors for the equivalent of the Australian Medical Council (AMC) Part 2 certificate.

Rationale: Approximately 2800 OTDs working in Australia are waiting to sit the AMC Part 2 examination; with 1700 of these OTDs working in general practice on limited registration in areas of medical workforce need. ACRRM was funded by the Department of Health and Ageing (DoHA) to undertake the first pilot of WBA in the general practice setting; there are four ongoing WBA hospital based programs.

Methods and discussion: ACRRM was accredited by the AMC in February 2012 to deliver a pilot in the general practice setting of WBA for overseas trained doctors who are eligible to be assessed for the equivalent of the AMC Part 2 Clinical examination. WBA was delivered in association with a number of Regional Training Providers (RTPs) around Australia. The RTPs provided resources to support the OTDs including a nominated Medical Educator who will undertake formative assessments and provide training guidance for the candidates. Delivery of the program utilised an innovative approach to recording consultations for formative feedback using a smartphone with a camera lens mounted on a frame which held the phone and microphone ACRRM was responsible for conducting all summative assessments and for reporting the results to the AMC. The AMC then determined whether or not a candidate was eligible for the equivalent of the Part 2 certificate. WBA is an assessment process not a teaching or training program. The baseline assessment outcome is equivalence with AMC Part 2 and the expected clinical performance standard is end PGY1. The performance of candidates was measured against criteria specified in Australian Curriculum Framework for Junior Doctors (ACF). Formative assessment by RTP ME was case based discussions (CBD) and Mini-CEX with multiple assessors over time. Summative assessment by ACRRM included CBD, Mini-CEX and multi-source feedback.

Two cohorts participated in the WBA pilot, with 12 candidates completing the 12 month program. Ten of these candidate have been deemed by the AMC to successfully met the requirements of the AMC Part 2 certificate.

Conclusion: This innovative trial was the first time WBA has been used in a general practice setting in Australia. The outcomes strongly support this validity of this method particularly for assessing the clinical and consulting skills of overseas trained doctors.



Youth arts and mental health: exploring connections in the Top End

Jane Tonkin¹, Gretchen Ennis²

¹The Research Centre for Health and Wellbeing, Charles Darwin University; ²Corrugated Iron

Participation in youth arts activities is generally considered 'good' for adolescents' social and emotional wellbeing. Yet much of the literature on this topic comes from a 'big-city' perspective that may not take into account the (at times conservative) social and cultural norms found in remote and rural locations. Corrugated Iron Youth Arts and The Research Centre for Health and Wellbeing at Charles Darwin University have been working together to understand if and how participating in youth arts is good for young people in and around the Darwin area in the Northern Territory.

The aim of this presentation is to share early results from a qualitative research project, about the mental health benefits of participation in youth arts in Darwin and, using existing literature, to place this research in a broader national and international context.

Firstly we overview national and international literature about the mental health impacts of participation in youth arts activities, with a focus on rural and remote locations. We then introduce Corrugated Iron Youth Arts, an organisation with 30 years' experience delivering community based youth arts activity in the Northern Territory. We provide early analysis of our own qualitative research exploring the health and wellbeing impacts of participation in youth arts upon 17 participants, focusing in specifically on mental health. Finally we compare and contrast the early results of our research with broader literature in order to understand similarities and differences between our Northern Australian and other contexts.

With the rapid rise of mental illness among adolescents in Australia, and in rural and remote contexts particularly, creative approaches to prevention are required. For many young people the social and cultural norms, and the particular types of masculinities and femininities often found in rural and remote locations can contribute to feelings of isolation and difference. Such young people appreciate and require safe outlets to explore who they are and what they can contribute. The research presented here provides qualitative evidence that participation in youth arts activities (particularly performance-based activity) can assist young people with self-confidence, a sense of 'creative' identity, and feelings of social connectedness and belonging. All of these things are important for good mental health.

Update on the nutrition situation in the Asia-Pacific region

Mike Toole

Burnet Institute, VIC

In low- and middle-income countries, undernutrition is associated with between one-third and half of child deaths globally. Of those children that survive undernutrition, more than a quarter—or 165 million children—are stunted (low height-for-age). This has long-term negative consequences affecting educational outcomes and employment opportunities.

While the highest rates of stunting are in South Asia and sub-Saharan Africa, some countries in Southeast Asia and the Pacific have very high rates, including Timor-Leste (50%), Papua New Guinea (44%), Cambodia (41%), Indonesia (39%), Myanmar (35%) and Solomon Islands (33%).

While health concerns often focus on overweight and obesity among adults in the Pacific region, child stunting rates in 2013 were the highest in the world (39 per cent). This highlights the challenge of addressing the *double burden* of over- and under-nutrition in a region where adult female overweight prevalence exceeds 90% in some countries, such as Tonga and Nauru.

Online resource to empower Indigenous communities to reduce harmful substance use

Avinna Trzesinski

Australian Indigenous Health/InfoNet, WA

Aboriginal and Torres Strait Islander people experience disproportionate levels of harm from alcohol and other drug use compared with other Australians. Minimising alcohol and drug related harm among Aboriginal and Torres Strait Islander people and using the Internet to provide evidence based information are identified as priorities in the *National Drug Strategy 2010–2015*.

This presentation highlights how people working to reduce the harms of alcohol and other drug use in Aboriginal and Torres Strait Islander communities can be supported through an online resource. A specifically designed resource providing culturally appropriate and evidence based information can strengthen drug and alcohol initiatives at a community level.

Development of the online community resource (community portal) began with the engagement of community members through collaborative partnerships. Data was collected from a national online survey and four focus groups (in NSW, SA and WA), to ascertain the information needs of Aboriginal and Torres Strait Islander community members about alcohol and other drugs. Participants provided information on: the main substance use issues in their community; where they accessed information about alcohol and other drugs; what issues were important; and what type of information and resources would be useful to them and their community for an online resource.

Participants indicated that:

- all drugs were of concern but the biggest problems were harms related to alcohol, tobacco, and cannabis use
- the use of emerging drugs like ice (methamphetamine) and the misuse of prescription drugs (pharmaceuticals), and sniffing of volatile substances was an issue for some communities
- accessing appropriate and evidence based information about alcohol and other drugs was important

- young people (young men, women and families) and families impacted by alcohol and other drugs needed the most support.

Participants wanted information on:

- different drug types, where to go for help, and treatment options
- mental health and substance use, alcohol and pregnancy, and youth-specific issues.

Strong themes emerged of what to include on the Community portal including a focus on successful stories and programs and the use of community role models. Information presented with clear messages using visual and audio mediums was also requested.

There was strong support for providing fact sheets in plain language format, listings for services and organisations and the development of an app.

The community portal was developed with continuous feedback. It provides a synthesis of knowledge to help empower community members to reduce the harms arising from substance use.

Natural disasters and women—we need to think about vulnerability differently

Karen Tully

National Rural Women's Coalition, ACT

This general paper presentation will examine measures that could improve gender responsiveness whilst addressing the mitigation of the economic impact on women in approaches to disaster preparation, emergency management, disaster relief and recover, and how a gendered approach could make a difference.

Two organisations facilitated roundtable discussions in 2014 with a range of rural and remote stakeholders to examine how women often shoulder a disproportionate burden of the effects of natural disasters. As primary family carers and as community carers, women often play key unpaid roles in disasters—both before and after. Gender concerns are often overlooked in the 'tyranny of the urgent'. During and after natural disasters, women's health and welfare is often impacted, yet these women continue undertake unpaid and voluntary work which contributes to community recovery and general resilience.

This general paper presentation will look at some key issues and measures that could improve gender

responsiveness at a policy and local implementation level. The vulnerability of women will be examined and solutions proposed that would assist in improving the physical and mental health of women, as well as their economic circumstances in times of natural disasters. The **people** are our women, the **places** are those impacted by natural disasters and the **possibilities** for addressing the gendered impacts of natural disasters on women are numerous.

Anyone with an interest in natural disaster preparedness, response and recovery or an interest in women's health and economic wellbeing will learn how a gendered approach can make a difference to individuals, families and rural and remote communities.

Achieving good health and wellbeing in rural Australia: perceptions of older men

Anna Tynan^{1,2}, **Liane McDermot**^{1,2}, **Fiona Mactaggart**¹, **Christain Gericke**^{1,2,3}

¹The Wesley-St Andrews Research Institute, QLD;

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³Queensland University of Technology, QLD

In Australia, disease risk factors, mortality rates and degrees of illness are positively associated with increased distance from major cities. It is well known that men often do not live as long as women, and that the challenges that face rural health service delivery may further exacerbate this issue for rural men. Men are also known to attend doctors less often and are less likely than women to report efforts aimed at improving their health. It has been suggested that expectation to be 'tough' is stronger among rural men than their city counterparts, which also has implications for health and wellbeing outcomes. This research aimed to explore the perceptions of health and wellbeing needs of older men in rural and regional Queensland in order to understand avenues for strengthening services for men in rural areas.

Method: Three focus groups and six in-depth interviews were completed with older men (>50years old) from three different rural and regional shires of Queensland as part of a larger community health and wellbeing study. Men were recruited via word of mouth and expression of interest through a health survey that was sent to a random selection of community participants through the Queensland electoral role in each of the shires. Thematic analysis was conducted to explore health and wellbeing perceptions.

Results: Although men from rural and remote areas in Queensland might face particular challenges in achieving good health and wellbeing status due to reduced access and a culture of stoicism, small communities offer opportunities for increasing men's access to social health networks. However accessing these social health networks are often triggered by illness. The men identified that lack of purpose has a particular impact on achieving overall health and wellbeing. They also noted that a 'bullet proof' attitude in younger years meant they did not consider any need to invest in health and wellbeing activities. Word of mouth and support from peers is the major channel of communication for older country men.

Conclusion: The findings of this study suggest that addressing health and wellbeing issues are often achieved through informal settings for older rural men. This study identifies that it is critical for individual health workers, organisations and policy makers to be aware of the social conduits for supporting acceptability of health and wellbeing activities for older rural men.

Outcomes following cardiac arrest in remote areas of the Northern Territory

Colin Urquhart¹, Jodie Martin¹, Mark Ross^{1,2}

¹Careflight; ²Royal Darwin Hospital

Out of hospital cardiac arrest is a common cause of death worldwide, and studies assessing outcome frequent the literature. Although several papers have looked at survival rates in rural locations, to our knowledge none have assessed outcomes in the remote regions of the Northern Territory. There is evidence demonstrating that mortality is adversely affected by distance from population density and tertiary medical care. The top end of the Northern Territory encompasses a vast area and a low population density, suggesting that patients suffering out of hospital cardiac arrests in these remote areas would have poorer outcomes than their city counterparts. In addition, the NT primary response to emergencies and retrieval set up for transfer to a hospital is relatively unique in comparison to the predominantly road ambulance based systems presented in the literature. The initial emergency response is most commonly provided by rural clinic staff, with further critical care treatment advice and subsequent retrieval provided by the Top End Medical Retrieval Service (Careflight). Although advanced life support is often administered in a timely manner, the time for the patient to reach hospital can be several hours and the aim of

Careflight is to bring critical care management to the patient in the remote community. With the World Health Organization predicting the burden of ischaemic heart disease to increase over the coming years, cardiac arrest will certainly become a more prevalent problem. We aim to retrospectively identify all cardiac arrest cases since January 2010 with whom the Careflight retrieval service has been involved. From the Careflight medical database and hospital notes, we aim to identify all cardiac arrest referrals and associated information: response times; retrieval times; team composition; interventions performed; outcomes (survival at 1 day post arrest, 28 days and to hospital discharge). Preliminary review of the medical database has revealed 41 cases with a primary or secondary diagnosis of cardiac arrest, although more cases may be revealed using wider search parameters and case note review to illicit cases in which it was not a labelled diagnosis. In addition we will review and include all cases that were referred but did not survive to retrieval team arrival. We aim to show similar outcomes to published data on survival from cardiac arrest compared to other areas of the country and demonstrate that the current rural emergency response and retrieval systems provide a comparable outcome to the rest of Australia and the world.

Kelso Indigenous chronic disease clinic—your one-stop health clinic

Anne Vail¹, Jacqueline Gibbs²

¹Western NSW Medicare Local; ²Kelso Indigenous Chronic Disease Clinic, NSW

The benefits of a collaborative team approach model to Indigenous health care will be discussed in the presentation. Communication is the vital link between providers and referrers into the clinic for improved cohesiveness within the patient journey.

The weekly run health clinic is in an Indigenous suburb of Bathurst in western NSW. The clinics aim is to improve chronic disease outcomes for Aboriginal patients within the community and enhance access to support services. In the quarter Jul–Sep 2014, 80% of patients seen accessed three or more providers at the clinic.

Seven allied health and specialists are involved at the Thursday clinic which runs out of a local council community venue. Different providers are available on different weeks to offer patients a holistic approach to chronic disease management through targeted health goals. Providers include

endocrinologist, diabetic educator, dietitian, exercise physiologist, podiatrist and clinical psychologist. The position of respiratory physician is currently vacant.

Our lovely Aboriginal health worker is the frontline face who runs the clinic ensuring that patients are able to access the clinic by coordinating referrals, booking appointments, providing reminder calls and assistance with coordination of transport. The AHW provides monthly clinic attendance letters to general practitioners and connecting care staff within the Local Health District and Western NSW Medicare Local regarding any referred patients as part of our Team Care Arrangement collaboration.

The team at the clinic work within the same building utilising the same clinical software which allows for a shared clinical patient file. This allows for joint goal setting for the patient in line with best practice clinical management. The team coordinates case conferences for clients if required and also assist with facilitation of telehealth visits when required. This has worked well for patients travelling >100kms to access the clinic as well as during pregnancy for our visiting endocrinologist.

Patient survey and feedback is regularly sort for ongoing improvement of the clinic. Analysis of the health improvements of the patients who have been accessing the clinic for greater than one year will be assessed through review of clinical markers such as HbA1c levels, weight and BMI measures as well as health outcome scores such as K10 scores and fitness rating scales. These findings and recommendations for ways to replicate this health service delivery model will be provided in the presentation.

☆ 'We're beside you'—tailored preparation to remote health practice

Fiona Wake

Remote Area Health Corps, NT

Remote Area Health Corps (RAHC) recruits, prepares and mobilises urban based health professionals to supplement the permanent workforce in remote primary health services throughout the NT.

History: Remote Area Health Corps (RAHC) is funded by the Australian Government Department of Health under The Indigenous Australians' Health Program: Stronger Futures Northern Territory to contribute to "address persistent challenges to accessing primary health care services for

Aboriginal and Torres Strait people in the Northern Territory".

RAHC collaborates closely with health services to supplement their permanent workforce by providing clinically safe and culturally sound health professionals (HPs) for short term placements. RAHC was set up in response to stakeholder requests to access the pool of urban based HPs interested in working in a remote setting. Provision of tailored preparation, training and support is an essential part of the RAHC model to assist HPs to make a successful transition to remote practice.

Process: RAHC applies a rigorous approach to credentialing to identify HPs that will meet the requirements of health services and then provides a range of information and training to prepare the HP for a placement. This approach has delivered almost 3,000 placements and overwhelmingly positive feedback from both the HPs and the health services and a repeat rate approaching 80 per cent. Further, over 25 HPs have transitioned into permanent positions in the NT.

Remote Educator (RE) support program: RAHC's RE support program provides REs to deliver one on one support on the ground for nurses to assist their successful transition to remote practice. The program begins with the RAHC clinical team guiding a nurse to prepare for their first placement. RAHC's suite of 15 eLearning modules provide an introduction to remote health practice along with additional resources including the CARPA manual and the NT immunisation training course (AGV).

Arriving in the NT, the nurse completes 2 days of face to face clinical and cultural orientation. A RE then accompanies the nurse for the first week (longer if required) to their placement and works with them side by side to support a safe and effective clinical and cultural transition. Feedback is solicited from the HP, RE and the Health Centre Manager about this process.

Summary: RAHC's high repeat rate and the increasing use of the RE program by health services provides evidence that our preparation and support is contributing to supplementing the workforce in the Territory.

Diabetic retinopathy screening for Indigenous Australians in the Kimberley

Shelley Walters¹, Verity Moynihan²

¹Kimberley Aboriginal Health Service; ²Lions Eye Institute

Aim: To provide an overview of the Kimberley diabetic retinopathy screening program and examine the strengths and barriers to the provision of this model for the early detection of diabetic retinopathy.

Methods: A detailed description of the screening program model will be presented, focusing on the coordination of screening and the role of community-based Aboriginal Health workers. The efficacy of the program and barriers to screening for diabetic retinopathy will be discussed.

Conclusions regarding the screening program will be supported by data collected on the number and quality of screening episodes for each site at which screening occurs, as well as the age, gender and presence of retinopathy for those who have undergone screening from 1 January 2014 to 31 December 2014.

Relevance: The screening program aims to provide a self-sustaining, functional screening program in isolated communities that is culturally appropriate and adaptable to a range of health services and settings. To deliver the program, training is provided to Aboriginal Health Workers and Nurses on eye care and the operation of a retinal camera. The screening program is an example of a successful community based eye health program and has provided a sustained service to the residents of the Kimberley region for over 20 years. The Kimberley program model is becoming increasingly relevant as interest in a national approach to screening for diabetic retinopathy grows, and may provide a blueprint for the implementation of similar services across Australia.

Conclusions: Based on the findings from the study, recommendations will be made on logistical and cultural processes to enhance the screening service in the Kimberley and elsewhere.

Remote Opportunities for Clinical Knowledge, Education, Training and Support for Health in Primary Care—the ROCKET+SHIP project

Lachlan McIver, Bonnie Ward
ROCCT-SHIP program

In recognition of the vital role of primary health care in improving health systems efficiency and population health in the Pacific region, and the importance of social and environmental determinants of health, a network of partnerships and activities has been established under the banner of ROCKET+SHIP-Pacific—Remote Opportunities for Clinical Knowledge, Education, Training and Support for Health in Primary care in the Pacific.

ROCKET+SHIP seeks to help communities in need improve their health and wellbeing through sustainable development initiatives, implemented via four key strategies: strengthening primary health care systems; building the capacity of health care professionals; optimising social and environmental determinants of health; and ensuring equity and sustainability in all aspects of health and community development.

This presentation describes the purpose, objectives and activities of ROCKET+SHIP, and its potential impact on primary health care systems and population health in the Pacific.

Shape Up For Life: peer-led lifestyle modification based on preventive self-management

Kate Warren
University Department of Rural Health, SA

Introduction: Obesity prevalence is higher in rural Australia than in urban centres and a population health study provided evidence to show rates of abdominal obesity alarmingly high in a rural city but without a corresponding higher rate of diabetes diagnosis when compared nationally. These findings were interpreted as predictive of a spike in diabetes cases locally if no action was taken. Local government and non-government organisations partnered with UniSA Whyalla campus to apply for a Healthy Communities Initiative grant to address the identified needs and were successful.

Shape Up For Life was first developed in 2006 and delivered to this rural community as the intervention

phase of a randomised controlled trial successfully reducing the symptoms of metabolic syndrome, a recognised precursor to diabetes. The program has been re-developed as a peer education led, lifestyle modification program based on the principles of self-management.

Methods: A process of building community capacity was undertaken in the lead up to program implementation. Peer Educators were recruited who were already skilled in specific self-management skills via the Stanford Chronic Disease Self-Management program. They were trained in the lifestyle education modules and the delivery mode via interactive power point presentations weekly over eight weeks. Eight of the nine trained delivered at least one complete eight week course over the length of the project to a collective cohort of 290 people.

Baseline measures taken prior to the education phase were: height, weight, waist, hips, blood pressure, HbA1c, Albumin/Creatine ratio (ACR) and lipid panel. Demographics, lifestyle behaviours and knowledge were collected via questionnaire. Risk factor self-management scores were collected via the Flinders University Living Well Scale™. Measures were repeated immediately following the eight week education intensive and then at the end of the study period following three, monthly group sessions. Qualitative feedback was also collected via focus groups.

Results: Interim results have shown clinical measures improved following the intensive education phase and dropped off slightly by the end of the study as engagement diminished. This is reflected as common in the literature based on similar lifestyle modification programs. This suggests that a program delivered via peer education is at least as effective as others taught by experts in the field. Community engagement and feedback was overwhelmingly positive with participants wishing to remain in an ongoing program based in the community.

Conclusion: Lifestyle modification programs can be safely delivered via peer education and are inexpensive to deliver to rural communities and should be strongly considered as part of the overall health service delivery model. Further population health measures need to be undertaken to ascertain the level of impact this intervention has had on preventing diabetes in this rural community.

Doll making: yarnning with Elders about motherhood

Loretta Weatherall^{1,2}, Pearl Slater², Jessica Bailey², Kym Rae^{2,3}

¹Mothers and Babies Research Centre, Faculty of Health, University of Newcastle; ²Gomerioi gaaynggal Centre, Faculty of Health, University of Newcastle; ³Department of Rural Health, Faculty of Health, University of Newcastle

Introduction: The Gomerioi gaaynggal centre offers an Artshealth program that is designed for young Aboriginal mums. The centre is a cultural space and a safe environment to make the mums feel comfortable. Respect of the Elders and their knowledge is an important part of Aboriginal traditions and spiritual practice. The mums that attend the Gomerioi gaaynggal Centre often don't have their Elders around because they have either moved here from their own community or all of their Elders have passed on. These women miss the presence of Elders in their lives.

Aim: To make an educational DVD about female Aboriginal cultural practices.

Methods: All Elders groups in Tamworth and Walgett were consulted and all agreed it was a good idea. We thought that instead of just sitting and yarnning, we could to yarn while making dolls that had stories. The doll making project gave Elders a starting point to telling their own stories. Their doll represented a person in their own lives and Elders were interviewed and filmed about their doll and lives in order to make an educational DVD about Aboriginal cultural practices. Doll making occurred weekly over a period of time with both Elders and mums together.

Results: The Elders and mums reported that they really enjoyed making the dolls and many have continued their doll making. The doll making project opened up a lot of the discussion of their upbringing, motherhood, what bush medicine and food they used and ate. The DVD will be used as a cultural learning tool for all of our young mums, school and health students.

Conclusion: Elders and mothers have requested the continuation of the doll making. Video from the doll making will be presented at this conference.

Urban responses to Aboriginal visitors to Darwin

Louise Weber

Larrakia Nation Aboriginal Corporation, NT

The NT has the nation's highest rate of homelessness and 17 times higher than anywhere else in Australia. With one-third of the NT population Aboriginal, we see a continual urban drift from remote communities resulting in high numbers of people sleeping rough in Darwin and a rapid deterioration of physical and mental health. Health determinants of poverty, racism, service gaps and policy limitations are magnified by a dire lack of affordable accommodation.

The profound impact of stigma on health outcomes is well documented, with homeless people living in the 'Long Grass' arguably the most stigmatised section of the Aboriginal population.

Against this backdrop and lethal combination of factors that Larrakia Nation has developed a suite of award-winning and innovative evidence-based programs to minimise the negative health impacts on First Nations people. Moreover, these programs are designed and delivered by Aboriginal staff and service providers, including former 'Long Grassers'.

Core deliverables include:

- access to primary health care and social engagement through our renowned 'Arts in the Grass' activities
- clinical care and case management to help 'close the gap' for the most marginal
- assisting thousands annually to return to communities like Wadeye, Galiwin'ku, Maningrida and Groote Eylandt
- interventions and diversionary activities for people on release from protective custody
- increasing community safety and reducing harm to people in the Long Grass with Larrakia Night Patrols unique urban based service
- sourcing housing through an 'Assistance, Care and Housing for the Aged' program, with many 'Long Grassers' in the aged and prematurely aged demographic.

The most recent addition is the Healing Centre Project, designed to reduce intergenerational trauma and address root causes, using holistic

therapeutic support to local Larrakia people, and build capacity to assist Longgrass visitors.

The presentation will draw on evidence, unique challenges, successes and current policy context.

Shout A Mate

Kieran Wicks

Shout A Mate program

When the founder of Shout A Mate first started the project in 2011 she did not expect that she would be attending this conference and sharing stories with you.

Giving our 'country cousins' a hand up, not a hand out is our motto.

It co-exists alongside our 'Visit Australian Small Towns' sister network, to bring awareness of rural issues and attributes to wider Australia.

The ethos of the VAST Network is that if only 10% of Australians headed inland for a holiday, instead of going overseas, our economy would be fixed in a jiffy!

Shout a Mates' mission is to bring social and mental respite to rural and remote communities who are suffering from isolation, drought, economic or social decline.

Mental and social wellbeing is paramount in rural and remote communities where members of the community often suffer isolation and depression is increasing.

It has been noted that the suicide rate within small communities rises once the football season has finished as often those involved feel a sense of isolation post-season.

It has also been noted that isolation, and economic and social decline also contributes to mental health, family breakdown and unfortunately suicide.

We all must help kick that black dog!

Through music and laughter our programs are able to connect with young and old.

The combination of patron musician Kieran Wicks and celebrity comedian Chris Franklin is just one example of a program that has proved successful. Giving adults the opportunity to laugh and 'chill out' at a show is priceless. Shout A Mate shows are produced specifically for each communities' needs.

These unique social occasions can be made possible through community-minded organisations and individuals who recognise the importance of 'chilling out' and socialising with friends.

Autism and Aboriginal and Torres Strait Islander children

Florence Williams, Yvonne O'Neill

Autism Queensland Limited, QLD

A 2012 review of global prevalence estimates of autism spectrum disorders found a median of 62 cases per 10,000 people. The disorder is reported to occur in all racial, ethnic, and socioeconomic groups and is 4-5 times more prevalent in boys. In Australia the incidence rate for young children is 1:100. Evidence from worldwide best practice evaluations supports the early intervention will provide the best outcomes for children on the autism spectrum. Despite a federal government response to the increasing needs of support for children with ASD and their families, the number of Aboriginal and Torres Strait Islander children and families accessing support is disproportionately low. This raises questions in relation to identification of the condition, access to services and suitability of services for Indigenous families.

The Aboriginal and Torres Strait Islander Liaison Officer Project (Helping Children with Autism DSS) has been working since 2012 to increase awareness of ASD in Aboriginal and Torres Strait Islander people and communities. This presentation provides a longitudinal appraisal of available data from aligned ASD services to identify the current incidence and prevalence of ASD in young Aboriginal and Torres Strait Islander children, discusses the challenges of identification and service provisions and highlights a pathway for improved identification and support services for these children and their families.

Preparation for health professional students' practice in rural and remote primary health care settings

Robyn Williams

CDU, NT

How prepared are health professionals to work in rural and remote primary health care settings and what type of preparation is necessary for them to be effective and culturally safe practitioners?

It is well known that there are many challenges working rural and remote; including working cross-culturally; an aging work force, high staff turnover and variable provision of appropriate education and training. Anecdotally, it appears that there is still quite a gap between the education and training that received at undergraduate level and the requirements of the specific work context. There also often appears to be a 'dis-connect' between the theory in the curricula and the practicalities or realities of the health professionals' role.

The author's PhD research is on preparation of health professionals working in Indigenous primary health care settings. This paper explores part of the research project which is to talk with students enrolled in a Rural and Remote Health unit about the preparation they believe that they need to work in rural and remote health. What are the motivators and deal breakers? Does it include factors like placements, lecturers, and/or explicit units in the curriculum? The research also examines strategies around developing the capacity and resilience of students from enrolment to graduation and transitioning into the rural and remote workforce.

The outcomes or the conclusions reached from the research will contribute to the development of appropriate curricula in the short term and hopefully better retention and preparation of graduates in the longer term.

Smarter Safer Homes for older Australians: providing feasible, virtual in-home care

Stephen Winn¹, Leanne Nisbet²

¹University of Southern Queensland, QLD; ²PhD student, The University of Queensland, QLD

The Smarter Safer Homes Project has been undertaken with a small cohort of older Australians living within independent residential units at an aged care facility in rural New South Wales. The project, which was a collaborative effort between researchers from the University of New England and CSIRO e-Health, aimed to improve the quality of life of participants, by investigating the way that e-Health technology could be used to actively support healthy ageing in regional rural Australia. Smarter Safer Homes' researchers examined the use of remote in-home sensors, which included acoustic sensors, reed switches and videoconference accessibility via tablet devices to support older Australians who wished to remain living independently, within the familiar environment of

their homes. Digital links via high-speed broadband connection were set up to download data from participants and their environment to their medical and health care specialists, but to also connect participants to friends, online social networking groups, family and others, providing a practical solution to the sociological issues of loneliness or depression of aged Australians as a result of their remote location or physical isolation.

Researchers associated with the project explored the myths that prevailed around older Australians in general, as being 'digitally disengaged' or at best, 'digital immigrants' reluctant to incorporate sophisticated 21st century technology into their everyday lives, and the culture of utilising technology by medical and health professionals. This project explored associated academic research and scholarly literature regarding the delivery of technology to aged citizens and found a surprising lack of positive 'success stories', and furthermore suggestions that remote health sensing raises a number of issues relating to an individual's privacy. The Smarter Safer Homes Project suggests that the major factors underpinning the positive, successful engagement of older Australians with remote health monitoring and quality of life focused digital technology, are: reliable internet connectivity, secure transfer and IT server availability, excellent communication skills on behalf of health care professionals and third party providers, a willingness by health professionals to utilise a virtual delivery, a continuously evolving constructivist perspective of older Australians within the context of their community—and the practical application of flexible, situation-appropriate, change management principles. Fundamentally, the impact of removing people from familiar surroundings has a negative impact on Quality of Life and by its association, Family Quality of Life. There is potential benefit in utilising a range of low cost technologies that could potentially have a major positive impact on the health and wellbeing of older Australians.

★ A physiotherapist led inpatient spirometry service in rural Victoria: a service review

Brooke Winzer, Mark Tamaray
Northeast Health Wangaratta, VIC

Introduction: Spirometry is an essential tool in the diagnosis and management of respiratory disease. An inpatient spirometry service was developed in 2013 by Physiotherapists at Northeast Health

Wangaratta (NHW), a 228 bed acute hospital in the Hume region of Victoria. The service aimed to i) aid accurate diagnosis and enhance management of respiratory patients and ii) increase hospital revenue via optimising activity-based funding.

Method: Investigations into the feasibility of a spirometry service commenced in February 2013. Due to the limited resources and support available rurally, The Alfred hospital's Lung Function Laboratory agreed to act as NHW's 'resource laboratory' and provided expert advice regarding which spirometer to purchase, the testing procedure and quality assurance measures.

The EasyOne-Line World™ spirometer (NicheMedical) was selected, as it is portable, permitting bedside testing; uses disposable mouthpieces; can be cleaned with alcohol wipes; and does not require routine calibration.

Two physiotherapists completed a two-day spirometry course endorsed by the Australian and New Zealand Society of Respiratory Science.

A protocol based on the American Thoracic Society and European Respiratory Society guidelines was developed by NHW physiotherapists and reviewed by the Head Scientist from the Alfred's Lung Function Laboratory and the Medical Director of NHW.

Results/discussion: The spirometry service commenced operation in July 2013. During the first 12-months, 30 patients were referred, resulting in a total of 48 tests being performed. This represented a 300% increase in the use of spirometry by Medical Officers compared with the previous 12-months where testing occurred offsite by a private laboratory.

The top three reasons for referral included review of known COPD (n=10), assessment for new diagnosis of COPD (n=9) and monitoring respiratory function in patients with Guillain-Barre' Syndrome (n=4). Patient care was enhanced by aiding the diagnosis of COPD (n=3), pulmonary fibrosis (n=2) and fixed upper airway obstruction (n=1).

Prior to July 2013, NHW was paying a private laboratory to conduct spirometry offsite. With testing now onsite, this represented a saving of \$5,718.72. Furthermore, spirometry results were used to more accurately code patient presentations resulting in an additional \$10,154.28 in WIES funding. Minus start-up costs of \$4832.00, the net financial gain to NHW over 12-months was \$11,041.00.

Key insights:

- Partnering with a metropolitan hospital was key to developing a successful spirometry service within a short timeframe with minimal resources.
- Spirometry in the acute setting enhanced patient care and increased revenue with minimal impact on running costs and current staffing.

☆ Understanding eye care through the experiences of Aboriginal people in the NT

Aryati Yashadhana^{1,2}, **Ruby Stanley**^{2,3,4}, **Francis Hayes**^{2,3,4}, **Godfrey Blitner**^{2,3,5}

¹Brien Holden Vision Institute; ²Vision Cooperative Research Centre; ³Ninti One; ⁴Wurli Wurlijang Health Service; ⁵Sunrise Health Service

Preventable eye diseases cause 94% of vision loss in Aboriginal and Torres Strait Islander (herein Aboriginal) adults (Taylor et al, 2012). Despite this, blindness rates in Aboriginal adults continue to sit at 6 times the rate of the mainstream population (Taylor et al, 2012). Recent studies have identified structural and systemic factors that inhibit access to eye care for Aboriginal people. However there is little evidence of the phenomenological factors that affect Aboriginal people's access to eye care, and the influence this has on decisions around eye health and care.

This study investigates why some Aboriginal people complete or do not complete their clinical eye care pathways, and why some do not access eye care at all. With a focus on cataract and diabetes eye diseases, we present the barriers and enablers around prevention practices, and primary, secondary and tertiary pathways of care, that have been identified through the perspectives of Aboriginal people in 2 remote Top End communities in the Northern Territory.

Three of the authors are Aboriginal community based researchers, who played an integral role in the conduct of interviews, and the thematic analysis of data. Engaging community researchers facilitated cultural and contextual appropriateness, knowledge exchange and capacity building. This presentation outlines (a) the research process (b) barriers and enablers to eye care through the voices of Aboriginal patients and (c) community driven recommendations to strengthen eye care systems in rural and remote communities.

Using a qualitative, Participatory Action Research (PAR) design, and in collaboration with Aboriginal Community Controlled Health Services (ACCHS), we aim to privilege the voices, experiences and lives of Aboriginal people, through understanding how human experiences and the social determinants that shape them, impact equity in eye health.

Deadly choices, healthy lives: promoting health in rural and remote Indigenous communities

Rachel Yates, Dallas Leon, Glenn Clarke

¹Gidgee Healing, Mount Isa Aboriginal Community Controlled Health Service, QLD

The Mount Isa Aboriginal Community Controlled Health Service (MIACCHS) Tackling Indigenous Smoking and Healthy Lifestyles (TISHL) team have been implementing the Deadly Choices and Good Quick Tukka (GQT) programs to Indigenous communities in the Mount Isa region since February 2014. The **aims** of these evidence based programs are to:

- increase awareness, health literacy and knowledge of the risks of smoking, high levels of alcohol consumption, poor nutrition and physical inactivity amongst Indigenous school children, pregnant women, disadvantaged men and other community members
- provide community members with encouragement and opportunities to make healthier lifestyle choices
- provide practical knowledge and skills in preparing healthy food
- increase links to primary health care services, including increased opportunities for health checks/early intervention, to lessen avoidable hospital use.
- increase exposure to healthy role models and provide leadership opportunities to become a champion within the community.

The TISHL team implements the program using a strengths-based, culturally appropriate **method** that builds on the benefits of making healthy choices and on existing positive examples within the community. It also leverages its links with the existing MIACCHS' medical clinic to cross refer and promote greater use of health services. Implementation of the program is highly **relevant** as the target community has a high Indigenous population as well

as poorer health, wellbeing, early development, education and employment outcomes than much of the rest of Queensland¹.

This presentation will examine the relevance of using a strengths-based, culturally appropriate, health promotion model linked to an Aboriginal Community Controlled Health Organisation (ACCHO) in engaging Indigenous communities to take up appropriate health messages and behaviours. It will analyse and discuss **results** regarding the impact of these approaches on achieving the aims of the program as well as on the improvement in school attendance that the program has coincidentally achieved within the target community.

The presentation will also explore how the combined TISHL and MIACCHS clinic teams can be used as a future platform for building Indigenous health workforce capacity within the community while simultaneously promoting health to address the needs of Indigenous **people** in rural and remote **places** and communities through offering greater **possibilities** of training, employment-readiness and wellbeing.

Hunter New England clinical telehealth: removing the distance between patient and clinician

Ashley Young, Owen Katalinic

Hunter New England Local Health District, NSW

Every year, regional patients from Hunter New England (HNE) travel over 20 million kilometres to attend outpatient appointments at our facilities.

To address this, HNE Health is rolling out telehealth utilising smart technology to transform the delivery and practice of clinical health care through a secure, virtual and mobile health environment. The provision of health care through this innovation is developing new models of care that are benefiting regional and rural patients, Aboriginal people, and elderly and palliative patients. It is also continuing the delivery of world class care, while saving significant travel and personal costs and time for our patients.

Telehealth in HNE represents a shift in focus away from historical care models where instead of patients coming to tertiary facilities to receive specialist outpatient services, they can receive personalised, patient-centred care at home or much closer to home. Our focus is on embedding

telehealth into all aspects of care delivery, and making it available and accepted across all disciplines and specialties. We are also concentrating on removing all barriers that are preventing the widespread uptake of telehealth, including lobbying at state and federal levels for changes to the Medicare Benefits Scheme.

In implementing telehealth we are also mindful that as a health service we need to cater for all patients, regardless of their socio-economic status. Throughout our district a number of communities have relatively poor access to broadband internet and/or suitable devices for home-based telehealth. In these situations we offer viable alternatives where patients receive telehealth appointments at nearby facilities or local practitioner's premises. In select circumstances, people with high health care needs are also offered loan devices to facilitate more responsive, home-based care. For a health district the size of Hunter New England Health, this represents a strategic shift in health care delivery.

In the short time since telehealth has been introduced, we have saved patients over 1000 nights away from home and 530,000 km of travel. In terms of cost savings, our modelling indicates that patients have saved \$650,000 on direct transport and accommodation costs. The growth of telehealth services throughout the district has been doubling each year—a trend that looks set to continue into the future.

Through implementing telehealth, HNE Health is achieving the Triple Aim of health care improvement: Better patient-centred care, improved health of the population, and reduced per-capita cost of health care. Our models of care are the way of the future—but available now.

Adapting service delivery to reflect updated smoking cessation guidelines in remote settings

Lis Young, Aimee Riley

Department of Health, NT

Aim: Ensure all smokers residing in remote communities, the Top End, the Northern Territory (NT) have access to best practice for tobacco cessation support and education.

The problem: Smoking is responsible for 21% of the life expectancy gap between Indigenous and non-Indigenous Territorians for men, and 14% for women. Smoking prevalence is as high as 73% in some Remote Communities, NT. The Indigenous

¹ Citations provided on request

population residing in Top End remote regions is estimated at 17,531 males and 17,129 females.

The Closing the Gap (CTG) Remote Community Tobacco Cessation Support Project was funded in 2008 to meet the need for evidenced and sustained tobacco control initiatives in remote communities. Their brief are to work within a community development framework, adapting best practice brief interventions resources for use in NT remote communities. From mid 2014 the Updated Smoking Cessation Guidelines, the RCAGP were incorporated into a client and family centred, bio-psycho-social model of care: assessment of dependence/addiction, including CO levels (Smokolyzer); customised pharmacotherapy, community follow up, and facilitation of family smoking discussions. The Tobacco Team work collaboratively with the medical services, the Primary Care Branch, Top End Health Services embedding the Tobacco Assessment Tool at a system level.

Assessment is offered in the family/community setting, clients are assisted in developing their own management plan, including their preferred pharmacotherapy; nurturing self-management skills and enlisting family support are integral to the intervention.

To ensure consistency of message all primary care outreach staff, clinical and non-clinical, are trained in the application of the Tobacco Assessment Tool and family support. An electronic version is embedded in the Patient Client Information System (PCIS) used in remote clinics, the Top End. Training is delivered in a structured workshop format with follow-up/assessment at the point of delivery.

Roll out of the program is staggered, five communities are targeted at a time: each site is visited up to six times over a six months period to consolidate family and self-management capacity. The project is designed as a complex system intervention; the PCIS electronic tobacco smoking cessation care plan has the functionality to provide monitoring and evaluation at the system level, the service provider level and the client and family level.

The Tobacco Assessment Tool; the Family Discussion Tool; process and outcome measures at the client level (addiction levels, pharmacotherapy, clients who quit, relapses); passive smoking levels in client homes, and the proportion of service providers trained will be presented for six communities.

Poster abstracts

POSTER

Bachelor of Midwifery (Indigenous) Away from Base Enhancement Program

Denise Burdett-Jones, Paula Schulz, Machellee Kosiak, Gail Baker, Joclyn Neal, Lynne Dunne

¹School of Nursing, Midwifery and Paramedicine (Qld), Australian Catholic University

Maternal mortality for Australian Aboriginal and Torres Strait Islander people is four times higher and infant mortality is three times higher compared to non-Indigenous populations¹. A key strategy towards closing the gap in maternal health outcomes is to increase the number of Indigenous Australian midwives who are able to work within their own communities². In 2013 only 186 midwives employed in Australia identified as Indigenous, representing 0.8% of all employed midwives³. An increase in the number of Indigenous people in the maternity workforce able to work in their home communities is an Australian workforce priority.

The Bachelor of Midwifery (Indigenous) Program, also known as the Away from Base (AFB) BMid Program, now in its fifth year of delivery, is a small, innovative program designed to prepare Indigenous midwives to lead and champion midwifery services in their home communities and address the workforce shortage of Indigenous midwives. One of the key challenges for the Program however has been progressing students to graduation in a timely manner. To optimise learning and engagement for Indigenous students studying in away from base mode the *AFB Mid Enhancement Program* was initiated. This project (supported by a Queensland Regional Training Network grant) enhanced the AFB BMid with two specific strategies informed by the recommendation of the Review of Higher Access and Outcomes for Aboriginal and Torres Islander People⁴.

Firstly an Indigenous Lecturer in Midwifery was engaged to contribute culturally relevant midwifery knowledge to the curriculum, provide cultural advocacy and support and strengthen connections with the Indigenous community. Secondly an additional clinical placement in a tertiary hospital

enabled students to meet increased midwifery registration requirements. These program enhancements, evaluated with staff and student focus groups, had a positive impact on student experience, student engagement, learning outcomes and course progression and directly resulted in the course completion of four students by early 2014.

In direct response to student feedback a suite of innovative strategies have also been implemented: the *AFB BMid Student Learning Community*, a culturally inclusive platform that facilitates student interaction with peers and teachers; as well as a 'virtual staff room' and *Midwifery Education Resource Kit* to creatively support curriculum and professional development for clinical industry partners. Enhanced support and additional resourcing has resulted in strengthened relationships with industry partners and improved clinical facilitators' preparedness for students undertaking placement.

POSTER

Social determinants of health: opportunities for youth through education and social support

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¹Department of Rural Health, University of Newcastle,

²Careers Network

The Youth Opportunities to Education (Yo2Ed) program creates opportunities for youth who are disengaged from mainstream schooling, to participate in nationally accredited courses through TAFE New England Institute, Tamworth. The Yo2Ed program is based on a wrap-around service model to support the mental health, wellbeing and healthy lifestyle development of participants. Youth who experience social disadvantage are more likely to adopt harmful health habits, which if not addressed may lead to poor health outcomes in adulthood.

The Yo2Ed Project is a partnership brokered by Careers Network under the Links to Learning funding program. The Yo2Ed wrap-around services are developed in collaboration with Hunter New England Health Aboriginal Drug and Alcohol Team and Tamworth Aboriginal Medical Service. The program addresses social determinants of health such as education, social support networks and

¹ National Perinatal Epidemiology & Statistics Unit, Australian Institute of Health and Welfare (2011).

² The National Maternity Services Plan 2010-2015.

³ Australian Institute of Health and Welfare (2013).

⁴ Review of Higher Education Access & Outcomes for Aboriginal and Torres Strait Island People (Final Report) (2012)

social exclusion. It achieves this by providing a safe and supportive environment for education and skills training, workshops from social support and health services, and opportunities for participants to give back to the community and in return receive recognition for their achievements.

It was identified that Yo2Ed participants had limited cooking skills and poor nutrition awareness. This led to a community nutrition project being developed in conjunction with students and staff from the University of Newcastle Department of Rural Health (UoNDRH) community engagement program and Yo2Ed Tamworth. Barriers to education included low literacy and numeracy, low self-esteem, varying ages and learning or mental health issues. It was identified that a tactile, participatory approach to education incorporating experiential learning would best engage youth in nutrition workshops. Existing nutrition resources and recipes were modified, and new resources and recipes developed in collaboration with Yo2Ed participants. Four workshops were conducted and an end-of-year presentation night offered an opportunity for participants to give back to the community and showcase skills and knowledge learnt by preparing food for family and community members.

A group process evaluation demonstrated a high level of satisfaction with meals, with students confident in their ability to replicate recipes at home. Due to their active involvement in the initial planning stages, students were motivated to complete the tasks and achieve agreed outcomes. This collaboration between the Yo2Ed program and UoNDRH has the potential to provide at risk youth with the skills and self-efficacy that will enable them to better manage the emotional and social pressures that lead to the adoption of detrimental nutrition-related health habits.

POSTER

TeleDentistry for residential aged care facilities in Darling Downs Hospital and Health Service

Lisa Deeth, Carolyn Bourke, Shane Stenhouse
Darling Downs Hospital and Health Service, QLD

Issue: All permanent residents in our Aged Care Facilities are required to have a yearly dental assessment. Previously staff from Toowoomba Hospital Dental Clinics were able to attend Age Care Facilities to perform these assessments. Due to increased work loads, this is no longer an option. Removing the residents from each facility and

transporting them to the Dental Clinic is also time consuming, not cost effective and disruptive to the residents.

Objective: A dental therapist performs an in person initial assessment of each resident and identifies who will require further assessment by a Dentist via Telehealth.

Outcome: The Dental Therapist uses an Inline Flexi Scope camera with an intra oral probe attached to provide a real time live feed. From his office in Toowoomba, the Dentist can direct the Dental Therapist and provide advice on dental care locally or arrange to see the resident in person.

Future: The initial work has all been documented and procedures put in place so the work can be implemented in other Aged Care Facilities and with other Dental Clinic Teams. The dental assessments including TeleDentistry in the Residential Aged Care facility will ensure each resident has a yearly review and reduces the need for residents to travel unnecessarily to the Dental Clinics.

POSTER

Conversion by immersion: outcomes of short and long-term rural allied health placements

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Introduction: Commonwealth funded University Department of Rural Health programs have been developed, to support health student placements in rural and remote locations, in order to build rural health workforce capacity. There has been no published data of the workforce outcomes of these programs to date. This paper will report on the outcomes of the University of Newcastle Department of Rural Health (UoNDRH) allied health student immersion placement program. This program offers short-term to year-long immersion placement options that involve students living and studying in a multi-disciplinary environment with the purpose of extending their understanding of inter-professional practice, rural health issues and community engagement.

Aim: To evaluate the placement experiences and workforce outcomes for allied health students undertaking a rural immersion placement experience at UoNDRH.

Methods: This study is a mixed methods longitudinal study of student placement experiences and workforce outcomes. Students from the disciplines of Diagnostic Radiography, Nutrition and Dietetics, Occupational Therapy, Physiotherapy and Speech Pathology undertaking immersion placements at UoNDRH sites of Tamworth and Taree were invited to participate in the study. Participants were asked to complete (i) an end of placement survey, (ii) a semi-structured interview and (iii) a follow-up survey at one, three and five years after graduation. Findings from the end of placement and follow-up surveys will be reported.

Results: End-of-placement surveys were completed by 172 students. Following a rural placement, 37% of students indicated a more positive attitude to working in a rural or remote area, while 44% remained equally positive in their intention to work in a rural area, independent of their placement experience. Of those students who had not previously lived in a rural or remote area, 52% had a positive change in their intention to work in a rural location, while 24% remained equally positive in their intention. One year after graduation (n=25), 52% of students were working in rural or remote areas. Of the eight students from a metropolitan background, six were working in a non-metropolitan area and 41% of those from a rural background (n=17) were working in a rural or remote area.

Conclusion: The UoNDRH student immersion placement program is demonstrating a positive impact on the rural and remote workforce outcomes for new graduates, particularly for those from metropolitan backgrounds. Further longitudinal data, is required to provide evidence of the longer term impact of the rural immersion placement program on the rural and remote workforce.

POSTER

Spreading epilepsy services across Australia—going online

Libby Hardy, Jane Burford
Epilepsy Action Australia, SA

Introduction: Living in rural and remote areas presents unique challenges, one being limited access to health care. In these settings, online support, services, education and information can be valuable and effective.

Epilepsy can impose a substantial burden, and management is more than just treating seizures. Surveys and studies show a deep unmet need in the

community regarding epilepsy and seizure first aid education.¹ Increased epilepsy knowledge and awareness has shown to improve self-management, seizure control, seizure first aid and safety precautions, thereby reducing hospital admissions.

To improve equity and access to epilepsy information and education across Australia, online learning tools, resources and courses for different target audiences were developed.

Regular epilepsy education sessions, workshops, meetings and emergency medication training are now conducted via webinar, allowing access to anyone across Australia as long as there is internet access and phone.

Purpose: To demonstrate effective delivery of epilepsy education and support online.

Method: A number of online epilepsy courses and self management tools for different audiences were launched in June 2012. There are currently eight courses and seven online tools/resources. Participants provide personal information including geographical location along with feedback (which in some cases is optional). Webinar feedback is obtained after the session.

Results: Overall, clients geographical spread is 66% urban and 34% rural. This percentage is also represented in users of our online self-management tools. Figures below have been collected from July 2012 to June 2014.

Users of the online training and education resources are 828 (73%) urban and (311) 27% rural.

Webinars have been delivered to 21 (37%) urban and 36 (63%) rural regions.

Online seizure diary has been used by 742 (66%) urban and 380 (34%) rural clients.

Discussion: Lack of epilepsy knowledge leads to inappropriate or inadequate responses to seizures, increasing the risk of injury or serious consequences.

Our online services are reaching across the country to areas of need. Considering over two-thirds (69%) of Australians live in major cities,² our reach to rural regions has been consistent with this figure, even higher with webinar sessions.

¹ O'Hara KA. First aid for seizures: the importance of education and appropriate response. *Journal Child Neurol.* 2007 May;22(5 Suppl):30S-7S.

² <http://www.aifs.gov.au/institute/pubs/factsheets/2011/fs201103.html>

Organisations must be strategic in the design and delivery of services to ensure ongoing viability and optimal reach. Online services and information represent an efficient mechanism to do this and meet growing demand in a sustainable manner.

POSTER

Promoting safety and supporting culturally valued infant care: the Pēpi-pod Program

Jeanine Young^{1,2,3}, Leanne Craigie^{1,2}, Karen Watson¹, Lauren Kearney^{1,2}, Stephanie Cowan⁴, Margaret Barnes^{1,2}

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Background: The risk of sudden unexpected death in infancy (SUDI) is three times higher for Aboriginal and Torres Strait Islander babies compared with non-Indigenous infants [1]. Co-sleeping is a common practice particularly for breastfeeding infants, and the cultural norm in many Indigenous communities. However infant deaths are associated with co-sleeping in hazardous circumstances.

The use of portable sleep spaces to reduce the risk of SUDI for families with identified risk factors has not been previously reported in Australia. Indigenous communities have identified this area as a priority for investigation [2].

Aim: This study aimed to determine the acceptability, feasibility and effectiveness of the Pēpi-pod Program, a portable infant sleep space embedded within safe sleep health promotion, within Aboriginal and Torres Strait Islander families.

Methods: A community participatory approach was used to report parent experiences (target n=300) of using the Pēpi-pod Program to support safe infant sleep. Families were selected through ten health services which provide maternity and child health services to Aboriginal and Torres Strait Islander families, in metropolitan, rural and remote areas of Queensland. Eligible participants were parent/s and/or carers of a baby (ideally <1 month of age) with the presence of one or more known SUDI risk factors [1].

The Pēpi-pod Program [3] comprises three interlinked components: 1) Safe Space: a polypropylene box transformed into an infant bed through addition of a fabric cover, mattress and bedding; 2) Safe Care: parent education and safety

briefing; 3) Role of family: families share what they learn about safe infant sleeping. Parent questionnaires were administered face-to-face or by telephone within 2 weeks of receiving the Pēpi-pod; then monthly thereafter until pod use ceased by local health care provider.

Results: A total of 90 families meeting eligibility criteria were recruited by November 2014, with a minimum of 150 families anticipated by May 2014. The acceptability of the Pēpi-pod as a safe sleep space for babies was supported by parent responses that related to three key themes: safety, convenience and portability. Awareness of safe sleeping messages has been raised in families and through social networks. Pēpi-pod Program has been integrated into current service provision within several organisations.

Conclusion: The Pēpi-pod program was accepted and used appropriately by parents living in Queensland Indigenous communities. To further reduce SUDI, innovative strategies which allow for co-sleeping benefits, respect cultural norms and infant care practices, whilst enabling safe sleep environments are necessary.

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3. Cowan S, Bennett S, Clarke J & Pease A. (2013) An evaluation of portable sleeping spaces for babies following the Christchurch earthquake of February 2011. *Journal of Paediatrics and Child Health* 49(5): 364-8.

POSTER

Bringing breast screening services to the remote Northern Territory

Sarah Webb, Louise Croft

Department of Health, NT

In July 2014, BreastScreen NT launched a state of the art 4 wheel drive truck, with the ability to take specialised breast-screening equipment out into communities that had previously not been able to access this service.

In this poster presentation, we will share our experiences, the lessons and the successes of this year, and how we have worked with different teams across the Northern Territory to provide this potential lifesaving service.

Hub communities across the Northern Territory were identified, with considerations of location, facilities, eligible population and convenience for other communities to access. A tentative schedule was then proposed, using the above data to calculate how long the truck needed to be in each place.

At each site we visited, we encountered many challenges, with many learning opportunities. Our staff all developed skills very rapidly; it was a steep learning curve, but overall exceptionally rewarding. We aim to include some personal reflection on our experiences as well.

Included in the lessons that we have learned are some statistical data that shows what a successful venture this has been so far. In our first 6 months we have developed new methods in how we approach communities, the information that we require ensuring we can provide a safe and effective service, how we staff the truck and ways to improve the logistical challenges associated with this vehicle. This learning is fluid and constant, the team has to be adaptable and open to changes that can occur sometimes on a daily basis.

This poster presentation will be shared from our radiographer staff who have worked on the truck over the last few months. We will also be including some reference to the radiography work that is performed on the vehicle while working remotely. Our radiography staff have developed new skills, including becoming truck drivers of this vehicle. For us to share our experiences and stories and to reflect on our learnings we hope to inspire others. The radiographers have had to adapt their technique and work flows when working with remote clients, who for the most part have never experienced a mammogram.

Providing this remote breast-screening service has been ground breaking in so many ways, we are proud to bring this service to the many women who live remotely in the Northern Territory, and are excited for the opportunity to share with other like-minded people.

POSTER

Embracing youth ... GPs and PNs the key to driving down STIs

Melissa Cromarty, Nerida Walker

Hunter Medicare Local, NSW

The incidence of Sexually Transmissible Infections (STI) in the Hunter Medicare Local area (Urban, RA1, RA2) is one of the highest in NSW. Although all health services and primary care teams work to the best of their current knowledge and experience, the STI rate has continued to increase. It appears that there are service challenges to be overcome in order for STI screening rates to increase. The agencies involved in this area of prevention; Family Planning NSW, NSW STI Programs Unit and the Local Health District's HIV and Related Programs Unit, have collaborated with Hunter Medicare Local to reinforce effort through a project to improve the screening, detection and ultimately treatment of STIs in this diverse geographic region.

Through data analysis and review of current practices in general practice, it has been identified by project participants that 'gaps in screening' are occurring. Within a RA1 and RA2 areas, the general medical practice is one of the few consistently accessible settings for health promotion and screening activities for patients. Capacity building for General Practice in the absence of specialised sexual health satellite services and improved quality systems for service delivery of youth sexual health is the focus of the project.

Hunter Medicare Local is working closely with General Practices and encouraging teamwork in a 'whole practice approach' including reception, pathology providers and clinicians, to increase sexual health screening for patients in the 15-29 years age cohort. The project is supported, documented and endorsed by the Royal Australian College of General Practitioners Quality Improvement Plan-Do-Study-Act (PDSA) program for Sexual Health. This isn't actually a program of the RACGP. They suggest PDSA as a way of meeting the mandatory QI component of CPD and STIPU created the sexual health PDSA resource. To date we have 53 practitioners from 29 practices involved across our Medicare Local.

Qualitative data from youth consumers collected by Family Planning NSW in a rural setting needs analysis, informed the providers of the importance of privacy and confidentiality and the inclusion of a 'youth friendly' self-assessment for General Practice. With an objective to normalise the STI

screening process as standard practice through the development of PDSA cycles, progress to date has seen positive changes in STI screening rates in young people attending general practice. A shared focus of the project is for sustainable change in increasing STI screening rates for not only young women but young men as well in the age cohort of 15–29 years.

Through implementing the PDSA cycles in sexual health, Hunter Medicare Local and its key partners are supporting practitioners and their teams to implement sustainable changes increasing STI screening rates and ultimately decreasing STI transmission in young people.

POSTER

A one-stop assessment to measure key health indicators in rural South Australia

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Aims: A report by the Australian Institute of Health and Welfare (AIHW) identified several areas of concern in rural and remote communities including a higher prevalence of mental health problems, lower rates of health literacy and higher rates of alcohol abuse. The Health Check Pit Stop Project was a medical student led project which sampled the population on the Fleurieu Peninsula to determine the prevalence of some of the key health indicators raised by the AIHW data. The aim of this project was to assess the psychological wellbeing, alcohol consumption, tobacco use and health literacy among this population in rural South Australia and compare it to the national data.

Methods: The Health Check Pit Stop, a one-stop health assessment, was conducted at two community-based locations on the Fleurieu Peninsula. Volunteer participants attending the Pit Stop provided demographic and health data, including smoking status and alcohol consumption (AUDIT-C alcohol screen). Participants engaged in a standardised health literacy nutritional information questionnaire based on a representative nutritional label. Participants were also administered the Kessler Psychological Distress Scale, a validated mental health screening tool used as a global measure of distress based on questions about anxiety and depressive symptoms. The data were

compiled and compared to the national data along the key demographic and health parameters.

Results: 50% of participants reported levels of alcohol consumption that place them at risk compared to 19.5% of adults in the general Australian population. Moreover, 52.6% of females, compared to 47.4% of men reported risky levels of alcohol consumption. Participants reported lower ever and current smoking rates than the broader population (51.1% vs 58.8% and 6.6% vs. 18.3% respectively). 66.2% of participants had adequate or better health literacy. This compares to Australian Bureau of Statistics data which demonstrate that 41% of adults have adequate or better health literacy skills. 11.8% of participants screened positively for significant levels of psychological distress which closely matches national data. Gender differences for psychological distress also correlated to national averages.

Relevance and conclusions: Levels of psychological distress in rural South Australia are broadly similar to national averages and this population is less likely to have ever or currently use tobacco. The data suggested that half of individuals on the Fleurieu Peninsula are consuming alcohol at levels that significantly increase their lifetime risk of alcohol-related disease or injury and this rate is markedly higher than the national average. The proportion of women consuming excessive alcohol differs from national data showing a male predominance. Interestingly, levels of health literacy are higher in this population suggesting that knowledge about health is not translating into healthy behaviours regarding alcohol but do correlate with reduced tobacco use. This is significant because it suggests that health education and knowledge in rural communities may not be effectively communicating the harms of excessive alcohol consumption and represents a potential area for future public health intervention. The use of a one-stop health assessment in the community may be an effective way to measure, and potentially modify, health behaviours in rural Australia.

POSTER

Resilience, compassion satisfaction, and the professional practice environment for rural nurses

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Objective: To ascertain if differences exist in the perception of the professional practice environment and personal wellbeing of nurses across different geographical areas in Queensland.

Design: Prospective, self-report cross-sectional online survey.

Setting: Nurses employed in public and private health care settings: acute hospitals, community health and aged care in Queensland, Australia.

Participants: 1608 registered and enrolled nurses and assistants in nursing, who were current members of the Queensland Nurses Union in 2013 and who provided a workplace postcode. 1008 worked in major cities, 382 in rural locations and 238 in remote areas.

Main Outcome Measures: Scores of wellbeing as determined by DASS21, ProQoL5, CD-RISC25 and of Professional Practice Environment using the PES-NWI [R].

Results: Nurses employed in major cities perceived “nursing foundations for quality care” more favourably than those from other settings. Remote area nurses had lower levels of secondary traumatic stress than nurses in major cities and rural areas. There was no difference between nurses across their geographical locations for stress, anxiety, depression, compassion satisfaction, burnout, resilience and the four other measures of the Practice Environment Scale.

Conclusions: The study findings provide new data suggesting that, with the exception of secondary traumatic stress, the personal wellbeing of nurses does not differ across geographical settings. Similarly, with the exception of the sub-scale of “nursing foundations for quality care” there was no difference in perceptions of the professional practice environment. As secondary traumatic stress is

associated with burnout, this finding needs to be investigated further.

POSTER

AHAs in care coordination—people, places and possibilities

Annalee Gardam, Samantha Coonan

Gateway Health, VIC

Following participation in the Allied Health Assistant (AHA) Implementation program and finding that 30% of allied health professional (AHP) time for clinical and non clinical tasks could be transferred to an AHA, the Hume Region Strategic Plan recommended that Gateway Health needs to improve the access and utilisation of services by creating a model for AHAs in facilitating care coordination.

Gateway Health is a rural health service providing a broad range of services predominantly to the North East Hume region, with a concentration of services delivered in the Central Hume Primary Care Partnership catchment. Gateway Health delivers HACC funded Rural Allied Health Team services to this catchment. The service is predominantly home based, presenting significant resource challenges when faced with an ageing population, the geography and sparse population in the catchment. Services such as Occupational Therapy are experiencing increased demand, resulting in extensive wait times and pressure on demand management systems.

With the assistance of the Workforce Innovation Grant, Gateway Health is developing a new role for Allied Health Assistants (AHAs) so they can deliver flexible and timely care coordination. The AHA role will be piloted between October 2014 and June 2015 and is the first of its kind in Australia. It is anticipated that outcomes of this role will include documentation describing the integrated Care Coordination Model of Care for the management of complex HACC clients, including:

- care coordination guidelines
- interagency agreements
- resources and tools to support integrated care
- referral pathways and processes
- consumer journey maps
- scope of practice and position description outlining AHA tasks

- competencies developed for the role in consultation with TAFE
- professional and clinical supervision and delegation arrangements and structures for AHP and AHA roles
- orientation resources, staff training/professional development provided to AHAs and AHPs

This presentation/poster will explore the role of the AHA Care Coordinator in improving the capacity of rural HACC allied health teams to deliver coordinated and flexible support intervention to people with complex needs. It will reflect on the experiences of developing and implementing the AHA role, and will share key learnings from the project, including change management of the existing workforce and ensuring ongoing sustainability of the project. It will also provide preliminary data from 9 months of implementing the new AHA role.

POSTER

Increasing engagement in exercise physiology-physiotherapy for Indigenous people living in remote communities

Bridie Groenen, Kia Naylor

Bodyfit NT

Through delivering outreach services to remote communities across the Northern Territory, the service provider is delivering improved access to primary health care, namely exercise physiology and physiotherapy services, by currently visiting sixteen Indigenous communities in the Northern Territory. The service provider engages individuals with chronic conditions with aim of improving health outcomes of communities and Aboriginal and Torres Strait Islander health.

Over a two-year period, chronic diseases treated using exercise therapy was recorded for each patient to produce data indicating total number of contacts made during scheduled visits. As a result, we have seen community engagement improve in the majority of communities serviced, building community capacity to address chronic conditions through physical activity and health eating.

Many barriers related to cultural, geographical, and other factors require addressing in attempting to engage community populations successfully. In striving to overcome this, a number of strategies are presently being applied which involve forming

partnerships with key stakeholders, developing a strong rapport with community members, nurturing community ownership of programs and ensuring servicing remains flexible. Achieving these then enables promotion of community engagement in allowing individuals in the community to feel supported and comfortable in participating in a service that is provided specifically for them and created in consultation with them.

POSTER

Men's health training for rural primary health care nurses

Wendy Thomas, Taletha Rizio, Carol Holden

Andrology Australia

Background: The National Primary Health Care Strategy recognises the need for an improved primary health care system to respond to current gaps and inequities for different population subgroups, particularly for those living in regional/remote communities. Underpinning the Strategy is a focus on providing a flexible and well-trained workforce that works together to deliver best care to patients. Strengthening the current primary health care workforce in regional settings through appropriate and evidence-based training in men's health is imperative to reduce the health disparities experienced by men living in regional/remote communities.

Aim: To develop workforce capacity in men's health, a multidisciplinary approach across the health professional sector is required. To supplement our GP and Aboriginal Health Worker (AHW) men's health education program, a primary health care nurse (PHCN) men's health Train-the-Trainer (TTT) pilot program was developed to equip PHCNs with the skills and knowledge to better engage men in primary health care and community settings. The evaluation aimed to identify strategic issues to inform nationwide implementation.

Methods: The pilot program included an eight hour, Australian Primary Health Care Nurses Association (APNA) endorsed workshop to train PHCNs as facilitators who then delivered the men's health education to their peers. The evaluation involved semi-structured interviews and/or questionnaires.

Results: Eighteen, mostly practice nurses, representing 11 GP Divisions/Networks from across Australia attended the TTT program. Most felt confident to facilitate a workshop for their peers and seven GP Division/Network workshops were

subsequently held in two metropolitan and five regional settings (including two smaller towns). Following training, facilitators and participants from all settings reported confidence in identifying the major health issues affecting men, had a greater appreciation of men's help-seeking behaviour and an awareness of available men's health resources. Feedback from facilitators in regional settings suggested the program's adaptability for flexible delivery and the capacity to accommodate local needs and experts will suit the rural workforce.

Conclusion: Evaluation suggested that the PHCN men's health TTT is an effective and flexible model to raise awareness and improve the skills of PHCNs, particularly in regional settings. Online training to complement this program is currently being developed which will further increase access for rural and remote PHCNs and other health professionals. Furthermore, this training will support a multidisciplinary approach to men's health in communities where access to health services is limited.

POSTER

Health students eager for multidisciplinary teamwork opportunities

Rebecca Irwin, Gerry Corrigan, Lillian Smyth
National Rural Health Students Network, NT

Objective: Evaluate the first inter-professional health student networking and skills night in Canberra.

Design: Evaluation survey.

Setting: Inter-professional health student night at The Canberra Hospital, A.C.T.

Participants: University health students from Australian National University, Australian Catholic University and University of Canberra.

Intervention: Three hour inter-professional health student night involving ten multidisciplinary health student teams rotating through eleven clinical skills stations.

Relevance: Effective multidisciplinary care is the key to maintaining patient safety and providing comprehensive patient centred care. Current rural health professional shortages amplify the need for improved collaboration between health disciplines. However university programs to promote health student multidisciplinary teamwork are limited. This

compromises the ability for health students to successfully work together in their future health professional careers.

The Inter-professional health student networking and skills night is a joint rural health club initiative of ANU Rural Medical Society and Canberra Rural Allied health and Nursing Collective. It aimed to improve knowledge of other health professions, promote networking and provide exposure to multidisciplinary teamwork. The evaluation explores student perception, satisfaction and future ideas for multidisciplinary initiatives.

Results: Of the fifty-six participants, most were in the first (46%) or second (25%) year of their degrees. Participants were predominantly female (77%). Paramedicine (18%), Pharmacy (18%), Medicine (16%), Nursing (14%) and Occupational Therapy (9%) accounted for three-quarters of the health students present.

On evaluation, the majority of participants (61%) had little experience with other health disciplines prior to the event. Afterwards, participants (96%) noted an increase in knowledge of other health professional's scope of practice. Similarly, participants (88%) agreed the event improved how they would approach their future work environment. Participants (95%) found the event allowed sufficient opportunities to network. Overwhelmingly, participants (98%) would recommend the event to other health students and were overall satisfied with the evening.

On qualitative analysis, participants expressed the most useful aspects of the evening were the hands-on activities, inter-professional contact and opportunity for teamwork. More time was the most common theme for improvement. Participant comments strongly supported future multidisciplinary clinical skills nights and further networking opportunities.

Conclusions: The inter-professional night provided a successful opportunity for health students to network and gain knowledge about other health professionals. The interactive, teamwork and inter-professional aspects of the event were highly valued. Health student comments clearly supported the need for greater multidisciplinary teamwork opportunities at a university level.

POSTER

Bonded medical schemes: health student views

Joshua Mortimer, David Khoo, Natalie Kew, Viktor Ko, Anthony Wall

National Rural Health Students' Network

Background: Since their inception, debate has surrounded the utility and fairness of the Bonded Medical Place (BMP) and Medical Rural Bonded Scholarship (MRBS) schemes. These schemes provide a Commonwealth Supported Place to study medicine and/or a scholarship in exchange for a 'return of service' obligation to be completed in a rural or remote area after completing specialist training. A recent independent review recommended the abolition of at least one of these schemes with funding re-directed towards scholarships for students of allied health professions. Much of the debate to date has been anecdotal and based on limited data.

Aims: The aim of this research was to obtain the views of BSP, MRBS, non-bonded medical students and non-medical health students towards the BSP and MRBS schemes.

Specific research questions included:

- Do health students support or oppose bonded schemes as a mechanism to address rural workforce shortages?
- How does the level of support vary between bonded and non-bonded medical students?
- Do non-medical health students support the schemes?
- Do health students support the broadening of the schemes to non-medical health students?

Methods: Health students enrolled at 28 Australian universities were invited via email to participate in an online survey. Participants included BMP, MRBS, non-bonded medical students and non-medical health students.

Results: 920 responses were received, comprising:

- 307 bonded medical students
- 316 non-bonded medical students
- 267 non-medical health students.

65.7% of all respondents were in favour of the schemes as a means of addressing workforce shortages.

17.6% of medical students opposed bonded schemes. There was no significant difference in levels of opposition between bonded and non-bonded medical students 18.3% versus 16.8%; $p=0.665$). Amongst bonded medical students, those studying under the BMP scheme were significantly more likely to be opposed to the schemes than students studying under the MRBS scheme (24.3% versus 3.5%; $p<0.001$). Opposition to the schemes also increased with increasing year of study.

72% of non-medical health students were in favour of similar schemes for non-medical health students, with a further 27.5% being undecided.

Conclusion: There is overall broad support for bonded medical schemes as a means of addressing workforce shortages. Health students express strong support for similar schemes in non-medical health disciplines.

POSTER

Building evidence-based practice capacity: a journal club for nursing and midwifery students

David Lindsay

James Cook University, QLD

The use of journal clubs in health professional education have been found to be effective forums for increasing information literacy, enhancing professional reading proficiency, improving critical thinking skills and exploring the links between research evidence and clinical practice. There is a growing body of research supporting the value of a journal club for undergraduates and virtual journal clubs (VJCs), using a synchronous (real-time) platform such as Blackboard Collaborate, together with asynchronous platforms such as blogs, wikis and Twitter, have been found to bridge the limitations associated with face to face contact, whilst creating a non-threatening environment that time-poor students can access at any time. The broad aims of the student journal club are to build information literacy and assist students to acquire knowledge and skills for critically appraising published research, and explore how it can contribute to evidence-informed decision making when planning and delivering patient/client care. The objectives are to:

- acquire skills in obtaining relevant information, organising it, and sharing it with others

- gain an understanding of research design, as described in various types of research publications
- share current knowledge and discuss ways of translating research evidence into practice
- improve professional reading habits and skills in using databases to locate high quality journal articles
- raise research awareness, and assist students to make clinical decisions that incorporate relevant research evidence
- become familiar with tools for undertaking critical appraisal of research publications
- develop understanding of the links between theory, research, practice and care quality improvement.

The student journal club will be implemented at the commencement of the first study period in February, 2015, as a voluntary, extra-curricular, active learning opportunity. Monthly, face to face meetings will be convened and students in Mackay, Mt Isa and Thursday Island linked in via videoconferencing. Academic staff at each of these sites will assist students in their preparation for, and contributions during, journal club meetings. A virtual journal club will be run concurrently primarily for external students, but also made accessible to all on-campus students.

This presentation will outline the preliminary, evaluative findings following the establishment of the student journal club. Participants will be surveyed against the achievement of the above objectives, together with their experiences as remote area students engaging in the face to face and virtual components of the club. Based on this feedback, suggested areas for change will be proposed.

POSTER

A systematic review of the health and wellbeing outcomes of mining communities in high-income countries

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Aim: It is recognised internationally that rural populations often experience greater barriers to

accessing services and have poorer health outcomes compared to urban populations. In Australia, rural communities are associated with higher mortality rates and health care costs. In some settings, health disparities may be further exacerbated by externalities such as the mining industry, which can affect the social, physical and economic environment in which rural communities reside. Toxins and environmental health concerns for the population are often associated with mining and are frequently investigated, however there are broader implications for community health that need to be considered. Health and wellbeing encompasses physical, psychological and social outcomes, and can provide a greater understanding of public health challenges facing a community. This systematic review aims to report the available scientific evidence of health and wellbeing outcomes in communities in residential proximity to mining operations in high-income countries.

Methods: The electronic databases PubMed, MEDLINE, ScienceDirect and PsycInfo were searched. The inclusion criteria were: adult target population described as resident in the community; high income country setting; population was proximate to mining operations (from exploration to closure); individual and community wellbeing or general health outcomes reported; published in any year and in English; and peer reviewed studies that used original or secondary data. A narrative synthesis framework was utilised to report the findings from the studies.

Relevance: It is integral to measure changes in health outcomes in mining affected communities to enable evidence-based priority-setting and effective planning for rural service provision.

Results: Sixteen articles were included in this review, which consisted of both qualitative and quantitative studies; all were observational. Studies were conducted in Australia, Canada, USA, Italy and England and measured health and wellbeing outcomes associated with living in proximity to coal or coal seam gas industries. Three key themes emerging from the qualitative studies were relationships and family health; social isolation and feelings of powerlessness. Quantitative studies reported on the increased prevalence of cancer and cardiovascular diseases and poor self-reported health status.

Conclusion: The findings from this study show that although there is heterogeneity in the stage of the mining operation and country, common health and wellbeing outcomes can be identified in

communities living in proximity to coal. Furthermore, investigating wellbeing outcomes is imperative to gain a deeper understanding of the health effects of the mining industry, to guide service delivery that reflects the current needs of the community.

POSTER

Descriptive analysis of the delays in management of cancer in rural Australia

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¹Lyell McEwin Hospital; ²University of Adelaide; ³Hawkins Clinic General Medical Practice; ⁴Whyalla Hospital and Health Services

Cancer patients in rural Australia are likely to have poorer outcome due to delay in diagnosis (primary delay), in referral (referral delay), and in treatment (secondary delay) as compared to the urban population. While these delays are likely to be due to diverse reasons, each category of delay in relation to cancer type is an important initial consideration that would help understand and develop strategies to improve health care in rural Australia. Our study aim to quantify the category of delays in relation to the type of cancers at a large GP practice in a rural Australian city.

Study design was a retrospective case note review of cancer patients presenting to a large general practice in a south Australian rural city. Inclusion criteria were first presentation between January 2011 to June 2013 with cancers. Exclusion criteria were skin cancers. Symptoms of initial presentation, primary delay, referral delay, secondary delay, locations of oncologists, treatment and follow up were included as study variables. A total of 127 malignancies were included in 121 patients. Descriptive analysis of data was carried out using an EXCEL database.

The most common were breast, prostate, and colorectal cancers at 24%, 24% and 16% respectively. Cervical and stomach cancers were less common, each accounting for 2% of cases. Breast cancer patients typically had a primary delay of 7.5 days, a referral delay of 15.1 days and a secondary delay of 24.75 days. Prostate cancer patients had a primary delay of weeks to months, a referral delay of 30.7 days and a secondary delay of 30 days. Colorectal cancer patients had a primary delay of weeks to months, a referral delay of 48 days and a secondary delay of 51.3 days for a colonoscopy. Lymphoma and leukaemia patients typically had a combined primary and referral delay period of 99 days. Lung cancer patients had a

referral delay of 18.7 days, and a secondary delay of 10 days. Bladder cancer patients typically had a referral delay of 27.8 days and a secondary delay of 10 days. Endometrial cancer patients experienced a 35 day referral delay and a 27.8 day secondary delay.

Prostate and colorectal cancers had the highest delays between initial symptoms and specialist treatment. Main limitation of this study was inclusion of only one general practice. However, this study provides valuable insight into distribution of types delays.

POSTER

Using simulation in teaching interprofessional team skills to undergraduate rural health students

Rebecca Marley, Tony Smith

University of Newcastle, NSW

Introduction: Improving teamwork and communication amongst in health care has been linked to higher quality of care and improved patient outcomes. Interprofessional learning (IPL) is useful in promoting collaborative practice and has relevance to rural practice where health professionals often work collaboratively. Using simulation in IPL sessions encourages student engagement, provides realistic, flexible and interactive learning opportunities, creating an in-depth and sustained educational experience.

Methods: Health professional academics at University of Newcastle Department of Rural Health in Taree presented an IPL module using simulation and didactic presentation to forty-six undergraduate students from medicine, nursing, pharmacy, physiotherapy, occupational therapy and diagnostic radiography. The aim was to improve the students understanding of communication and teamwork, drawing on the TeamSTEPPS model.

Firstly, six interprofessional groups of students were formed and performed a teambuilding task and short videos were used to demonstrate positive and negative teamwork attributes, highlighting the importance of non-technical skills to effective teamwork. Each group then participated in a different simulation—discharge planning, a teenage pregnancy, fracture in a community pharmacy, contrast media reaction, dealing with hospital hierarchy, and the emergency response team. Debriefing of groups took place in a combined

forum, to reinforce the learning and highlight key concepts to all.

Results: Of the 41% who completed evaluation questionnaires, 58% were previously aware of multidisciplinary teamwork but gained new information, and 11% indicated that the information about teamwork was completely new to them. Even though education about teamwork was not new, 90% felt more likely to refer patients based on information learned in the IPE module. Most (85%) felt more inclined to work in a multidisciplinary team-oriented environment. Further, 16% of respondents learned strategies to manage conflict within a team. All of the respondents said simulation enhanced their learning experience in the module.

Conclusions: Evaluation suggests that the students gained a great deal from participating in the IPL Module, even if communication and teamwork education was not new to them. However, most teamwork education takes place in mono-disciplinary groups, with no opportunities for interprofessional interaction. Students agreed they were more likely to collaborate with other health professionals as a result of this IPL experience. Much great use of IPL should be considered in interprofessional team-building, especially when students are on placements in rural locations. Furthermore, the key concepts of multidisciplinary teamwork, communication and conflict resolution can be well demonstrated using simulation learning techniques.

POSTER

Three initiatives promoting safety and quality in rural and remote practice

Peter McCormack

Rural and Remote Clinical Support Unit, QLD

The **Primary Clinical Care Manual** (the PCCM) is the principal clinical reference and policy document for health professionals in rural and remote Queensland, where it is supported by legislation and specific education, training and support for staff. It provides evidence based clinical care guidelines where they may be working in isolation from immediate medical support. The PCCM also provides the authority for appropriately trained and endorsed rural and remote health professionals to engage in advanced practice under the *Health (Drugs & Poisons) Regulation 1996* by administering and supplying medications which would otherwise require a doctor's order.

The **Chronic Conditions Manual** (CCM) is the statewide clinical practice manual for the prevention and management of common modifiable lifestyle related chronic conditions. The CCM provides a simple, easy to read standardised tool to inform clinical practice. It consolidates national and international evidence based guidelines as well as nationally recommended age related early detection health checks for children and adults. The manual also includes current national recommendations for modifiable lifestyle behaviours and is endorsed by leading local, statewide and national clinical networks, and leading specialists and clinicians in their fields.

The **Pathways to Rural and Remote Orientation and Training** (PaRROT) program has been developed for the multi-cultural, multidisciplinary health team. It supports education, orientation and training of all health care workers in rural, remote and primary health care settings from pre-recruitment to the provision of ongoing care in chronic disease prevention, detection and management in a comprehensive primary health care framework. PaRROT is available as a free online training program with access to supporting resources including workbooks, links to resources and other education programs.

The Rural and Remote Clinical Support Unit (RRCSU) takes pride in the work invested in these three initiatives as they address the full spectrum of patient presentations that may be encountered by rural and remote practitioners. The PCCM deals with acute presentations and immediate treatments and follow up; the CCM supports health staff to respond to chronic conditions over time; the PaRROT Program links the two by providing support and extra information not only on the best use of these manuals, but also relating to working in the rural and remote environment. The RRCSU will showcase not only the structure, content and function of these initiatives, but also the links between them and how they can improve quality and safety for rural and remote health services.

POSTER

Off the beaten track: characteristics of rural Australian families accessing a mental health intervention

Antonio Mendoza Diaz^{1,2}, Joshua Broderick^{1,2}, Christina Thai^{1,2}, Mark Dadds¹

¹School of Psychology, Faculty of Science, UNSW; ²Royal Far West, NSW

Although there is increasing awareness of the need for mental health services in rural Australia, interventions are not usually developed with this population in mind. It is imperative to recognise the unique characteristics of rural families that pose distinctive strengths and challenges—for mental health interventions in general, and parenting interventions in particular. In an attempt to identify these key characteristics we compare a sample of families accessing parenting interventions in two regions: urban and rural New South Wales. A descriptive analysis of the data reveals important differences in key areas such as socioeconomic status, internet usage, and the quality of family environments. Emerging differences between rural and urban families reveal important targets that ought to be considered when undergoing treatment development and delivery.

POSTER

Student Clinical Placement Accommodation Website Portal—a collaborative stress-free approach for students

Amanda Urquhart, Jacqui Michalski, Michael Coates

Greater Green Triangle University Department of Rural Health, VIC

Aims: To provide easy access to low-cost, high quality accommodation for health science students on placements in South West Victoria and South East South Australia through a custom designed website utilising owned, leased and partnership accommodation.

Method and approach: Accommodation is recognised as being a major factor in supporting students on rural placement.

The Greater Green Triangle (GGT) University Department of Rural Health purchased or leased suitable housing in various towns around the GGT region and entered into partnership agreements with rural health services to share existing student lodgings.

A custom designed website was created with a student portal consisting of a fully automated online booking system, similar to 'wotif'. The website included details of accommodation and information pertaining to each town in the GGT region. It has been expanded to include the following program functions:

- bookings
- payments
- cancellations
- emails
- policies.

Progress/outcomes: The website has been designed so that it is a gateway of information on the region.

Students find it easy to locate and self-book accommodation online to suit their needs.

It has greatly reduced the administrative tasks for Departmental and Hospital partnership staff. Once students are registered on the website, whether they utilise the accommodation or not, they are provided with information on social and educational activities being conducted each week in their placement town, encouraging them to immerse themselves in the town and its people.

Conclusions: The GGT UDRH has seen a considerable increase in the number of students undertaking placement in the region over the past 10 years.

The number of student placement weeks has grown from 1000 in 2005 to more than 5000 in 2013. We anticipate similar numbers in 2014. The Department has also been recognised as the highest performing UDRH in this program area since 2005.

This clearly demonstrates the value of the online booking system and of the accommodation that is available in this region.

POSTER

Cogs of possibilities: streamlining individual choices and increasing self responsibility

Amanda Norton

Ayr Health Service, QLD

In a climate of change within policy changes at State and Federal level, financial restraints and ever changing boundaries, it is important to streamline service provision in rural towns. Shared programs which include local visiting service providers, non government agencies needs an active approach from local health service providers in referrals for program initiation and shared responsibility when delivering workshops or community expos. Each service provider still has to show a certain growth in productivity to enable sustainable programs gain ongoing funding per annum. Streamlining staff resources and preventing duplication in programs has meant a growth in open sharing of knowledge and resources across a board spectrum of staff. Difference in expectations and experience between health professionals and individual clients has led to confusion in the past.

Strategies that inspire new ways to engage individuals to approach their chronic disease in a positive light for increased uptake of programs are always a challenge. Importantly how do we identify the client's learning and behavioural style and how do we include them in the planning of self improvement through multi disciplinary teams?

The skill most needed in a rural town is to teach an individual with chronic disease the importance of the cycle of care and their own self monitoring. This includes the impact on drivers licence and annual medical certificates, especially if the individual does not understand the impact at not looking after their own self responsibility in health matters.

Within this community, initial identification of adult learning style helps assist in planning shared care across the spectrum of service providers. The correct identification allows increased uptake in self management and of service provision whilst combining holistic approach. Increasingly engagement with the client improves attendance to programs and reporting open communication without feelings of being judged. Client needs a health professional to guide them in meeting their goals for sustainable reduction in chronic disease markers. They are many tools for health professionals to use, but finding the right style per

person remains a challenge through time constraints and resource reduction.

Once the correct learning style is established, the needs relevant to the individual are planning scaffold learning in a format suitable to the individual. Scaffold learning is a style that involves incremental reductions of the health professional, as the client skills increase and practice self assessment and reporting. Equates learn, apply or integrate their theoretical knowledge to skills and goal setting.

POSTER

The Stayin on Track project—supporting young Aboriginal fathers through a user-developed website

Richard Fletcher¹, Brian Kelly¹, Josephine Gwynn², Tonelle Handley¹, Lisa Shipley¹, Geoffrey Skinner³, Nicole Turner⁴, David Perkins², Craig (Burkie) Hammond¹, Darren (Charlie) Faulkner⁵

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⁵Hunter New England Area Health, NSW Health

The issues for young Aboriginal men becoming fathers are well known: lack of role models, substance abuse, poor housing, few resources and relationship breakdown. What isn't well understood is how to provide support when it is needed.

Mobile phones are widely used by this group for social engagement, entertainment and information gathering. However, web based resources and mobile phone apps focusing on young people's mental health do not currently provide content tailored to this group. Very little information or data exists in Australia regarding either the mental health or fathering of young Aboriginal men.

Stayin on Track will build a phone-optimised website to provide a portal for young Aboriginal men to link in to information and support when it is needed. The project is unique in using the young Aboriginal fathers from urban and rural locations to design the website. Young fathers from Newcastle, Tamworth and Moree in northern NSW will record their own experiences and advise on website design and content.

The *Stayin on Track* mobile app will test sending information on father-infant care, partner support and mental health as SMS. *Stayin on Track* will also test a 'Mood Tracker' and 'Dad Tracker' sending

regular text messages to check on how the men are managing the stress which can be part of their fathering role. Two respected mentors from the community, one a senior counsellor, will be alerted to make telephone contact when the young dads indicate distress.

The project is a joint venture of The University of Newcastle and the Young and Well Cooperative Research Centre. It is supported by researchers in rural health, fathering, psychiatry and Indigenous health. An award-winning filmmaker will create brief accounts of the young fathers' stories that will be used to engage others. The stories include themes of pride in being a father, tough times, culture and fathers, the emotions on finding out, feeling down, and role models. Young Aboriginal men will be able to see other young dads telling their stories.

Once the website has been approved by the young fathers it will be advertised through Indigenous websites and social media channels. Presentations will be made to Aboriginal-controlled organisations such as Aboriginal Medical Services, Aboriginal men's groups and Indigenous children's services to alert them to the websites' availability. Traffic through the website will be monitored to form part of the overall project evaluation.

POSTER

Remote allied health practice— perspectives from Australia, Canada and the United States of America

Felicity Pidgeon

Top End Remote Disability Services, NT

A Churchill Fellowship in 2013 allowed the presenter to travel to Canada and the United States of America to visit four teams that provide Physiotherapy (PT), Occupational Therapy (OT) and Speech Pathology (SP) services to Indigenous persons living in the very remote areas. As an OT with experience working in the Top End of the Northern Territory it was an opportunity to share and learn.

The project allowed me to learn about ideas, modifications to practise and service delivery models other teams are using towards providing effective and culturally appropriate allied health and rehabilitation services.

The poster will provide a brief description of each of the five teams (including the presenters own team), their area and scope of practise and service model used.

Similarities in the challenges to practice: Despite the very different climates and countries, many common themes emerged around the barriers and challenges which teams face when providing therapy (OT, PT, and SP) services. The common challenges will be identified on the poster.

Solutions: Each team demonstrated different ways in which they had adapted their practice and service models to address key challenges and improve service delivery. Ideas and practise varied between teams but some ideas included the use of video technology to make service provision more regular, training or up-skilling local workers to build community capacity, modification of service models, adapting the therapeutic services provided to meet presenting needs, and developing clear prioritisation tools or eligibility criteria to filter clients.

Each of the teams and the resources available were different however many of the ideas observed have the scope to be adapted and implemented within other remote settings. The poster will detail some of the ideas and strategies, particularly those that are relevant and applicable within Australia, which have been implemented by teams towards improving remote service delivery.

POSTER

Making after hours primary care sustainable in the Grampians region

Meredith Johnson, Deidre Rennick

Grampians Medicare Local, VIC

Aim: To assist regional and rural GP's in the Grampians region to sustainably provide after-hours services to the local community whilst managing demand on local Emergency Departments.

Methods: Supporting and promoting the use of a single after-hours number 1800 022 222 by practices and Health Services for patients and visitors to ensure callers are initially triaged over the phone by trained telephone triage service providers (Nurse On Call and After Hours GP Helpline). Once a caller has been triaged as needing face to face care, we utilise an existing local call centre provider to provide a centralised care coordination service to assist patients to the right point of care.

We negotiated with General Practice, local Health Services and the telephone triage service providers (Nurse On Call, After Hours GP Helpline and Ambulance Victoria) to obtain their commitment to supporting the centralised care coordination service. Known as a Patient Streaming Service (PSS), this

service ensures care is coordinated with local providers so that callers go to the most appropriate point of care based on real time service capacity and capability.

Results: In the last 12 months, 18,480 calls have been received from the region to the 1800 022 222 number. After phone-based health professional assessment, 385 callers required care coordination through PSS to the on-call GP. These callers were identified through an extensive triage process as patients who needed to be seen by the GP in the after-hours period.

The balance of the calls was managed by the triage providers over the phone with home care advice. Prior to the commencement of our service the majority of these calls would have gone directly to the local GP's who are often the VMOs for their local Health Service or the nurses in these Health services. Low acuity presentations decreased at both Emergency Departments (Horsham 213 less; Ballarat 2792 less) compared to the previous 12 months.

Conclusions: By utilising existing providers we have designed a fully integrated after hours system that is effective at reducing the demand on the on-call GP in our rural areas making the provision of after-hours services more sustainable as well as reducing the Emergency Department demand.

POSTER

Preparing for and maintaining competency in a career in rural and remote health

John Setchell, Rosemary Moyle
Royal Flying Doctor Service, NSW

Preparing for and maintaining competency in a career in rural and remote health

The challenges of maintaining the numbers of health professional staff having the required skills and competencies to work safely in rural and remote Australia are ever present. Over the past 15 years, a large non-government rural and remote health service has strategically developed a broad range of health education and training programs covering the range of experience from undergraduate students to senior fellows of professional colleges such as RACGP and ACRRM. The underlying philosophy of this strategy is not only to entice and encourage increased uptake of health professional careers in rural and remote Australia, but also to increase the level of understanding of the particular challenges

associated with providing health services in rural and remote locations.

This paper will describe each of the programs, the target audiences and the competencies that are acquired. Data will be provided on the numbers of participants that have undertaken the various courses along with summary details of their responses and feedback. The courses range from an undergraduate medical and nursing student 'Ride-along' program, to Basic and Advanced First aid training for residents of remote locations, General Practice Registrar advanced training and on to a remote emergency skills program for senior rural GP's. To date over 1,000 undergraduate students have taken part in the 'Ride-along' program and the remote skills program has provided emergency medicine skills practical training to over 700 rural and remote GPs in South Australia.

The paper will conclude with a discussion on the future training challenges for rural and remote health professionals and how information technology may have an increasing focus in providing that training across the vast distances over which the NGO provides health services.

POSTER

Dial 'T' for trepidation: junior doctors early encounters with telehealth in the emergency department

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Background: The majority of recent medical graduates undertaking their first rotation in rural health have had little or no training to prepare them for the challenge of examining, diagnosing and treating a patient using Telehealth.

In 2014, a Telehealth after hours emergency service was developed in Central and Upper Hume region of Victoria to support outlying urgent care centres when there are no after hours medical practitioners available. Junior doctors rostered in the referral hospital treat patients triaged as Category 3, 4 and 5 from the outlying sites via Telehealth as part of their usual workload in the emergency department.

Aims: To assess the clinical comfort of junior doctors in a regional emergency department providing care to patients presenting via Telehealth.

To design a short on-line Telehealth training module targeted to junior doctors in a regional emergency department.

Methods: Junior doctors in the regional emergency department were invited to either respond to a self report questionnaire, structured face to face or structured telephone interview. The survey and interview questions followed the AIHW framework health performance indicators. Clinician confidence was measured using visual analogue scale (VAS) with higher scores indicating greater confidence. Thematic analysis was undertaken to reveal key aspects of the Telehealth encounter.

Results: 9 junior doctors participated in the study (43%). The mean score on 100mm VAS was 37, (range 0-80). The dominant themes were the challenge of remote physical examination, confidence in choosing the appropriate patients, determining the capacity of the staff from the referring hospital in assisting the examination and establishing mutual trust. An online training package were developed in response to the issues raised by the junior doctors.

Conclusions: Undertaking a successful clinical assessment via Telehealth can be a new and potentially stressful situation for the junior doctor in an emergency department setting. A short orientation teaching module may help to equip the new junior doctor in the skills required to successfully treat patients presenting via Telehealth.

POSTER Rural Transfer Project

Meaghan Trovato

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Our health service consists of a major tertiary referral centre, with six smaller (rural) facilities, which are between 90 and 500km from the major facility. The major centre was having difficulty with to facilitating patient flow and hence the NEAT, while the rural facilities had continuing low occupancy. Monthly average occupancy across all facilities for 2013, ranged from 50%-63%, with an average of 56%. The individual facilities occupancy ranged from 39%-79% in 2013.

A trial period of 8 weeks initially set up and a 0.8 FTE Rural Transfer Coordinator, an experienced Clinical Nurse from one these facilities, was appointed. The aim was to realign occupancy mismatch and improve communication, ease of

transfer and clinical handover, while maintaining a patient-centred care focus.

After 6 months working from a rural facility, the role was relocated to the tertiary referral centre, where more comprehensive information could be gathered to maintain the communication continuum. This was also assisted with early identification and planning for transfers. Working from the tertiary facility also increase visibility of the role to wards and departments.

In the 10 months since the implementation of the project all facilities saw an increase in occupancy, an average occupancy increase across all facilities was 14.3%. One facilities occupancy increased by 40%. There was an 8.6% increase in the numbers of transfers from the tertiary facility from 2013 to 2014, and a 66.6% increase since 2012.

The benefits of this project included allowing patients to continue their care episode closer to home. The rural sites were able to increase the scope of their clinical skills to include skills such as skeletal and skin traction, vacuum assisted closure and continuous ambulatory peritoneal dialysis. Some long term patients, who agreed to transfer, were relocated to other facilities to continue their care.

The outcome of this project was the position was made to full time Rural Patient Flow Coordinator, who widened the scope to include all aspects of patient flow, including preadmission, discharge and outpatient process' and telehealth. The position is one that could sit within either a Service Group or Patient Flow Support Unit, however close liaison with Patient Flow and a thorough knowledge and understanding of rural facilities is vital.

POSTER Rural communities experiencing climate change: a systems approach to adaptation

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Introduction: Rural areas are vulnerable to climate change because of their direct dependence on natural resources, weather-dependent activities, and their inequitable access to services. Communities are affected in two main ways: firstly, extreme weather events that impact on infrastructure and cause loss of life and secondly, the impact on ecosystems and agriculture. Furthermore, in different locations people's health is at greater or

lesser risk, but over and above these vulnerabilities all sub-groups of the rural population are influenced by unique characteristics of rural settings.

The inextricable link between rural people and the effects of climate on their daily lives is illustrated in this presentation. Some creative programs build optimism about capacity to meet the health needs of rural people, despite the diversity of the climate, geography, economy, demography and culture. Adaptation potential will vary between locations.

Method: The issues that challenge the wellbeing of rural people and their communities in the face of climate change was explored using a conceptual framework developed by Bourke et al. (2012 a,b). The framework was then used to explore 'ways forward' for health and community service organisations. This systems approach examined climate change and rural communities in terms of the interrelationships between six key concepts: rural locale; local health actions; broader health systems and broader social structures in the context of power relations.

Results and discussion: Research on the current impacts of climate change in inland Australian settlements is at an early stage and somewhat fragmented and we are only beginning to understand the issues and how to manage them effectively. We do know that direct and indirect health impacts of climate change amplify the health challenges already faced by rural communities.

Adaptation for health in rural communities cannot be too prescriptive because rural Australia is diverse. However, building community resilience requires health and social services to develop knowledge of, and attachment to, rural culture. Health and social service workers need to have capacity to relate to rural communities and have a specific rural focus.

Although stakeholders within rural communities differ in their vulnerabilities and adaptive capacities, they are bound by similar dependence upon critical infrastructure and resources, economic conditions, government policy direction, and societal expectations (Loechel et al. 2013).

In essence we need to:

- assist health and social service agencies to adapt their services to meet the needs generated by the impacts of climate change
- build on rural communities' local knowledge, resources and networks

- assist communities to plan and implement adaptation strategies for major vulnerabilities such as agriculture, service management and communication.

Only interdisciplinary, collaborative approaches that draw on the wisdom of rural people are likely to be effective in health enhancement.

POSTER

Traverse the barriers in paediatric emergency care: a model to support rural GPs

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Introduction: General practitioners (GPs) are an important group of health professionals looking after sick patients, including sick children. We seek to develop a cost effective model to support rural clinical education and to establish ongoing synergy between rural and regional health centres within our health district, thus helping to build local capability, improve patient outcomes, minimise risks and connect regional and rural sites.

Aim: To develop a new effective model to provide the rural health professional with the opportunity to update and refresh clinical skills in paediatric emergency care in their own community setting.

Method: Seven members of the GP Outreach team from our health district took turns to travel to targeted rural centres to deliver the education sessions through combining didactic lectures on topics essential to clinical practice, case-based discussions and hands on interactive workshops held on site at a location and time suitable to the attending general practice workforce.

Feedbacks from the attendees were collected at the end of each session. These attending GP were awarded Category II points as part of continuing professional development through Royal Australian College of General Practitioners and Australian College of Rural and Remote Medicine.

Results: This GP Outreach Project has provided access to on site education and training to 17 rural communities and delivered the Paediatric Emergency Care training model to over 215 doctors (most of the attendees) and nurses.

Formal feedback from the attendees after each session was very positive. Seventy-eight per cent of the attendees were very satisfied (78.07%, C.I: 71.51%, 83.47%) and 23% (C.I: 16.52%, 28.48%) of them were satisfied with the workshops. The objective of recognising sick child was achieved in most attendees (95.18%, C.I:90.96%, 97.49%). The majority of them (81.28%, C.I: 74.98%, 86.29%) strongly agreed that this Program was a valuable learning experience for revision. Some suggestions in content and format were received from the feedback.

Conclusion: The GP Outreach project uniquely provides the rural health professional with the opportunity to update and refresh clinical skills in their own community setting.

This standalone model is fully established and transportable, and can be adapted to provide local solutions for varying sites, district and state wide to meet the specific learning needs of rural health clinicians treating children in the ED.

ABOUT THE NRHA

The National Rural Health Alliance is Australia's peak non-government organisation for rural and remote health. Its vision is good health and wellbeing in rural and remote Australia.



NATIONAL RURAL
HEALTH
ALLIANCE INC.

Fundamental to the Alliance's work is the belief that, wherever they live, all people in Australia should have the opportunity for equal health outcomes, and equivalent access to comprehensive, high-quality and appropriate health services.

Currently the Alliance comprises 37 Member Bodies, each of which is a national organisation. They include consumer groups (such as the Country Women's Association of Australia), representation from the Indigenous health sector, health professional organisations (representing doctors, nurses, allied health professionals, dentists, pharmacists, paramedics, health students, chiropractors and health service managers) and service providers (such as the Royal Flying Doctor Service and Frontier Services of the Uniting Church in Australia).

With such a broad representative base, the Alliance is in a unique position to represent the views of people in rural and remote Australia. It collects and disseminates information so that it can determine the key issues affecting rural and remote areas and provide a coherent view on them to governments, the public, media, educational and research institutions and other bodies.

The Alliance takes a broad view of health and a long-term view of the development of rural and remote Australia. It supports initiatives that help the diverse communities of rural and remote Australia to be sustainable, healthy and health-promoting places in which to live and work.

The Alliance manages the biennial National Rural Health Conference and the *Australian Journal of Rural Health* (AJRH), and produces position papers, submissions, media releases and newsletters. It is also the national management agency for the Australian Government of the Rural Australia Medical Undergraduate Scholarship (RAMUS) Scheme and Stream 2 of the Rural Health Continuing Education program (RHCE2).

There are many and varied determinants of health, and work to improve it in rural areas will continue to depend in part on strong partnerships between individuals, organisations and governments in metropolitan as well as rural and remote Australia.

The core support the Alliance receives for its work from the Australian Government bears testament to the partnership between the government and non-government sectors that is bringing greater equity and access for rural people.

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MEMBER BODIES OF THE NRHA

ACEM-RRC	Australasian College of Emergency Medicine's Rural, Regional and Remote Committee
ACHSM	Australasian College of Health Service Management (rural members)
ACM-RRAC	Australian College of Midwives Rural and Remote Advisory Committee
ACN	Australian College of Nursing (Rural Nursing and Midwifery Community of Interest)
ACRRM	Australian College of Rural and Remote Medicine
AGPN	Australian General Practice Network
AHHA	Australian Healthcare and Hospitals Association
AHPARR	Allied Health Professions Australia Rural and Remote
AIDA	Australian Indigenous Doctors' Association
ANMF	Australian Nursing and Midwifery Federation (rural nursing and midwifery members)
APA (RMN)	Australian Physiotherapy Association (Rural Members Network)
APS	Australian Paediatric Society
APS (RRPIG)	Australian Psychological Society (Rural and Remote Psychology Interest Group)
ARHEN	Australian Rural Health Education Network Limited
CAA (RRG)	Council of Ambulance Authorities (Rural and Remote Group)
CRANa ^{plus}	CRANa ^{plus} —the professional body for all remote health
CWAA	Country Women's Association of Australia
ESSA (RRIG)	Exercise and Sports Science Australia (Rural and Remote Interest Group)
FRAME	Federation of Rural Australian Medical Educators
FS	Frontier Services of the Uniting Church in Australia
HCRRRA	Health Consumers of Rural and Remote Australia
IAHA	Indigenous Allied Health Australia
ICPA	Isolated Children's Parents' Association
NACCHO	National Aboriginal Community Controlled Health Organisation
NRF of RACGP	The National Rural Faculty of the Royal Australian College of General Practitioners
NRHSN	National Rural Health Students' Network
PA (RRSIG)	Paramedics Australasia (Rural and Remote Special Interest Group)
PSA (RSIG)	Rural Special Interest Group of Pharmaceutical Society of Australia
RDAA	Rural Doctors' Association of Australia
RDN of ADA	Rural Dentists' Network of the Australian Dental Association
RFDS	Australian Council of the Royal Flying Doctor Service
RHWA	Rural Health Workforce Australia
RIHG of CAA	Rural and Indigenous Health-interest Group of the Chiropractors' Association of Australia
ROG of OA	Rural Optometry Group of Optometry Australia
RPA	Rural Pharmacists Australia
SARRAH	Services for Australian Rural and Remote Allied Health
SPA-RRMC	Speech Pathology Australia—Rural and Remote Member Community



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