SFT-26

INTERNATIONAL CONFERENCE ON

Successes and Failures in Telehealth

5-6 NOVEMBER 2026

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CONFERENCE PROCEEDINGS



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Successes and Failures in Telehealth 2026

Building a better health system with telehealth and virtual care



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Acknowledgements

The organisers are grateful to many individuals and organisations, including the sponsors and exhibitors. We thank all delegates for their contribution and efforts.

November 2026.

The SFT conference is hosted by:
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THURSDAY 5 NOVEMBER 2026

	Auditorium	B1	B2
7:30 AM - 4:45 PM	**Registration Open**		
8:30 AM - 8:55 AM	SFT- 26 Conference Opening Welcome to Country: **Refiti Tovi** Opening: **Professor Anthony Smith, Conference Chair** University Welcome: **Professor Craig Munns, Dean, UQ Medical School**		
9:00 AM - 9:40 AM	Keynote Address: eHealth Queensland's strategic direction and virtual care. **Dr Tanya Kelly** 9:00am - 9:30am - Keynote presentation 9:30am - 9:40 am: Q&A session		
9:40 AM - 10:00 AM	**Industry Engagement Session**		
10:00 AM - 10:50 AM	Panel Session: Consumer Session **Dr Jaimon Kelly and Mr Brian Beh**		
10:50 AM - 11:20 AM	**Morning Tea, Exhibition & Poster Viewing**		
	Concurrent Session 1 - Rural Health	**Concurrent Session 2 - Evaluation & Effectiveness**	**Concurrent Session 3 - Outpatient & Community Care**
11:20 AM - 11:35 AM	Addressing the postcode lottery: Soaring Acuity and Evolving Virtual Models of Care for Regional EDs **Dr Tatiana Lowe**	Does Direct to Consumer Telehealth for Upper Respiratory Infections Reduce the Need for In-Person Care? **James Marcin**	When outpatient cardiac care and treatment go digital: A postphenomenological exploration of cardiac patients' actions and experiences with video consultations and home monitoring. **Nina Cecilie Tjustrup**
11:35 AM - 11:50 AM	Facilitators and Barriers of a Successful Hybrid Outpatient Telehealth Model in a Very Remote Aboriginal Community of Central Australia **Vishnu Khanal**	Digital health education and training in Japan: a scoping review of literature published in Japanese and English language **Kuriko Kudo**	A Literature Review on Research carried out on Digital Health Education and Training in Japan **Shintaro Ueda**
11:50 AM - 12:05 PM	Empowering Remote Healthcare Professionals through Community and Support **Manuel Gonzalez**	From Policy Gap to Practice Framework: Streamlining Telemedicine Prescribing in Sri Lanka **Gumindu Kulatunga**	Fracture Clinic Trial (RECITAL): What are the outcomes for patients with simple fractures attending a virtual clinic compared to the in-person clinic? **Min Jiat Teng**

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12:05 PM - 12:20 PM	Online counselling for rural concerned significant others: A randomised controlled trial **Heidi Gray**	Restoring Access: RACP Advocacy Lessons from the Reinstatement of Physician Telephone and Video Telehealth in the MBS **Peter Lalli**	Evidence-based recommendations for how to improve access to comprehensive primary health care in remote communities using digital technologies **Tim Shaw**
12:20 PM - 12:35 PM	Hospitals without walls: proving timely, expert, virtual emergency care in Queensland **Kim Hansen**	A Mixed Methods Evaluation of a Hospital-based Virtual Clinical Safety Net for Detecting and Responding to Patient Deterioration **Georgina Luscombe**	Physiotherapists' perspectives of the use of telerehabilitation: a qualitative systematic review and meta-synthesis **Joshua Simmich**
12:35 PM - 12:50 PM	Session 1 - Q&A with Speakers	Session 2 - Q&A with Speakers	Session 3 - Q&A with Speakers
12:50 PM - 1:35 PM	**Lunch, Exhibition & Poster Viewing**		
	Concurrent Session 4 - Co-design	**Concurrent Session 5 - Patient Experience & Communication**	**Concurrent Session 6 - Integrated & Multidisciplinary Care**
1:35 PM - 1:50 PM	Co-designing an AI-powered clinical chatbot in a remote digital primary care unit: A participatory action research approach **Virginia Zazo**	Enhanced patient-centred communication through implementation of a novel consultation summary software application in outpatient telehealth encounters **Laura Bird**	Implementation of the Virtual Integrated Practice (VIP) Partnership Program: Supporting access to primary care in rural Queensland **Jenny Job**
1:50 PM - 2:05 PM	Interprofessional Co-Design of a Virtual Care Curriculum for Continuing Professional Development at Sydney Local Health District Virtual Hospital **Shannon Saad**	Comparing memory-based safety and patient-centered quality outcomes across telephone and video telehealth consultations **Yangxueqing Jiang**	Treat the Patient, Not the Imaging: Updated Cost and Societal Value of a Telehealth Fracture Clinic in North West Queensland 14 Years After Initial Evaluation **Wesley Monts**
2:05 PM - 2:20 PM	Metro to rural: co-designing a hybrid GP service to sustain primary care in a thin market **Raymond Wen**	The Current State of Telemedicine Activities at National University Hospitals in Japan **Yukiko Hisada**	How the Central Foot Hub uses virtual care to treat patients with foot ulcers in Central Queensland **Alison McGill**
2:20 PM - 2:35 PM	CubCare – Clinical Co-design Creating a Technology-Enabled Paediatric Care Platform: Expanding Access to Acute, Developmental and Specialist Care **David Wood**	Safety and security as quality markers in telehealth consultations: deliberative workshops with consumers and clinician think-aloud interviews **Christine Phillips**	Royal Flying Doctor Service Northern Territory Virtual Emergency Care Trial **Caz Mason**

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2:35 PM - 2:50 PM	Equity by Design: Lessons from Co Designing a Telehealth Model to Improve Cancer Outpatient Attendance **Amber Anderson**	Technical challenges in comparing information exchange and outcomes across video and audio telehealth modalities **Yangxueqing Jiang**	A “Prescribable” mobile app for people with chronic low back pain attending general practice: Feasibility randomised controlled trial **Isha Mishra**
2:50 PM - 3:05 PM	Session 4 - Q&A with Speakers	Session 5 - Q&A with Speakers	Session 6 - Q&A with Speakers
3:05 PM - 3:30 PM	**Afternoon Tea, Exhibition & Poster Viewing**		
	Ensuring the Quality and Safety of Telehealth - NHMRC Targeted Call for Research Recipients **Chair: Professor Liam Caffery**		
3:30 PM - 3:45 PM	Cost-effectiveness analyses of virtual ED services across Australia: methods issues and findings **Jonathan Karnon**		
3:45 PM - 4:00 PM	Exploring reported quality and safety markers in telehealth **Jenna Graffini**		
4:00 PM - 4:15 PM	Towards safer telehealth consultations about medicines: comparing audio and video telehealth consultations for high risk medications and in cross-cultural settings **Christine Phillips**		
4:15 PM - 4:30 PM	Exploring telehealth activity in northern Queensland **Deb Smith & Karen Johnston**		
4:30 PM - 4:45 PM	Panel Session: Q&A **Facilitated by Professor Liam Caffery**		
4:45 PM - 4:45 PM	**Conference Close**		
6:30 PM - 9:30 PM	Conference Social Reception		

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FRIDAY 6 NOVEMBER 2026

	Auditorium	B1	B2
7:29 AM - 3:15 PM	**Registration Open**		
7:30 AM - 8:45 AM	**TEMDEC Breakfast Workshop**		
9:00 AM - 9:10 AM	**Welcome to Day 2**		
9:10 AM - 9:50 AM	Keynote Address - What quadriplegia, depression and moving to Australia taught me about equity through digital health **Dr Dinesh Palipana** 9:10am - 9:40am - Keynote presentation 9:40am - 9:50am - Q & A Session		
9:49 AM - 10:30 AM	**Oral Poster Session**		
9:50 AM - 9:55 AM	The Virtual Neurologist: Transforming Regional Care Through Telehealth Diagnosis of Functional Neurological Disorder **Mai Vu**		
9:55 AM - 10:00 AM	Teletrials Transforming Clinical Trial Access Across Queensland **Kimberley Bury**		
10:00 AM - 10:05 AM	Bringing the ward home: Early outcomes of a virtual care model **Kamil Pufal**		
10:05 AM - 10:10 AM	The Hybrid Telehealth Model in Physiotherapy - Training Wheels or the Finish Line? **Rebekah Robinson**		
10:10 AM - 10:15 AM	Experiences implementing Telemedicine for Heart-failure patients- A Case from a Danish department of Cardiology **Stine Rosenstroem**		
10:15 AM - 10:20 AM	Use of telehealth for Australian regional patients to improve access to specialized stereotactic radiosurgery in a post-pandemic era: A single institution study and literature review **Melanie Stanhope**		
10:20 AM - 10:25 AM	Restoring capsule endoscopy through a remote reporting model: what worked, and what got stuck downstream **Raymond Wen**		
10:25 AM - 11:00 AM	**Morning Tea, Exhibition & Poster Viewing**		
10:59 AM - 11:00 AM	**Concurrent Session 7 - Technology, Tools & Infrastructure**	**Concurrent Session 8 - Implementation**	**Concurrent Session 9 - Virtual Care Models**
11:00 AM - 11:15 AM	Successful implementation of a statewide general practitioner-to-specialist eConsult service in Queensland **Caroline Nicholson**	Lessons from deploying mixed reality tele-mentoring across eight rural hospitals: Workflow, training, and operational resilience **Trung Dung Bui**	Digital health interventions supporting integrated care for irritable bowel syndrome in Australia: Assessing patient and clinician needs through a mixed-methods study **Molly Fahey**

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11:15 AM - 11:30 AM	Feasibility of Digital Health App Prescriptions for Obesity Treatment in Australian General Practice: A Mixed-Methods Study with General Practitioners **Alice Petcopoulos**	From Phone Heavy to Video Enabled: Embedding Sustainable Telehealth in Outpatient Endocrinology **Shona Callum**	Digitally enabled outreach healthcare: Exploring the "Mobpod" service model **Paul Penumala & Michal Nosek**
11:30 AM - 11:45 AM	Assessment tools for health student telehealth competency: A scoping review **Kate Bridgman**	Successes and learnings from implementing a multifaceted telementoring intervention to support telehealth adoption in public allied health outpatient services **Renee Cook**	Care provided and Lessons learnt - Queensland Virtual Early Medical Termination of Pregnancy Service (QVEMTOPS) 1 year on **Claire Fotheringham**
11:45 AM - 12:00 PM	Applying Team-Based Problem Solving to Drive Innovation, Safety and Quality in Statewide Virtual Care **David Nouju**	Better Care, Lower Cost, Less Travel: A Cost-Effectiveness Analysis of eConsults in the World's Largest Universal Health System **Soraia De Camargo Catapan**	Virtual ward rounds – facilitating timely, equitable access to specialist care in Regional Victorian Health Services (A pilot) **Mai Vu**
12:00 PM - 12:15 PM		Delivering Integrated Acute Virtual Care at Scale in Rural and Remote Queensland: A Two-Year Service Evaluation of the Royal Flying Doctor Service **Megan Hobbs**	A virtual health treatment and management service for cancer patients to reduce the impact and cost for patients in rural areas **Associate Professor Alison Craswell**
12:15 PM - 12:30 PM	Session 7 - Q&A with Speakers	Session 8 - Q&A with Speakers	Session 9 - Q&A with Speakers
12:30 PM - 1:15 PM	**Lunch, Exhibition & Poster Viewing**		
	Concurrent Session 10 - Service Support Mechanisms	**Concurrent Session 11 - Policy, Governance & Scaling**	**Concurrent Session 12 - Artificial Intelligence**
1:15 PM - 1:30 PM	Reflections on the development of a Virtual Community of Practice Approach to Paediatric Brain and Spinal Cord Injury Mental Health Care **Professor Karen Barlow**	Implementation of a virtual health navigator to support new virtual model of outpatient care in a tertiary hospital allied health department **Jaimon Kelly**	Would you like a side of AI with that? An organisational journey implementing AI in a national telehealth environment. **Glynis Sandland**
1:30 PM - 1:45 PM	Measuring Trust and Confidence in Telehealth modalities in Australia: a nation-wide validation study of the trust and confidence in telephone and video consultation scales **Soraia De Camargo Catapan**	Whole-of-System Ownership for program implementation: Lessons from the Australian Teletrial Program **Sabe Sabesan**	Does clinician AI use undermine trust in physiotherapy delivered in-person or via telerehabilitation? An online randomised experiment **Megan Ross**

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FRIDAY 6 NOVEMBER 2026

1:45 PM - 2:00 PM	Beyond Data Breaches: A Cross-Sectional Analysis of the Human, Experiential and System-Level Factors Shaping Trust in Telehealth Modalities in Australia **Soraia De Camargo Catapan**	Policy evolution in digital health education and training: a scoping review **Sisira Edirippulige**	The mediating role of trust in telehealth between AI knowledge and consumers' comfort across the AI-HCP involvement spectrum **Jia Wan**
2:00 PM - 2:15 PM	Telemedicine in medical education after COVID-19: a convergent mixed-methods study of medical students in Peru **Victor Gallegos-Rejas**	Increasing the Use of Video Telehealth in Residential Aged Care Homes: Evaluation of a Practical Telehealth Training Program **Annie Banbury**	Understanding patient distress from speech: Lessons for AI in telehealth **Cody Hu**
2:15 PM - 2:30 PM	Teledermatology models of care: A snapshot of services in Australia **Monica Taylor**	From Promise to Practice: Scaling Telepharmacy in New Zealand **Hina Saeed**	
2:30 PM - 2:45 PM	Session 10 - Q&A with speakers	Session 11 - Q&A with Speakers	Session 12 - Q&A with Speakers
2:45 PM - 2:55 PM	Short break - delegates move into plenary session		
2:55 PM - 3:35 PM	Keynote Address - Ideas for monitoring AI in telehealth and virtual care **Professor Adam Dunn** 2:55pm - 3:25pm - Keynote Presentation 3:25pm - 3:35pm - Q&A		
3:35 PM - 3:50 PM	Awards and Conference Close Best Paper Prize, SFT-28 Announcement and conference close		
	End of SFT 2026		

Keynote Presentations

Keynote Address

Thursday 5 November 2026, 8:30am

Dr Tanya Kelly

Deputy Director General, eHealth Queensland
Queensland Health

Presentation Title: eHealth Queensland's strategic direction and virtual care

As Queensland Health advances its digital health agenda, virtual care is playing an increasingly important role in how health services are delivered across the state. In this keynote, Dr Tanya Kelly, Deputy Director-General of eHealth Queensland, will provide an overview of eHealth Queensland's strategic direction and explore how virtual care is evolving across Queensland. Her presentation will offer valuable insights into the opportunities and priorities shaping the future of digital health and virtual care in the state.

Correspondence:
Dr Tanya Kelly
DDGeHQ@health.qld.gov.au

Keynote Address

Friday 6 November 2026, 9:10am

Dr Dinesh Palipana

Dinesh was the first quadriplegic medical intern in Queensland. Dinesh is a doctor, lawyer, disability advocate, and researcher. While in medical school, he was involved in a car accident that caused a spinal cord injury. Dinesh was born in Sri Lanka, moving to Australia at the age of ten during the civil war.

Dinesh works in the emergency department at the Gold Coast University Hospital. He is a researcher and senior lecturer at Griffith University and assistant professor at Bond University. Dinesh is a researcher in spinal cord injury, co-leading the BioSpine research team.

He is a doctor for the Gold Coast Titans physical disability rugby team. Dinesh was a senior advisor to the Disability Royal Commission. He is an advisory board member to HealthyLife, a Woolworths company. Dinesh is a John Monash Scholar. He is an independent non-executive director of George Steuart & Co, one of the oldest companies in the world. Dinesh is on the community advisory committee at SBS.

Dinesh was awarded the Medal of the Order of Australia in 2019. He was the third Australian to be awarded a Henry Viscardi Achievement Award. He was the 2021 Griffith University Young Alumnus of the Year. Dinesh was the Queensland Australian of the Year for 2021. His autobiography, Stronger, was published by Pan Macmillan in 2022.

Presentation Title: What quadriplegia, depression and moving to Australia taught me about equity through digital health

Dinesh was a lawyer before he became a doctor. In law school, he had a journey through depression. In medical school, he was involved in a car accident that caused a spinal cord injury and quadriplegia. But, before all of this, his family moved to Australia from Sri Lanka during its war. Dinesh will share his unique experiences and perspectives, with an emphasis on how telehealth and virtual care can help create equity - not only in disability, but also in culturally diverse communities.

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Keynote Address

Friday 6 November 2026, 2:55pm

Adam Dunn

Professor of Biomedical Informatics, University of Sydney

Adam Dunn (PhD 2007, FAIDH) is Professor of Biomedical Informatics at the University of Sydney, where he leads research at the intersection of artificial intelligence (AI), digital health and evidence-based medicine. Originally trained in computer science, he has nearly 20 years of experience in health informatics. His research examines how AI can be safely and effectively applied across clinical care, public health and clinical research. This includes the use of language models and other AI methods to improve health communication, clinical decision support and access to reliable health information, as well as research on the evaluation, implementation and governance of AI-enabled health technologies. Adam is Chief Editor of npj Digital Public Health and Deputy Editor of npj Digital Medicine.

Presentation Title: Ideas for monitoring AI in telehealth and virtual care

AI adoption in telehealth remains patchy, but digital scribes, automated triage and remote monitoring are entering care faster than evaluation and regulation can adapt. Here we will go through opportunities to go beyond early validation and pre-market approval to ask how AI might be monitored throughout deployment. A plan is needed for continuous oversight combining real-world performance data, safety signals, workflow impacts, equity measures, clinician and patient feedback, and transparent accountability. Using current examples, this talk will cover how health services can generate evidence as technologies evolve, and how proactive monitoring could shape proportionate regulation rather than waiting for failures to reveal what static oversight missed.

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Oral Presentations

Addressing the postcode lottery: Soaring Acuity and Evolving Virtual Models of Care for Regional EDs

Dr Tatiana Lowe[1]

1. My Emergency Doctor

Background
Virtual Emergency Departments (vEDs) have evolved from digital pilots into essential networks providing equitable, fiscally responsible access to senior emergency expertise across geographically dispersed communities.
Traditionally focused on low-acuity presentations, mature vEDs now experience the same rising demand and patient acuity seen in physical regional networks - challenging traditional limits of remote care.

Objectives
To evaluate the clinical impact of escalating patient complexity on vEDs and assess whether progressive approaches can expand the scope of virtual care to manage patients in situ (MIS), reduce local rural and regional hospital admissions, and mitigate bed block.

Method
A retrospective analysis of an Australian vED over a two-year period (2025–2026) tracked high-acuity presentations (Australasian Triage Scale [ATS] Categories 1–3) alongside consultation times and MIS rates.

Results
Between 2025 and 2026, despite stable overall volumes (40,381 versus 40,254), high-acuity cases surged:

- Category 1 increased 229% (159 to 523)
- Category 2 increased 291% (2,084 to 8,148)
- Category 3 increased 99% (5,994 to 11,947)
- Conversely, Category 4/5 presentations fell 39% (32,144 to 19,636)
- Weighted average call durations for high-acuity cohorts remained steady (31.5 minutes to 30.7 minutes)
- Despite this acuity shift, a senior-led virtual workforce framework maintained an 85% MIS rate

Conclusion
Adopting virtual emergency networks that can support rising case complexity can combat the regional healthcare postcode lottery. The capacity to safely maintain an 85% MIS rate - even amidst surging ATS Category 1, 2, and 3 presentations - demonstrates that advanced virtual care models can successfully alleviate downstream pressure on both local rural facilities and larger regional base hospitals.

Correspondence:
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My Emergency Doctor
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Facilitators and Barriers of a Successful Hybrid Outpatient Telehealth Model in a Very Remote Aboriginal Community of Central Australia

Dr Vishnu Khanal[1], Miss Kureisha Wilson[1], Dr. Josielli Comachio[2], Dr. Emily Saurman[2], Dr Nicki Newton[3], Ms. Karina Coombes[1], Mr. Alexandar Puruntatameri[1], Ms. Hilda Bert[1], Dr Amy Von Huben[4], Dr. Sarah Norris[4], Prof. John Wakerman[1], Professor Tim Shaw[2], Dr Deborah Russell[1]

1. Menzies School of Health Research, Remote Health Systems and Climate Change Centre, Mparntwe (Alice Springs), Australia
2. School of Public Health, Faculty of Medicine and Health, The University of Sydney, Warrane (Sydney), Australia
3. Centre for Human Factors and Systems Science, University of the Sunshine Coast, Sippy Downs, Australia
4. Leeder Centre for Health Policy, Economics & Data, Faculty of Medicine and Health, The University of Sydney, Warrane (Sydney), Australia

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

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

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

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

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Empowering Remote Healthcare Professionals through Community and Support

Dr Manuel Gonzalez[1], Dr Virginia Zazo[1], Mr Jonas Vickström[1], Mrs Malin Vesström[1], Mrs Angela Deocampo[1]

1. Renos AB, Umeå, Sweden

Digital transformation in healthcare is frequently framed around technology, efficiency, and access. Far less attention is paid to how new digital models affect the healthcare workforce — particularly clinicians working remotely or in digitally distributed settings.

This presentation explores workforce resilience as a critical but underdeveloped dimension of digital health transformation, drawing on experiences from RenosHub, a digital community developed by Renos AB for remote and digitally enabled healthcare professionals.

During its pilot phase, Renos Hub brought together clinicians from multiple countries and specialties through structured digital spaces, live events, and peer-driven initiatives. One such initiative is Teledermazonia, developed within Renos Hub as a community-supported teledermatology model connecting volunteer specialists with primary care centres in the Ecuadorian Amazon. Teledermazonia illustrates how digital care initiatives depend not only on technology, but on trust, shared clinical practice, and ongoing professional support.

By combining engagement data, qualitative feedback, and field-based experience, the session demonstrates that sustainable digital health transformation requires social and organisational infrastructure alongside technical solutions. The talk addresses how digital communities can function as workforce enablers—supporting resilience, professional identity, and equitable care delivery across both high- and low-resource contexts.

The session is relevant for healthcare leaders, policymakers, clinicians, and innovators seeking to align digital transformation with workforce sustainability and long-term system resilience.

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Online counselling for rural concerned significant others: A randomised controlled trial

Heidi Gray[1], Dr Nicola Ivory[2], Dr Nicole Snowdon[1], Dr Kedir Ahmed[1], Dr Matt Thomas[2,3,4], Professor Julaine Allan[1,5]

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2. School of Psychology, Charles Sturt University, Bathurst, NSW, Australia
3. Marathon Health, Bathurst, NSW, Australia
4. Discipline of Psychiatry and Mental Health, University of NSW, Randwick, Australia
5. National Drug and Alcohol Research Centre, University of NSW, Randwick, Australia

Aim
This study aimed to evaluate the effectiveness of an online, practitioner led delivery of Community Reinforcement and Family Training (CRAFT) for concerned significant others (CSOs) supporting individuals who use alcohol and other drugs in rural Australia, where access to face-to-face services is limited.

Methods
A randomised controlled trial with a two arm, parallel group design was conducted. Participants (N = 126) living in rural and regional Australia were randomly allocated to either a six session online CRAFT intervention (n = 64) or a waitlist control group (n = 62). CRAFT was delivered via telehealth by trained psychologists. Outcomes were assessed at baseline, post intervention, and follow up using the Depression Anxiety Stress Scales 21 (DASS 21), Satisfaction with Life Scale (SWLS), Flourishing Scale (FS), and Brief COPE. Primary outcomes focused on psychological wellbeing, with secondary outcomes examining coping strategies. Data was analysed using intention-to-treat methods.

Results
Compared to the waitlist group, participants receiving online CRAFT demonstrated significant improvements in mental health and wellbeing outcomes. Depression scores decreased significantly (adjusted mean difference = −2.71, 95% CI −5.36 to −0.06), life satisfaction increased (mean difference = 1.98, 95% CI 0.45 to 3.50), and use of problem focused coping strategies improved (mean difference = 2.92, 95% CI 1.33 to 4.51). High program completion rates indicated strong engagement with telehealth delivery.

Conclusion
Findings indicate that online, practitioner led CRAFT is an effective telehealth intervention for improving wellbeing and coping among CSOs in rural Australia. This study supports the use of virtual care models to extend access to evidence based family focused interventions in underserved regions and highlights the potential of telehealth to address workforce and geographic barriers in rural substance use services.

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Cost-effectiveness analyses of virtual ED services across Australia: methods issues and findings

Dr Kim Hansen[1]

1. Virtual Emergency Care Service, 15 Butterfield st Herston, Australia

Emergency Departments and hospitals are necessary for urgent health concerns; however, many physical ED visits could be managed in alternate settings. Preventing avoidable, physical ED presentations may decrease ED overcrowding and limit adverse outcomes related to waiting times and lack of access to appropriate treatment spaces. Queensland's Virtual Emergency Care Service (VECS, previously known as Virtual ED) was set up in 2020 to provide timely, expert care by linking patients and referrers to emergency specialist doctors by video or telephone consult. In 2022, presentations directly from patients were accepted, prior to that the only presentations to Virtual Emergency were via a clinician referral. Retrospective, quantitative, observational data will be presented to evaluate the effectiveness of this public, dual-model, state-wide Virtual Emergency service using routinely collected health service data. The data will assess the reach and accessibility of VECS across diverse patient populations (age, gender, location, cultural background) and identify opportunities to better target the service toward patients who would otherwise present to physical emergency departments but are well suited to virtual emergency care. Of the patients seen, over 85% do not require an ED attendance, indicating that Virtual ED is an effective substitute for a physical ED presentation for suitable patients. By encouraging services to refer to VECS, and increasing community awareness, it is expected that more patients will receive timely and effective emergency care at home or wherever they are. Queensland's Virtual Emergency Care Service has had good uptake from patients and a broad range of referrers, supporting the use of virtual care pathways in emergency management.

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Does Direct to Consumer Telehealth for Upper Respiratory Infections Reduce the Need for In-Person Care?

Dr James Marcin[1], Seyedehyasmin Moghaddamziabari[1], Patrick Romano[1], Guibo Xing[1], Sarah Haynes[1]

1. UC Davis Health, Sacramento, United States

Background: On-demand telehealth services are available to improve access and convenience of care, with some expectation that these visits may replace scheduled video visits and in-person visits.

Objective: This study evaluates an integrated, on-demand telehealth service (Express-Care) at an academic health center and how its availability and adoption influenced healthcare utilization and charges for upper respiratory tract infections (URIs).

Research Design: A retrospective cohort study was conducted using electronic health record data between July 2018-October 2024.

Subjects: A cohort of patients using Express-Care for URI were compared to patients receiving URI care via other modalities on sex, age, race/ethnicity, insurance, California Healthy Place Index, comorbidities, and household income.

Measures: Use of Express-Care for URIs after its launch on September 5, 2020. The primary outcome was URI visit rates per 100 patients per year before and after Express-Care deployment. Secondary outcomes included 7-day follow-up visit rates and total healthcare charges per episode.

Results: Among the 26,605 patients, Express-Care users were more likely to be female (66.9% v 61.9%, $p<0.001$) and commercially insured (84.6% v 78.5%, $p<0.001$) than non-users. In the matched patient cohort, Express-Care use replaced scheduled video visits and in-person visits 70% of the time. Follow-up rates were higher after Express-Care visits compared to non-Express-Care visits (5.1% v 1.6%, $p<0.0001$). Adjusted difference in mean charges was $190 lower for Express-Care episodes than for non-Express-Care episodes ($p<0.0001$).

Conclusions: Access to Express-Care resulted in 42% more visits for URIs among users than among matched non-users. Despite higher follow-up rates, Express-Care was associated with lower mean charges.

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Digital health education and training in Japan: a scoping review of literature published in Japanese and English language

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Aim
While digital health is essential for transforming healthcare, its clinical integration is hindered by delays in education and training. In Japan—a technologically advanced yet rapidly aging society—domestic initiatives remain largely undocumented in international literature, as no comprehensive review including Japanese sources has been conducted. This study aims to fill this gap by systematically mapping the landscape of Digital Health Education and Training (DH E&T) in Japan through a scoping review of both Japanese and English literature.

Methods
This scoping review followed the PRISMA-ScR guidelines. We searched six databases (Ichushi, CiNii, PubMed, Embase, Web of Science, and Cochrane Library) for English and Japanese literature published between 2010 and 2025. Studies were included if they focused on DH E&T within a medical context in Japan. Data were extracted and categorized by publication type, discipline, educational target, format, and geographical location.

Results
We identified 42 papers, 93% of which were written in Japanese. A significant surge occurred post-2021 (64% of total). Primary fields were “Telemedicine and Medical Informatics” (43%) and “Medical Education” (24%), with all medical education papers published after 2021. Targets included physicians (30%), students (21%), and various professionals in dentistry, nursing, pharmacy, and technical staff. Content ranged from foundational concepts and security/ethics to practical topics like telepharmacy, online medication management, and digital psychiatry. Applications also extended to rehabilitation for the general public. However, 91% of studies were single-arm, with no randomized controlled trials identified.

Conclusion
DH E&T in Japan is undergoing rapid, academia-driven expansion but remains linguistically isolated and methodologically immature. The predominance of domestic-language reporting limits global accessibility and benchmarking. Future efforts must prioritize international dissemination of findings, rigorous research designs, and the development of standardized curricula and evaluation metrics to establish robust evidence for digital health competency.

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From Policy Gap to Practice Framework: Streamlining Telemedicine Prescribing in Sri Lanka

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Introduction/Aim
Telemedicine has expanded rapidly in Sri Lanka, improving access to remote consultations. However, this growth occurred without comprehensive legislation or standardized guidance for telemedicine and internet-based prescribing. Concerns regarding patient safety, practitioner accountability, privacy, prescription misuse, and continuity of care highlighted the need for a nationally applicable operational framework. This study aimed to develop a structured framework to support safe and standardized telemedicine practice and prescribing in Sri Lanka.

Methods
A rapid systematic literature review was conducted to identify international best practices and regulatory approaches related to telemedicine and internet-based prescribing. A draft framework document was developed and evaluated using a modified Delphi technique involving a multidisciplinary specialist panel through two iterative rounds to achieve expert consensus in 2018/19. The draft framework was subsequently reviewed through multistakeholder consultations in 2023 to address evolving healthcare and digital health service requirements.

Results
The Delphi panel reached strong consensus on key governance and clinical practice requirements. Experts agreed that all practitioners providing telemedicine services and issuing online prescriptions should be registered with the Sri Lanka Medical Council. Additional consensus areas included obtaining informed consent before teleconsultations, maintaining patient privacy and confidentiality, implementing two-factor authentication for prescribing controlled substances, and preventing unauthorized reuse of electronic prescriptions. Panelists also emphasized maintaining comprehensive medical records to ensure continuity of care and avoid fragmented clinical management. This process directly contributed to the development and publication of the National Telemedicine Guidelines for Sri Lanka V1 in 2024.

Conclusion
The study demonstrates a practical and consensus-driven approach for developing governance frameworks for telemedicine prescribing in resource-constrained settings. The same methodology could be adapted by LMICs to develop contextually appropriate national telemedicine guidelines. The findings have also informed proposed amendments to the Medical Ordinance of Sri Lanka to formally incorporate telemedicine practice into the national regulatory framework.

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Restoring Access: RACP Advocacy Lessons from the Reinstatement of Physician Telephone and Video Telehealth in the MBS

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When Medicare items for specialist physician telephone and video telehealth were rolled back following the COVID-19 pandemic, many patients risked losing access to essential specialist care, particularly those with mobility barriers, competing responsibilities, and those living in rural and remote communities. For the Royal Australasian College of Physicians (RACP), this created an urgent advocacy challenge: influencing telehealth policy in a way that preserved equity, clinical flexibility, and patient-centred care.

This reflective case study presents an experiential account of the College's multi-year advocacy campaign to restore physician telephone telehealth items within the Medicare Benefits Schedule (MBS), culminating in their reinstatement with caveats in 2025. It examines the advocacy strategies used, including member engagement, interagency coordination, policy submissions, stakeholder engagement, media advocacy, and the deliberate use of evidence and influencing strategies to support reinstatement.

Key successes included developing a compelling evidence base, sustaining engagement with government decision-makers, reframing telephone telehealth as an equity issue rather than a temporary pandemic measure, and leveraging multiple seemingly disparate but connected government advisory and consultation processes to progress reform.

Challenges included responding to concerns regarding quality assurance, funding sustainability, and perceptions that telephone consultations represented a lower-value substitute for video care. Another challenge was identifying the policy and political levers shaping government decision-making.

Lessons learned highlighted the importance of combining data with lived experience, building long-term policy relationships, and identifying and mobilising levers of influence. The presentation will also reflect on persistent and emerging barriers, perceptions, and policy assumptions that continue to shape specialist telehealth reform, and what is required to more fully embed physician and specialist telehealth within the MBS and future hybrid models of care.

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A Mixed Methods Evaluation of a Hospital-based Virtual Clinical Safety Net for Detecting and Responding to Patient Deterioration

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Background / Aim
Vital signs are essential for identifying patients at risk of clinical deterioration, enabling timely intervention and improved outcomes. In rural and remote hospitals, detection and response are challenged by limited onsite medical coverage, variable staffing, and competing demands, contributing to inconsistent monitoring, delayed escalation, and preventable harm. In 2019, the Western NSW Local Health District implemented the Virtual Support (VS) remote monitoring service as a virtually enabled clinical safety net across 33 facilities. This study evaluates the activity, impact, and acceptability of the VS service.

Methods
A mixed-methods approach combined routinely collected quantitative data with qualitative insights. Quantitative sources included the Admitted Patient Data Collection, electronic medical records (eMR), audits of between-the-flags escalation events and venous thromboembolism (VTE) risk assessments, enterprise alerting software for eMR vital signs, and internal VS datasets. Outcomes from a historical control period (2018/19) were compared with a full implementation period (2022/23) to assess adherence to safety protocols and escalation performance. Qualitative data were obtained through interviews and focus groups with clinicians, managers, and community members.

Results
Detection and management of clinical deterioration improved over time. Timely and complete vital sign monitoring increased by 12%, and VTE risk assessments rose from 2% to 27%. Remote monitoring generated 225,860 alerts for 47% of adult inpatients, prompting 5,802 direct VS clinician interventions during full implementation. The proportion of vital sign observations indicating deterioration decreased from 5.6% to 4.5%. Acceptability was high among community members, with broad clinician support. Reported challenges included workflow disruption, uncertainty about the service, and perceptions of surveillance.

Conclusions
VS implementation was associated with improved patient safety, more consistent management of deterioration, and greater clinician and consumer confidence in rural services. Virtual monitoring provides an effective additional safety net and demonstrates a scalable model for supporting high-quality care in geographically dispersed settings.

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When outpatient cardiac care and treatment go digital: A postphenomenological exploration of cardiac patients' actions and experiences with video consultations and home monitoring.

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Background
Digital health solutions, including video consultations and home monitoring, are increasingly integral to cardiac outpatient treatment and care. However, barriers persist in communication, relationships, and technical challenges, as well as in varying levels of digital competency. Understanding how cardiac patients and their family members experience and engage with these technologies is essential to meaningful implementation.
Aim: To investigate how video consultations and home monitoring mediate the experiences of cardiac patients and their family members, shaping their actions, perceptions, and relationships during cardiac outpatient care and treatment.

Methods
This qualitative study adopts a post phenomenological approach, informed by Don Ihde and Peter-Paul Verbeek, to examine how video consultations shape patients' and family members' experiences of cardiac outpatient treatment and care. Participants were recruited through convenience sampling from cardiac rehabilitation and heart failure clinics at the largest cardiology department in the Capital Region of Denmark. Data consist of observations of video consultations and semi-structured home interviews conducted January–March 2026. Abductive analysis examines how video consultations and home monitoring shape the cardiac outpatient treatment and care.

Results
Fifteen cardiac patients (3 women, 12 men; mean age 71.6 years [54–86]) and four family members (all women; mean age 77.3 years [72–84]) participated in observations and interviews. The analysis identified three overarching themes: (1) video consultations and home monitoring serve as active, responsible partners in collaboration among patients, family members, and nurses; (2) these technologies strike a balance between a fragmented body and a close connection with nurses; (3) video consultations and home monitoring make life more flexible for patients and family members.

Conclusion
Video consultations and home monitoring reshape how patients and family members act, perceive, and relate to nurses by enabling more flexible interactions and active participation.

This fosters more participatory and collaborative cardiac treatment and care but depends on digital competencies and organizational support.

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A Literature Review on Research Carried Out on Digital Health Education and Training in Japan

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Aim
This study aimed to review the characteristics and trends of research on digital health education and training (DH E&T) in Japan, with a particular focus on educational contents, target populations, educational formats, and methodological approaches.

Methods
A literature review was conducted using Ichushi-Web and CiNii for Japanese-language publications and PubMed, Embase, Web of Science, and the Cochrane Library for English-language publications. Articles published between January 2010 and May 2025 with available abstracts were screened. Eligible studies addressed DH E&T within medical or healthcare-related contexts in Japan. Data were extracted and categorized by publication year, educational content, research design, educational target, and educational format.

Results
A total of 1,760 articles were identified, and 23 research papers were included in the final analysis. The number of publications increased over time, with 48% published between 2021 and 2025. Educational content was primarily focused on telemedicine and basic IT competencies. A temporal shift in educational focus was observed: before 2020, introductory education, such as telemedicine concepts and IT literacy, predominated (8 studies), whereas after 2020, practical education, such as telemedicine implementation, videoconferencing use, and online medication counseling, became dominant (10 studies). Educational formats frequently incorporated hands-on training. Most studies targeted healthcare professionals, particularly medical doctors and hospital IT staff. Methodologically, studies were predominantly single-arm designs relying on subjective outcomes, such as satisfaction and self-reported confidence.

Conclusion
Research on DH E&T in Japan has increased substantially, particularly following the COVID-19 pandemic, and has shifted from introductory to practice-oriented education. However, the educational scope remains concentrated on telemedicine and basic digital competencies, with limited coverage of emerging digital health domains. Future research should expand educational content and adopt more rigorous evaluation methods to support the development of comprehensive digital competencies in healthcare.

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Fracture Clinic Trial (RECITAL): What are the outcomes for patients with simple fractures attending a virtual clinic compared to the in-person clinic?

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In Australia, orthopaedic clinics have the highest attendance of any outpatient service, with 1.2 million attendances in 2023-24. Providing timely follow-up care for this enormous number of fractures is challenging. ‘Virtual’ fracture clinics provide follow-up care remotely for patients with simple fractures, but whether they have non-inferior outcomes compared with standard, in-person hospital fracture clinic care remains unclear.

We conducted a parallel group, non-inferiority, randomised controlled trial recruiting adult patients with a simple fracture. We randomised participants to receive follow-up care via a physiotherapist-led, remotely delivered fracture clinic or via an orthopaedic surgeon-led, in-person hospital fracture clinic. The primary outcome was self-reported physical function measured with the Patient-Specific Functional Scale over 12 weeks. The pre-specified non-inferiority margin was a mean between-group difference of −0.7 points on the Patient-Specific Functional Scale. Secondary outcomes included adverse events, patient experience, pain, health-related quality of life, and health care utilisation.

A total of 312 participants were randomised between 20 November 2023 to 10 March 2025. Mean (±SD) age was 42.7±15.4 years and the most common injuries were metatarsal (25%), toe (24%), ankle (16%) and elbow (15%) fractures. At week 12, the mean between-group difference in function was 0.5 points higher with virtual care (95% confidence interval, 0.2 to 0.9; P=0.004) confirming non-inferiority. There was no difference in adverse events, pain or health-related quality of life associated with virtual care compared with in-person care. The virtual care group reported more positive patient experience in all categories. The follow-up response rate for our primary outcome was 90%, with high participant adherence (96%).

A physiotherapist-led virtual care pathway was as effective as an orthopaedic surgeon-led in-person fracture clinic for people with simple fractures. This home-based pathway for people with simple fractures could relieve pressure on in-person orthopaedic services allowing them to manage more complex injuries.

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Evidence-based recommendations for how to improve access to comprehensive primary health care in remote communities using digital technologies

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

A participatory-based research methodology was employed across this program of research to define a core set of recommendations to increase access to comprehensive primary healthcare using digital health in remote communities. Project partners include NT Health, The Department of Health Disability and Ageing, Healthdirect, the Australian Digital Health Agency, NT PHN, Aboriginal Medical Services Alliance NT, University of Sydney and Menzies School of Health Research. The program worked in partnership with four very remote communities in the NT, and tertiary hospitals that provided services to these communities. Community-based Aboriginal Researchers facilitated community level activities. Extensive community, provider and expert consultations were held regarding preferences for the use of digital technologies to improve access to care and a range of new or existing hybrid models of care were co-designed, implemented and/or evaluated in the remote communities.

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

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

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Physiotherapists' perspectives of the use of telerehabilitation: a qualitative systematic review and meta-synthesis

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Aim
Despite evidence supporting telerehabilitation for physiotherapy, including clinical and cost-effectiveness, high satisfaction, and comparable exercise adherence, it remains inconsistently offered in routine care. Clinician acceptance has been identified as a barrier to implementation. Though previous reviews have mapped qualitative findings for clinicians and patients within certain physiotherapy contexts, this review is the first to systematically review and synthesise qualitative research specifically on physiotherapists' perspectives regarding the use of real-time videoconferencing across all physiotherapy contexts.

Methods
A systematic literature search was conducted in May 2026 across five databases for qualitative studies exploring physiotherapists' perspectives of videoconferencing-based telerehabilitation. Two reviewers independently screened studies and appraised methodological quality. Study characteristics and findings were extracted; findings were accompanied by illustrative quotes and rated as unequivocal, credible or unsupported. Unsupported findings were excluded. Findings were grouped into categories, then synthesised into descriptive themes using a meta-aggregative qualitative evidence synthesis approach.

Results
Searches identified 2,525 unique records; 221 full texts were assessed and 44 included in the review. From 863 extracted findings, 112 categories were developed and synthesised into 12 descriptive themes. Telerehabilitation was viewed as a useful adjunct or hybrid model that improves access, facilitates continuity of care and provides insights into the home environment. However, it requires appropriate patient selection, reliable technology, organisational support, privacy safeguards and active rapport-building. Physiotherapists described a shift away from hands-on care towards coaching and self-management. Confidence increased through exposure, training and peer support, while concerns remained about assessment accuracy, safety, therapeutic touch, equity, workload, and suitability for complex patients.

Conclusion
Physiotherapists generally accepted telerehabilitation when it was clinically appropriate, adequately supported, and integrated flexibly with in-person care. Sustainable implementation requires clear patient selection processes, clinician training, technical and administrative support, privacy safeguards, and clear guidelines and protocols that recognise both the benefits and limits of remote physiotherapy.

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Co-designing an AI-powered clinical chatbot in a remote digital primary care unit: A participatory action research approach

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Aim
To describe and evaluate the participatory co-design and implementation of an institutional AI chatbot (Digge Direkt) in a remote digital primary care unit in northern Sweden, and to assess staff usage patterns and perceived utility during an unguided pilot.

Methods
A participatory action research design was employed across five phases: needs assessment, co-design workshop, technical build, unguided pilot, and evaluation, at 1177 Direkt Västerbotten, Region Västerbotten. The chatbot used a Retrieval-Augmented Generation (RAG) architecture indexed against an organisation-specific document corpus. Data sources included query logs (N=1,463) and a structured staff survey. Logs were categorised by knowledge domain; survey items reported descriptively; open-ended responses analysed using inductive thematic analysis.

Results
A total of 1,463 queries were submitted (November 2025 – April 2026) across 11 knowledge domains. The most queried domain was medications and treatment (22.8%), followed by auto-phrases and text templates (11.8%) and contact information (8.8%). Query efficiency improved iteratively: citation rate increased from 74% to 92% and unanswered queries dropped from 22% to 5%. The staff survey was completed by 12 of 20 members (60%; 67% nurses, 33% physicians). Usage was frequent: 17% daily, 50% several times per week. A total of 67% agreed Digge Direkt helped locate clinical information more quickly and 75% intended to continue use. Approximately 58% cross-checked responses against primary sources. Complex multi-symptom queries and poorly formulated prompts were the most cited limitations.

Conclusion
Participatory co-design of an institutional AI chatbot is feasible in a distributed telehealth setting and generates strong staff engagement. Iterative implementation produced measurable improvements in citation accuracy and query efficiency. These findings support structured prompting training as a standard component of clinical AI chatbot implementation.

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Interprofessional Co-Design of a Virtual Care Curriculum for Continuing Professional Development at Sydney Local Health District Virtual Hospital

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Aim
Health practitioner regulatory bodies have increasingly incorporated digital health competencies and virtual care considerations into programs and standards, however, services specialising in virtual care have experienced rapid saltatory progress, accruing organisational learning that extends beyond current frameworks. As Australia's first virtual hospital, Sydney Local Health District Virtual Hospital (Sydney Virtual) aimed to systematise its evaluated service experiences to extend current educational recommendations into an adaptable virtual care curriculum.

Methods
This project undertook co-design of an interprofessional competency-based virtual care curriculum for Sydney Virtual.

An executive-sponsored interprofessional working group (IWG) was established. This group undertook a scoping review of professional practice standards and competencies for relevant health professions to identify existing statements relating to virtual care capabilities. Australian virtual care and digital health curriculum frameworks were subsequently identified and reviewed for their relevance and applicability. The IWG discussed these findings and drew on Sydney Virtual policies, service and research evaluations and clinician experiences, to produce a draft curriculum. The draft was further refined in consultation with clinical and governance stakeholders within the hospital (including informatics, executive, and quality and safety).

Results
The curriculum comprises 5 domains, 20 subdomains and 73 nested competency statements. The domain "Clinical practice of virtual care" contains the greatest number of competencies, demonstrating the need for both explicit adaptations and extensions to traditional clinical skills and reasoning. Other domains reflect the unique pioneering context of the virtual hospital, (Excellence and innovation) circumscribed by compliance requirements (Governance and regulatory frameworks). A variety of aligned knowledge and experience-based learning activities are proposed, supported by a portfolio of achievement used to demonstrate learning and competency.

Conclusion
This curriculum advances existing frameworks by drawing on organisational learning, providing a virtual context-specific competency set as a foundation for professional development, offering a transferrable interprofessional model adaptable across other services.

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Metro to rural: co-designing a hybrid GP service to sustain primary care in a thin market

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Aim
To establish a financially sustainable, community-accepted, and clinically safe hybrid GP service combining in-person and telehealth consultations in a small rural community where conventional GP recruitment had repeatedly failed.

Methods
A 12-month co-design process commenced February 2024, led by the Director of Medical Services of Kyabram District Health Service, a Rural Generalist GP, and a metropolitan GP. The process engaged the Stanhope Community Voices Committee, the KDHS Medical Advisory Committee, KDHS executives, and an external practice management consultant. Model parameters (in-person/telehealth balance, escalation pathways, fees, financial support, practice nurse role) were iteratively refined. A formal proposal was finalised in May 2024 with contract execution, site visits, equipment procurement, marketing and staff training completed by July 2024. The service is owned and operated by Telecare with local administrative and clinical support partnership.

Results
The hybrid GP clinic opened in July 2024 in Stanhope. Initial on-site GP presence established patient relationships, followed by ongoing hybrid care with periodic face-to-face visits supported by regular telehealth clinics. The model has been accepted by the community and is being incorporated into Commonwealth/Murray PHN Thin Markets funding consideration. Strengthening Medicare rebate increases from November 2025 further improved viability.

Successes: deep community engagement before launch avoided cynicism; the model is welcomed by patients and demonstrates that hybrid GP is viable in genuinely thin markets.

Failures and unresolved issues: telehealth under-utilisation a structural barrier to sustainability — patients prefer in-person visits even when telehealth is clinically appropriate; the model depends on scale of adoption to achieve viability - single-town deployments remain marginal.

Conclusion
A hybrid GP service can restore primary care in a thin market, but telehealth under-utilisation by patients is the principal threat to sustainability. Expansion into neighbouring communities and patient education to use the telehealth component are both required to make the model economically durable.

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CubCare – Clinical Co-design Creating a Technology-Enabled Paediatric Care Platform: Expanding Access to Acute, Developmental and Specialist Care

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In 2019, a design sprint involving paediatric clinicians, software engineers and consumers led to the creation of a purpose-built software platform to support a safe after-hours paediatric urgent care telehealth service. Initially launched in 2020 as a private fee-for-service model, the platform has undergone continuous clinician-led development to address evolving patient and workforce needs.

While the original aim was to provide an alternative to emergency department presentation for children with acute illness, one of the most important lessons learned was that barriers to care extended well beyond urgent care. Families experienced similar challenges accessing developmental, behavioural and specialist paediatric services, particularly ADHD assessment and management.

In response, the platform evolved to support structured information gathering, multidisciplinary workflows and longitudinal care pathways. Parent coaching services were incorporated to support families beyond diagnosis and medical management. Additional specialist services including allergy, endocrinology, cardiology and general paediatrics were subsequently integrated, creating a broader technology-enabled paediatric care platform. Since launch, the service has grown from a single urgent care offering to a national platform supporting more than 100 clinicians and providing care to over 43,000 patients through direct-to-consumer and contracted service models. Patient satisfaction has remained consistently high, with an average Net Promoter Score exceeding 95.

Key lessons learned include the importance of clinician involvement in software design, the value of purpose-built workflows that reduce administrative burden for families and clinicians, and the need to design telehealth services around patient journeys rather than individual consultations. Telehealth has proven effective not only for episodic acute care but also for longitudinal management of developmental and chronic conditions.

Future development is focused on multidisciplinary care pathways, school-based assessments, parent coaching, GPwSI ADHD models supported by paediatric specialists, and AI-enabled clinical decision support tools to further improve access, efficiency and quality of care

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Equity by Design: Lessons from Co Designing a Telehealth Model to Improve Cancer Outpatient Attendance

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Aboriginal and Torres Strait Islander peoples and those from culturally and linguistically diverse (CALD) backgrounds make up 36% of patients accessing Metro South Health (MSH) Cancer Services, yet represent the majority of those experiencing the poorest cancer outcomes. Cancer is now the leading cause of death among First Nations peoples, while many CALD patients—particularly those with limited English proficiency—continue to face delayed diagnosis and barriers to timely care. These inequities underscore an urgent need for culturally safe, responsive models of care designed with, not just for, the communities they serve.

This project aimed to improve attendance at first cancer outpatient appointments for First Nations patients and those requiring interpreters. A 12-month co-design process, guided by a modified Knowledge to Action framework, engaged patients, families, and staff to develop two complementary models: a First Nations Cancer Clinical Nurse Consultant service and a Multicultural Health Liaison service. Implementation and evaluation were supported by PRISM and RE-AIM frameworks.

Baseline 2024 data showed these patients were three times more likely to miss their first appointment. During the co-design process patients and families identified barriers to attendance, such as fear, racism, cost, distance, transport, and communication challenges, alongside key enablers in particular trusted relationships with staff, culturally safe environments, preferred-language communication, family involvement, and practical supports.

These insights informed the co design of telehealth-enabled early referral and engagement models, launched in April 2026. By shifting engagement earlier and combining virtual care with culturally tailored support, early implementation shows promising improvements in attendance and patient experience.

This work highlights that while telehealth alone does not resolve inequity, when co-designed and grounded in cultural safety, it can be a powerful enabler of access.

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Enhanced patient-centred communication through implementation of a novel consultation summary software application in outpatient telehealth encounters

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Background
Although essential for quality healthcare, patient-centred communication practices vary across medical specialties and clinicians. Despite its many benefits, telehealth also brings technological challenges that can exacerbate inadequate patient-centred communication.

Aim
To evaluate the 6-month pilot implementation of a new, multidisciplinary and collaboratively developed Patient Consultation Summary software application within real-world routine telehealth practice across palliative care and cancer hospital outpatient services at Monash Health.

Methods
Surveys completed by patients and their clinicians captured quantitative and qualitative data around their expectations and experiences of using the application, alongside implementation insights from platform analytic data, guided by the Feasibility, Reach-Out, Acceptability, Maintenance, Efficacy, Implementation, and Tailorability (FRAME-IT) framework for evaluating health interventions.

Results
The application was used by 13 of 23 initially recruited clinicians (77% women, used telehealth a few times per week on average), and 17 of 36 patients (53% women, average 60 years old, typically used telehealth once a month) (29 total separate uses, >1 use for 41% of patients). Ease of using the application, quality and usefulness of the summary documents produced, were rated highly. Summaries were primarily used to provide instructions about medications or managing the patient's condition. Enabling patients to refer back and share with family and healthcare professionals, they reported positive impacts on communication, rapport, quality of care, understanding and remembering information. Clinician-perceived benefits of providing immediate written instructions outweighed workflow barriers and technical limitations.

Conclusion
Despite adding steps to telehealth workflows, real-time preparation and sharing of patient consultation summaries, via an application integrated within existing national public healthcare telehealth infrastructure, enabled immediate access to a written summary of important medical information, aligning with patient-centred communication practices and supporting patient agency and confidence in managing complex health needs. Outcomes guided refinement of the software for broader commercial roll-out.

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Comparing memory-based safety and patient-centered quality outcomes across telephone and video telehealth consultations

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Background
Telehealth consultations by telephone or video are widely implemented in primary care in Australia and internationally. Despite this widespread implementation, few studies have compared information exchange quality across telephone and video consultations from consumer and clinician perspectives, nor have they examined related indicators of safety.
Aim: We conducted a randomised controlled study to compare the safety and quality of telephone versus video telehealth consultations, reflected by patient-centered memory outcomes and consultation experience.

Methods
Australian community participants aged 18-44 took part in a simulated telehealth consultation with an actor-GP via telephone or video, during which they learned about a recently-prescribed, fictional, high-risk medication. At the end of the consultation, the GP used a teach-back method to check understanding. Participants then completed a survey on consultation outcomes immediately after the consultation, and a follow-up recall memory survey two days later.

Results
We examine whether telephone and video telehealth consultations differ in how well participants remember key medication safety information including dosage, timing, mode of administration, side effects, and interactions. We also investigate patient-reported experiences and outcomes including perceived therapeutic alliance with the GP, perceived empathy of the GP, and behavioural intentions and risk perceptions regarding medication usage.

Conclusion: By identifying which telehealth format supports patient understanding and safe care, this research can inform clinicians and consumers in their selection of the most suitable telehealth modality, supporting better practice in primary health care.

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The Current State of Telemedicine Activities at National University Hospitals in Japan

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Aim
Telemedicine has expanded in Japan, with advances in Information and Communication Technology (ICT). National university hospitals, which provide advanced medical care and lead regional and international medical collaborations, are expected to play a pivotal role in telemedicine. However, their operational structures and status of telemedicine remain unclear. Therefore, this study aimed to clarify the current status and challenges of telemedicine activities at Japanese national university hospitals.

Methods
In February 2026, we surveyed all 44 Japanese national university hospitals via an online questionnaire regarding domestic and international Doctor-to-Patient (DtoP) and Doctor-to-Doctor (DtoD) activities. We investigated implementation status, frequency, tools used, and encountered problems. Statistical analysis was performed using the Wilcoxon signed-rank test. Following ethical approval by Kyushu University (No. 25244), only participants who provided informed consent after receiving a detailed explanation completed the questionnaire.

Results
The response rate was 90% (40/44 hospitals). Domestic activities significantly outnumbered international ones for both DtoP (20 vs. 5 hospitals, P=0.00) and DtoD (24 vs. 4 hospitals, P=0.00). Domestic DtoP provided variety of departments such as internal medicine and pediatrics, while international DtoP focused on second opinions across 15 countries, most frequently China and South Korea. International DtoD involved consultations and case conferences with over 50 countries, primarily China and Taiwan. Common devices included PCs, and smartphones and tablets were also used. Regarding ICT tools, Zoom, Teams, and WebEx were commonly used. Reported problems included network connectivity issues, time burdens, operational complexity, and high implementation and maintenance costs.

Conclusion
This study revealed the previously unknown status of telemedicine activities at Japanese national university hospitals. Approximately half of these hospitals provide telemedicine services, and also international support by DtoP such as second opinions, were provided to 15 countries. It is essential to address technical infrastructure, administrative complexity, and financial sustainability.

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Safety and security as quality markers in telehealth consultations: deliberative workshops with consumers and clinician think-aloud interviews

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Aim
This study aimed to determine (1) how clinicians and consumers approach safety assurance in telehealth consultations, and (2) whether consumers may trade off some valued aspects of consultations against others in choosing different modes and models of telehealth.

Methods
Six deliberative workshops (61 consumers from urban, rural and remote communities in five Australian jurisdictions) addressed perceived value trade-offs for different telehealth modalities (audio, video and asynchronous) and delivery models (integrated with local general practice; stand-alone remote telehealth; offshore telehealth). Think-aloud interviews with 15 primary care clinicians addressed safety-management strategies across different modalities. Results were integrated and analysed using the framework method.

Results
Clinicians articulated an instrumental notion of safety, focusing on risk management in audio and video consultations, with similar in-consultation safety-netting strategies used by all clinicians. While consumers also prioritised instrumental safety, they did this by self-assessing the pre-consultation probability of needing an examination. Consumers also value ontological and organisational security as a feature of safety in the consultation. Ontological security reflects the heightened agency consumers hold in the telehealth environment, and is realised through determining the type and mode of consultation, including toggling to black during a video consultation to maintain privacy. Organisational security reflects cybersecurity concerns, particularly in relation to asynchronous consultations. Consumers may trade-off familiarity and trust in known clinicians for accessibility and privacy, depending on their pre-consultation assessment of their clinical needs. They did not regard safety or security as tradeable.

Conclusion
Security is not generally regarded as a quality attribute of face-to-face primary care consultations, as this function is enacted through organisational systems. For telehealth, a patient-sensitive quality framework may need to incorporate ontological and organisational security in addition to clinical safety.

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Technical challenges in comparing information exchange and outcomes across video and audio telehealth modalities

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Background
Telehealth consultations are widely implemented, yet direct comparisons of video and audio modalities remain methodologically complex. Controlled experimental designs are required to isolate modality effects on information exchange and patient outcomes, but introduce design challenges that may affect the validity and generalisability of findings.

Aim
We aim to discuss technical challenges in studies that compare information exchange and outcomes across video and audio telehealth modalities.

Methods
We reviewed the experimental design process for a randomised controlled trial study that compared video and audio telehealth modalities, identifying technical difficulties encountered during experiment planning and refinement.

Results
We identified two major areas of technical challenges: 1) environmental variability within each modality produced challenges in representing real-world environments within a single study condition, and 2) the controlled nature of a controlled randomised trial produced challenges between producing telehealth consultations suitable for studying information exchange and outcomes while maintaining authenticity for participants simulating patients.

Conclusion
Technical challenges inherent to the controlled comparison of video and audio telehealth modalities warrant careful consideration when interpreting and designing such research. Specifically, researchers should weigh the trade-off between the control necessary for valid modality comparison and the ecological validity of findings, given that controlled conditions may not fully capture the variability of real-world telehealth environments.

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Implementation of the Virtual Integrated Practice Partnership Program: Supporting access to primary care in rural Queensland

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Background/Aim
The Virtual Integrated Practice (VIP) Partnership Program, co-created to address general practitioner (GP) shortages, supports urban-based GPs to provide ongoing care to patients in rural/remote general practices via telehealth 1-2 days/week, augmented with biannual practice visits. This study aimed to evaluate the implementation of the VIP model in rural/remote general practices across Queensland.

Methods
VIP GP service, billing, cost and patient survey data collected were retrospectively reviewed. Qualitative interviews were conducted with practice staff, providers and patients to identify determinants of implementation. Thematic analysis was guided by Consolidated Framework for Implementation Research (CFIR) and implementation strategies informed by Expert Recommendations for Implementing Change (ERIC).

Results
Since 2021, 15 GPs have been recruited for 16 rural/remote practices and have provided 18679 clinical services. Patients were majority female (60.0%), average age 53.8 years (SD 21.9), and 5.4% identified as Aboriginal or Torres Strait Islander. Appointments were majority (62.9%) repeat patient encounters, 70.0% were delivered via video health and 63.6% of patients attended the appointment at the practice. Billings averaged $1674/day. Patient survey feedback (n=636) found 97% of respondents were highly satisfied/satisfied, 94% would use the service again, 92% said that VIP GP improved their access to primary care, and 111 patients (18%) reported that the consult prevented a visit to the emergency department. Interviews (n=27) highlighted key implementation determinants and strategies to support sustainability of the model including digital infrastructure and support from onsite staff to triage bookings and facilitate virtual appointments, partnership codesign and funding from the community agencies.

Conclusion
This evaluation demonstrates the feasibility of a virtual continuity of care model to support a declining rural GP workforce and improve patient access to primary care and is informing strategies to promote ongoing implementation of a virtual GP model to provide workforce sustainability for rural Queensland communities.

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Treat the Patient, Not the Imaging: Updated Cost and Societal Value of a Telehealth Fracture Clinic in North West Queensland 14 Years After Initial Evaluation

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Introduction and Aim
Patients in North West Queensland often travel significant distances to access specialist orthopaedic care. The Mount Isa Hospital (MIH)-Princess Alexandra Hospital (PAH) Telehealth Fracture Clinic (TFC) was established in 2011 to provide specialist review closer to home. This study evaluated the current health-service and societal value of the service and examined how it has changed over time.

Method
A retrospective cost-benefit analysis was undertaken for all appointments scheduled between January 2025 and May 2026. Health-service savings were calculated using clinic operating costs and estimated transfer costs avoided through telehealth review. Societal value was estimated using inflation-adjusted Queensland telehealth productivity values.

Results
During the study period, 140 clinics were delivered with 2,544 appointments scheduled and 1,757 attended (69.1%). An estimated 244 patient transfers were avoided, generating $765,284 in avoided transfer costs. After clinic operating costs of $216,706, net health-service savings were $548,578. Estimated societal benefit was $683,471, resulting in a combined benefit of $1.23 million. Benefit-cost ratios were 3.53:1 from the health-service perspective and 6.69:1 when societal benefit was included. Compared with the original evaluation, clinic activity increased substantially and inflation-adjusted clinic delivery costs decreased by 17.2%. In a combined conservative scenario, net health-service savings remained $46,066.

Conclusions
The MIH-PAH Telehealth Fracture Clinic shows that access to specialist review can change management decisions, not just confirm radiological findings. By treating the patient, not the imaging, the service enables more rural and remote patients to remain in their local community while reducing unnecessary transfer and delivering substantial economic value.

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How the Central Foot Hub uses Virtual Care to Treat Patients with Foot Ulcers in Central Queensland

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This presentation explores the development and impact of the Central Foot Hub - a multidisciplinary team who provide outreach care for patients with foot ulcers. We are based at the Royal Brisbane and Women's Hospital and offer a virtual care model to address the growing need for access to specialist care for patients in Central Queensland. Our team includes an Endocrinologist, diabetic educator/dietician, podiatrists, a Vascular Surgeon, psychologist, Infectious Diseases physician, social worker, Aboriginal Health worker, and administrative officer. We work collaboratively with local services to identify and holistically care for patients with foot ulcers, mostly commonly related to diabetes. Our goal is to prevent complications such as limb loss and death in this complex and vulnerable group of patients.

This presentation will outline the operational framework of Foot Hub, including its patient-centric philosophy, outreach activities, and partnerships with local healthcare organisations. The presentation will highlight key innovations such as teleconference multidisciplinary meetings, telehealth consultations, and local stakeholder engagement that have expanded Foot Hub's reach and efficacy. Case studies will illustrate how Foot Hub has successfully supported populations at risk, emphasising the importance of early intervention and ongoing care.

Our main developments in the 2 years that we have been providing care have been to develop and refine the referral process, leading to an increase in uptake by local sites, an increase in linking patient with local services after presenting for emergency care, and a reduction in HbA1c for our patients with diabetes.

By sharing the Foot Hub model, this presentation aims to inspire healthcare professionals, policymakers, and community leaders to reimagine specialist care delivery and consider strategies for enhancing patient health across rural and regional Australia.

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Royal Flying Doctor Service Northern Territory Virtual Emergency Care Trial

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Access to timely emergency healthcare remains a significant challenge for people living and working on remote Northern Territory cattle stations. Geographic isolation, vast distances from healthcare facilities, and limited on-site clinical support can delay the assessment and treatment of acute illness and injury.

To address these challenges, a Virtual Emergency Care Trial will commence in September 2026 through a partnership between the NT Cattlemen's Association (NTCA), NT Health's Medical Retrieval and Consultation Centre (MRaCC), and the Remote Outreach Consultation Centre (ROCC) in Alice Springs. The trial will evaluate a virtual emergency care model providing station residents and workers with direct 24/7 access to clinicians via advanced telehealth technology.

Phase one will equip eight cattle stations with portable telehealth systems, including fixed telehealth cabinets, trolley-based units, or mobile backpack systems for field use. Equipment will include high-definition examination cameras, infrared thermometers, blood pressure monitors, pulse oximeters, ECGs, and glucometers capable of transmitting real-time clinical data to on-call clinicians. Sites have been selected based on remoteness, workforce size, service utilisation, and satellite connectivity. Outcomes will be evaluated through audits at six and twelve months.

By combining real-time video consultation, clinical observations, and diagnostic capabilities, the model is expected to improve access to emergency assessment, strengthen triage accuracy, support earlier intervention, and enhance the efficiency of retrieval and consultation services.

Building on the successful unattended model introduced at the William Creek RFDS Clinic in 2024, this initiative offers a scalable solution for remote healthcare delivery. Supported by MRaCC and ROCC clinicians, White Chest custodians, and AED units, it has the potential to improve health outcomes and inform future virtual healthcare services across remote Australia and worldwide.

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A “Prescribable” mobile app for people with chronic low back pain attending general practice: Feasibility randomised controlled trial

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Access to timely emergency healthcare remains a significant challenge for people living and working on remote Northern Territory cattle stations. Geographic isolation, vast distances from healthcare facilities, and limited on-site clinical support can delay the assessment and treatment of acute illness and injury.

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Cost-effectiveness analyses of virtual ED services across Australia: methods issues and findings

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Aim
The study aimed to analyse the cost-effectiveness of virtual ED services (VEDs) in five Australian states.

Methods
Potential drivers of cost-effectiveness include the referrals streams into VEDs, patient volume and staffing levels, referrals options and discharge disposition from VEDs and subsequent hospital encounters. Two key potential drivers are the estimation of counterfactual outcomes (ED presentations and inpatient admissions) and the valuation of reduced hospital demand.

It was not feasible to identify a control group of people with similar conditions who did not use a VED and most VEDs were too small to create an observable effect on hospital demand. Thus, counterfactual outcomes were elicited by referral stream into VEDs from doctors working at VEDs.

The valuation of reduced hospital demand is challenging. From a cost perspective, hospital capacity is currently unlikely to be dis-established. However, reduced demand for hospital capacity may contribute to reduced construction of new capacity, for which cost savings can be estimated.

Despite the involvement of clinical leads at each VED as research investigators huge effort and time was taken engaging and following up with data custodian to access relevant data.

Results
To date, findings indicate significant differences in the cost-effectiveness of alternative referral streams into VEDs. Referrals from residential aged care facilities appear to be the most cost-effective streams. Self-referrals and referrals from HealthDirect appear to be the least cost-effective streams, but they may still be cost-effective.

Conclusions
VED funding decisions should focus on referral streams into VEDs. To inform such decisions, are the counterfactual capital and operational costs of new hospital capacity an appropriate comparator? Should all referral streams that are estimated to generate hospital capacity at a lower cost than building new capacity be funded, or is a margin required due to the uncertainties around the estimation of VED effects?

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Exploring reported quality and safety markers in telehealth

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Background
The North Queensland Telehealth Project is a five-year NHMRC-funded initiative designed to optimise the quality and safety of healthcare delivery for rural, remote, and Aboriginal and Torres Strait Islander populations through contextually appropriate models of telehealth. Early project work has focused on scoping reviews that examine how quality and safety are conceptualised, reported and measured in telehealth.

Aim
The objective was to identify, describe, and synthesise markers used to assess the safety and quality of synchronous telehealth consultations in Australia. The clinical priority area reviews applied a similar approach, with selected reviews extending internationally to identify field-specific patterns in reported markers.

Methods
Systematic scoping review methods were applied, including iterative search strategy development, comprehensive literature searches, and structured screening of abstracts and full-text articles. Synthesis focused on quality and safety markers relevant to rural, remote, and Aboriginal and Torres Strait Islander contexts. Identified markers were categorised using domains from the Improving Healthcare Quality in Europe framework and Donabedian's 'structure, process and outcome' model.

Results
Many studies reported quality-relevant markers without explicitly defining quality or safety. These markers were heterogenous, often embedded in satisfaction surveys, service evaluations, clinical audits or retrospective outcome analysis, but rarely aligned with recognised domains or benchmarks. Nevertheless, markers clustered across the domains of effectiveness, patient safety, and patient-centredness.

Conclusion
Findings suggest the need for more consistent, equity-sensitive quality and safety markers that can assess whether telehealth supports safe, timely, coordinated and patient-centred care in rural and remote settings. These findings will be integrated with geospatial mapping of telehealth activity to identify gaps, inform stakeholder engagement, and guide development of contextually appropriate telehealth models in subsequent project phases.

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Towards safer telehealth consultations about medicines: comparing audio and video telehealth consultations for high risk medications and in cross-cultural settings

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Background
Medication errors are a major contributor to preventable medical harm. Although approximately one in three telehealth consultations involve medication discussions, little is known about the impact of various telehealth modalities on safe communication about medicines, or whether or not there is an extra burden experienced by patients who speak English as a second language

Aims
This study aims to compare outcomes and processes across simulated audio and video telehealth consultations in relation to recall of high-risk medication instructions; and processes used in consultations with patients who speak English as a second language to support safe communication about medications.

Methods
This study incorporates two projects: (1) a randomised study of communication about high risk medications under video and audio telehealth conditions testing participants' immediate and delayed recall of medication instructions, and therapeutic alliance with the GP, and (2) a sociolinguistic study of processes used to ensure safe use of medication in simulated telehealth consultations with patients who are capable speakers of English as a second language.

Results
Study 1 provides insight into whether the mode of telehealth impacts upon the ability of the patient to retrieve relevant safety information about medication (how and when to take it, side-effects), Study 2 provides insight into strategies to clarify knowledge and understanding used by patients from non-English speaking backgrounds and their clinicians, using English as the consultation language. We will present results of the studies and integrated findings.

Conclusion
Each of these studies addresses an area of uncertainty about medication information exchange across different telehealth modalities. Results will be used to develop a framework to support the safety of discussions about medications in telehealth consultations.

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Exploring Telehealth Activity in Northern Queensland

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Introduction
Telehealth is a critical model of care in Northern Queensland, supporting access to services across geographically dispersed and underserved communities.

Aim
This study examined telehealth service provision and utilisation across northern Queensland to identify gaps and variation in service delivery and provide a foundation for improving equitable, high-quality care for rural, regional and remote populations.

Methods
A landscape analysis was conducted using telehealth service data for a five-year period (2020/2021 onward) for northern Queensland encompassing the area covered by Mackay, Townsville, Cairns and Hinterland, North-West and Torres and Cape Hospital and Health Services (HHS). Data were sourced by request from the Queensland Health Non-Admitted Patient Data Collection, Services Australia Medicare Benefits Schedule (MBS) claims, and Retrieval Services Queensland. Data aggregated by resident and provider location, and stratified by demographic indicators, were analysed descriptively. Data were also explored using geographic mapping and interactive visualisations to illustrate patterns of service use across the region.

Results
Preliminary analyses indicate an increase in telehealth service utilisation between 2020/21-2025 across all northern Queensland, although with notable variation across locations. Mackay HHS had the highest telehealth service event utilisation. Adults aged 60+ years accounted for the highest proportion of service events. MBS claims data highlighted higher levels of telehealth service provision in regional and generally larger rural communities. Telehealth use for primary healthcare generally aligned with areas of greater service availability, with lower utilisation in smaller rural and remote communities potentially reflecting differences in service availability, local needs, models of care or user preferences.

Conclusions
Findings demonstrate increasing use of telehealth across northern Queensland. However substantial geographic, demographic, and clinical variation demonstrate further work is needed to better understand factors influencing access and uptake, particularly in rural and remote communities.

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Successful implementation of a statewide general practitioner-to-specialist eConsult service in Queensland

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Background
Limited local availability of specialist access means rural/remote patients in Queensland travel long distances to access specialist services. In addition, with rising demand for outpatient services and limited health resources across Australia, patients are experiencing excessive delays for specialist input, linked with subsequent deterioration in health. Queensland eConsultant provides an asynchronous, digital, clinician to clinician advice service supporting care for patients who would otherwise require an outpatient department referral.

The aim is to improve patient access to specialist input compared to a traditional outpatient service. The main outcomes were adoption, barriers and enablers to implementation, and patient outpatient access issues.

Methods
Implementation adoption and service outcomes are informed by platform administrative data, determinants informed by implementation activity tracking, and GP feedback gathered via a REDCap survey.

Findings
Since 2018, 1839 Requests for Advice have been generated for patients by 526 GPs for 12 medical specialties. Of these, 68% were from urban, and 32% from rural areas, 97% from private practices, and 1% each from Aboriginal Community Controlled Health Organisations, RFDS and Health and Hospital services. The mean specialist response time was 1.4 business days (SD 2.1). Outpatient access issues affected 24% of patients, mainly due to geography (10%) health (8%), and age and mobility (3%) factors. A face-to-face OPD appointment was avoided for 83% of patients. GPs rated the advice as excellent value in 86% of cases. Challenges to implementation vary and include practice capacity for managing change, competing priorities, executive support, digital infrastructure and support, and cybersecurity concerns.

Implications
eConsultant provides a sustainable, equitable option to improve access to timely specialist patient support and reduced preventable hospital admissions, particularly for vulnerable people and those living in regional, rural and remote areas. This program supports boarder implementation, which will provide a fundamental change to health care delivery in Australia.

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Feasibility of Digital Health App Prescriptions for Obesity Treatment in Australian General Practice: A Mixed-Methods Study with General Practitioners

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Background
Obesity affects approximately 31% of Australian adults yet remains under-addressed in routine general practice. Although the market for weight management apps is saturated, many lack scientific validation. Unlike Germany's regulated framework for prescribing evidence-based digital health applications (DiGAs), Australia currently lacks a formal clinical app prescription system. Before adopting a similar model, it is crucial to assess General Practitioner (GP) acceptance. Therefore, this study aims to investigate Australian GPs' perspectives and willingness to prescribe digital health apps for obesity management.

Methods
Using a mixed-methods design, this study recruited Australian GPs via social media, the Royal Australian College of General Practitioners and the Western Victoria Primary Health Network. Participants completed a demographics questionnaire, the eHealth Literacy Scale, and a UTAUT-based survey on prescribing digital apps. Quantitative data were analysed using descriptive statistics, chi-square tests, and logistic regressions. Additionally, semi-structured interviews with 12 GPs were thematically analysed, mapping inductive themes to the Non-adoption, Abandonment, Scale-up, Spread, and Sustainability (NASSS) framework.

Results
Of 218 surveyed GPs, a significant perception-practice gap emerged. While 70.0% agreed digital health apps could improve patient outcomes, 76.1% do not currently recommend them. Multivariable analysis showed adoption is driven by professional culture, with colleague support and intention to prescribe as the sole independent predictors. Qualitatively, five themes mapped to the NASSS domains. A fragmented app landscape, clinical credibility, apps as care adjuncts, patient capability, and workflow barriers. Organisational and wider system constraints were the most prominent barriers to integration.

Conclusion
Australian GPs demonstrate strong conceptual readiness to prescribe digital health apps for obesity management, but face significant operational barriers. To foster consistent and confident prescribing practices, the primary care sector requires improved clinical system integration, clear regulatory guidelines, and access to curated directories of evidence-based

applications.

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Assessment tools for health student telehealth competency: A scoping review

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Following the COVID-19 pandemic, the rapid uptake of telehealth delivered health services has persisted and is now commonly being utilised in clinical placements. This has highlighted the need for health students to develop telehealth competencies to prepare them for safe and competent graduate practice.

Methods
A scoping review was used to answer the research question: What assessment measures are used to evaluate medical, nursing and allied health students' competencies for synchronous telehealth service delivery? The review also sought to identify the specific telehealth competencies measured within included studies. Relevant electronic databases were searched. Titles and abstracts were independently reviewed by two researchers against the inclusion criteria which were: studies published between 1995-2025 involving synchronous telehealth activities with real or simulated patients and assessment of student telehealth competencies. Data were extracted and analysed using frequency counts, descriptive statistics and inductive content analysis.

Results
Fifty-seven studies were included in the review with 82% being conducted in the USA. Forty-nine studies used a case series research design. Student participants were from ten health disciplines. Most studies (91%) used video in telehealth teaching activities while 73.5% included simulation, with half being pre-clinical simulation, didactic or self-directed learning and 26% involved an authentic patient. Outcome measures to evaluate student telehealth competencies were predominantly developed for the individual studies and most did not have psychometric properties established. Twenty-three telehealth competencies were assessed in three main areas: professional competencies, clinical competencies and telehealth specific competencies.

Conclusion
Simulation is the most commonly utilised learning activity to develop telehealth competencies in students. There is a lack of tools specifically designed to assess student telehealth competencies. Further research is needed to develop robust assessment tools with established psychometric properties.

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Applying Team-Based Problem Solving to Drive Innovation, Safety and Quality in Statewide Virtual Care

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The South Australian Virtual Care Service (SAVCS) commenced in December 2021, delivering virtually enabled urgent care to consumers in their residence. What began as a rapidly implemented statewide virtual urgent care model has continued to evolve intentionally, to meet identified consumer needs.

Operating within a rapidly evolving virtual healthcare environment required agile, safe, and practical approaches to innovation and operational problem solving. While safety, quality, and Lean principles remained central to service development, the demands of virtual care required more iterative and operationally streamlined approaches to pathway design and implementation.

To support continuous improvement, SAVCS developed a 3-Step Team Problem Solving approach focused on defining the current state, identifying performance gaps, and designing future-state processes. Protected staff time and structured multidisciplinary sessions enabled collaborative review of challenges, iterative testing of improvements, and scaling of successful initiatives. The approach supported frontline problem solving, while issues requiring deeper analysis or broader operational change were escalated through formal improvement methodologies and existing internal quality and safety pathways.

Importantly, the process created permission for the team to lead improvement activities, encouraging ownership, innovation, and timely resolution of operational challenges while maintaining focus on safety, quality, and value. Over time, the approach became embedded within routine service and pathway development activities and continues to support the expansion of virtual models of care.

Challenges included sustaining engagement across a fractional workforce, prioritising competing improvement opportunities, recognising when initiatives should cease, and increasing consumer involvement in improvement activities.

This presentation describes the development, implementation, and sustainability of the SAVCS team problem solving model and its role in enabling safe innovation within virtual urgent care.

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Lessons from deploying mixed reality telementoring across eight rural hospitals: Workflow, training, and operational resilience

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Provider-to-provider telementoring can strengthen rural clinical decision-making; mixed reality (MR) adds hands-free mobility and shared spatial context at the bedside. Hosted by an Australian university, we implemented an MR telementoring service linking a tertiary hospital to eight rural and regional facilities to support bedside decision-making by junior doctors. This paper reports a multi-site implementation case study focused on service design, workflow integration, and operational lessons from real-world deployment, rather than clinical or usability outcomes.

Key design elements included:
(1) role-specific user journeys (mentee on a head-mounted display; mentor on a computer);
(2) a seven-session training arc blending technical skills with scenario-based rehearsals;
(3) bilingual user guides and consult checklists;
(4) a remote-plus-onsite support model; and
(5) resilience measures for power interruptions, bandwidth variability and imaging availability.

Implementation occurred across eight sites and involved four specialist mentors and 18 junior doctor mentees, delivering 41 scheduled bedside consultations with 94 patients over four weeks. The five lessons emerged from the synthesis of training records, implementation logs/support tickets, facilitator field notes, and team debriefs conducted during and after deployment.

Five lessons include 1) Workflow first, device second: mapping bedside tasks and escalation pathways prevented technology-driven workarounds. 2) Role-sensitive experience: mentors on laptops reported lower situational engagement; shared annotation conventions and concise pre-briefs improved alignment. 3) Training as change management: sequenced skills, local champions and micro-refreshers accelerated confidence. 4) Resilience by design: offline job aids, modular consult scripts and clear fallback channels reduced disruption impact. 5) Policy alignment for scale-up: linking to national telehealth priorities improved buy-in and sustainability planning.

Practice implications: For telehealth teams considering MR, success depends not only on the device but also on service design—workflow integration, role-tailored collaboration routines and operational resilience. We will share a process map, a consult checklist and a training outline to aid replication.

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From Phone Heavy to Video Enabled: Embedding Sustainable Telehealth in Outpatient Endocrinology

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During the COVID 19 pandemic, telehealth use in outpatient endocrinology increased rapidly but was delivered predominantly via telephone, reflecting infrastructure constraints rather than clinical preference. Limited video ready equipment, reliance on virtualised desktop interfaces not optimised for video, and inconsistent clinic setups shaped early telehealth delivery and contributed to heavy telephone use.

This case study describes how a multidisciplinary outpatient endocrinology team transitioned toward a clinically appropriate, video enabled telehealth model using improvement methods and frontline led adaptation, without additional staffing, equipment, or infrastructure. Clinicians and outpatient administrative staff played a central role in supporting patients through telehealth adoption, including education, reassurance, troubleshooting, and shared learning as video consultations were introduced and refined.

Process mapping and cause and effect analysis identified appointment booking and preparation as key leverage points. Through iterative Plan–Do–Study–Act cycles, the team tested practical changes including video forward booking conversations, standardised patient communication using letters and staged SMS messaging, provision of direct video links, and clearer workflows for managing technical issues. Interim devices, such as borrowed tablets, enabled early testing while permanent infrastructure evolved.

Booked outpatient appointment data by mode was analysed monthly over a six year period (March 2020 to March 2026) to assess sustainability. Across 73 months, 63,793 appointments were booked. Video increased from near zero pre pandemic to a sustained 25–30% of booked appointments from 2022 onwards. Overall telehealth stabilised at approximately 55–60% of bookings, while telephone use declined proportionally as face to face care returned.

Key lessons include the importance of relational work in telehealth success, the value of small, testable changes shaped by frontline experience, and the role of improvement methods in embedding video telehealth as a routine, balanced component of outpatient care beyond emergency adoption.

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Successes and learnings from implementing a multifaceted telementoring intervention to support telehealth adoption in public allied health outpatient services

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Background
Telehealth via video consultations offers significant benefits for patients and health services. Despite strong evidence for its safety and effectiveness, routine integration within allied health outpatient services remains limited. Achieving wide-spread, sustainable adoption requires systematic identification of implementation barriers and targeted, scalable solutions. This study aimed to implement and evaluate a multifaceted intervention to improve telehealth capability and normalisation at both clinician and service levels.

Method
A pre–post interventional study was conducted across allied health outpatient services within a large metropolitan public health service in Queensland, Australia. The intervention began with a structured service-level evaluation to identify implementation gaps and learning needs. This informed goal setting using Goal Attainment Scaling (GAS), addressing individual capability development and local service-level needs, alongside co design of a targeted education curriculum. Education was delivered virtually across six interactive sessions using the Project ECHO® “all teach, all learn” model, incorporating clinician and consumer experiences and supported by tailored telementoring. Evaluation included telehealth activity, audit outcomes, GAS scores, normalisation process measures, and participant feedback.

Results
Eighteen clinicians from 11 services across six allied health disciplines completed the intervention. Telehealth occasions of service increased significantly post-intervention ($p < 0.01$), though changes varied between services, with some demonstrating limited or no improvement. Significant improvements ($p < 0.03$) were observed in 85% of audit components and over 70% of normalisation constructs. Participant feedback was highly positive, with all participants recommending the intervention and particularly valuing the inclusion of shared clinician and consumer experiences.

Conclusion
The multifaceted telementoring intervention supported telehealth adoption and practice change across allied health services, though impacts varied. Findings suggest that effective telehealth implementation in this setting requires more than education alone and depends on

integrated service level evaluation, goal setting, targeted education, and mentoring tailored to local context.

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Better Care, Lower Cost, Less Travel: A Cost-Effectiveness Analysis of eConsults in the World's Largest Universal Health System

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eConsults are asynchronous primary care clinician-to-specialist case consultations that can improve referral management. Comprehensive economic evaluations in middle-income countries' public health systems remain limited. This study aims to evaluate cost-effectiveness of mandatory eConsults before referral to specialist care in the Brazilian public health system (SUS), compared to the same referral pathway without eConsult use (usual care). Methods: We conducted a cost-effectiveness analysis using 104,941 mandatory eConsults in Endocrinology, Hematology, and Nephrology answered by the UFSC Digital Health Center in Santa Catarina, Brazil, between January 2019 and December 2025. A deterministic decision tree compared a mandatory eConsult strategy with a reference strategy without eConsult. Since follow-up outcomes were unavailable, effectiveness was modelled from the eConsult specialists' recommendation. All inputs in Brazilian reais (BRL) were updated in December 2025, and final results were converted to USD using the PTAX selling exchange rate. Results: eConsult specialists recommended primary care management in 47.7% of cases, avoiding 5,931,011km of travel and 94.90 tons of CO2 emissions. Total cost was $5,568,920.6 for the eConsult strategy and $6,684,541.5 for usual care, corresponding to $1.12 million savings (16.7%) when adopting eConsults. The cost-effectiveness ratio was $53.1 versus $121.9 per effective case, and incremental cost-effectiveness ratio was $-22.3 per patient managed appropriately. Conclusion: Under model assumptions based on eConsult specialist recommendations, mandatory eConsults were more effective and less costly, while reducing travel burden and carbon emissions.

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Delivering Integrated Acute Virtual Care at Scale in Rural and Remote Queensland: A Two-Year Service Evaluation of the Royal Flying Doctor Service

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Aim
To evaluate the scale, utilisation patterns, and operational characteristics of the integrated Royal Flying Doctor Service “1300 MY RFDS” acute telehealth service that supports rural and remote Queensland communities.

Methods
A retrospective evaluation of occasions of care delivered by the service between July 2022 and June 2024 was undertaken using routinely collected service data. Analyses examined service activity, patient and clinical characteristics, and care pathways including the use of the RFDS (Queensland Section) Medical Chest and Aeromedical Retrieval services.

Result
During the two-year study period, the service managed 21,991 occasions of care involving 12,564 patients. Care was delivered by 110 clinicians, with 31 clinicians managing 75% of all occasions of care. More than 92% of activity occurred within Queensland’s Northern and Western Primary Health Networks, with the most common presentations being injuries, respiratory diseases, symptoms and signs not elsewhere classified, and diseases of the digestive system and skin. The service supported both GP- and patient-initiated occasions of care, with a subset of patients using both pathways over time. Integration with the Medical Chest and Aeromedical Retrieval services extended capacity to support acute care in geographically isolated communities.

Conclusion
The RFDS (Queensland Section) model of care demonstrates the potential for integrated virtual acute care to operate at substantial scale across rural and remote areas. Linking telehealth assessment with treatment and escalation pathways strengthens access to acute care and may support optimised resource allocation, while informing future workforce and service planning.

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Digital health interventions supporting integrated care for irritable bowel syndrome in Australia: Assessing patient and clinician needs through a mixed-methods study

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Background
Irritable bowel syndrome (IBS) affects 1 in 25 people in Australia. Better access to integrated multidisciplinary care is needed. Digital health interventions show promise in improving care access and supporting integration of multidisciplinary therapies.
Objectives: This study aimed to inform the co-design of a digital health intervention to support integrated care for IBS by i) identifying patients' and clinicians' needs and perspectives, and ii) exploring desired features and functions of a digital health tool.

Methods
Adults with IBS and clinicians providing IBS care in Australia were invited to participate in a 30-item online survey and follow up semi-structured interview. Preliminary survey data were analysed using descriptive statistics and content analysis. Interview transcripts were analysed using reflexive thematic analysis.

Results
To now, 124 adults completed the survey (55 IBS patients, 69 clinicians). Most identified as women (84%), with a mean age 42.6 years (SD 12.9). Of all participants, over half felt that their needs were not met by the existing healthcare system (n=67/124, 54%), and the majority strongly agreed multidisciplinary collaboration is important (n=102/124, 82%). Participants were confident using digital tools (n=96/117, 82%), although data security, accuracy of information, cost and loss of human contact were common concerns. Nearly all clinicians (n=64/66, 97%) were willing to use a new digital tool that is evidence-based and user-friendly. Participants described a range of desired features and functions for a new digital tool, which related to education, monitoring and support. Themes developed from nineteen interviews (9 patients, 10 clinicians) included reducing fragmentation through aligned messaging, desiring personalisation, connecting gut with brain, people need humans, and digitally sharing care plans.

Conclusion
Findings reveal unmet needs in IBS care alongside demand for an evidence-based digital health tool. A carefully designed tool could support integrated care by reducing fragmentation, enabling personalisation, and strengthening multidisciplinary, human-centred support.

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Digitally enabled outreach healthcare: Exploring the MobPod service model

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The MobPod Project is a community-led, mobile and digitally enabled healthcare model designed to improve access to culturally appropriate healthcare services for Aboriginal and Torres Strait Islander communities living in rural and remote Queensland. Operated by Manngoor Dja – Aboriginal Health Services, the project combines face-to-face outreach with telehealth capabilities to address healthcare accessibility barriers, workforce shortages, and geographical isolation.

This presentation explores the early successes, challenges, and practical learnings from implementing the Mob Pod telehealth approach across multiple rural outreach locations. It also challenges common assumptions that rural and Aboriginal and Torres Strait Islander communities are resistant to digital healthcare models or lack digital literacy readiness.

Community survey findings from the MobPod Project demonstrated strong interest and openness towards digitally enabled healthcare delivery, with over 90% of respondents indicating interest in utilising Mob Pod services. Telehealth-supported GP access, allied health, chronic disease management, mental health supports, and specialist outreach services were among the most requested service areas.

The presentation will discuss how telehealth is being integrated into a culturally appropriate outreach model, including governance development, partnership collaboration, digital infrastructure considerations, operational challenges, workforce engagement, and community trust-building processes. Reflections will also be shared on barriers encountered during implementation, including connectivity limitations, service coordination complexities, and the importance of maintaining culturally safe and relationship-based care alongside digital innovation.

The MobPod model demonstrates how telehealth can complement community-led outreach healthcare and increase access for geographically dispersed populations when implemented through culturally responsive and locally informed approaches. The session will provide practical insights for organisations exploring hybrid healthcare delivery models in rural and remote settings.

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Care provided and Lessons learnt: Queensland Virtual Early Medical Termination of Pregnancy Service One Year On

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Background/Purpose
Despite decriminalisation of abortion in 2018, many pregnant Queenslanders face significant challenges and inequities in accessing termination of pregnancy care. The Queensland Virtual Early Medical Termination of Pregnancy Service (QVEMTOPS) was set up to improve access and equity in reproductive care for Queenslanders by providing early MTOP via telehealth from April 2025.

Methods/Approach
Care was provided based on the Queensland Clinical Guidelines including the option of MTOP without ultrasound if criteria were met. Routine clinical data was recorded and analysed. Starting May 2025, clients who had a clinical contact with the service were invited to complete a patient-reported experience measure survey. From November 2025, endorsed midwife providers provided MTOP prescriptions alongside medical providers.

Outcome/Impacts/Results
Demand for QVEMTOPS increased significantly. 2775 referrals were received (starting with 71 in April 2025 and peaking with 389 in Jan 2026), and 1813 MTOP consultations were performed. 60% of total consultations were telehealth and 96% of MTOP consultations were done by telehealth.

Almost four out of five patients accessing QVEMTOPS were identified as belonging to a priority population (78%), showing that QVEMTOPS is meeting its goal of improving reproductive access and equity. Just over 1 in 5 patients (21%) proceeded to MTOP without ultrasound scan and follow-up (although incomplete) showed <1% serious complication rate with no serious complications in the “No-scan” cohort.

Of patients that completed the PREMS, 94% rated the overall service as very good and none as poor or very poor. 98% felt that they were always treated with dignity and respect and 96% always felt listened to during their care in QVEMTOPS.

Conclusion
QVEMTOPS has improved access to MTOP in Queensland particularly amongst priority populations. Clients reported positively on their experiences in the service with 27% unprompted commenting on the ease or efficiency of telehealth.

data accurate to 8 Feb 2026

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Virtual ward rounds – facilitating timely, equitable access to specialist care in Regional Victorian Health Services (A pilot)

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Background
Royal Melbourne Hospital (RMH) and Austin Health, with Victorian Department of Health support, have piloted Virtual Ward Rounds (VWRs) to improve regional inpatient access to specialist care. Regional patients often require prolonged admission or transfer to metropolitan centres due to limited access to specialised expertise in regional settings. Virtual care offers an alternative model; however, the feasibility and effectiveness of jointly delivered VWRs between tertiary and regional centres have not been evaluated in the Victorian context.

Aims
- Reduce tertiary transfers for specialist consultations
- Strengthen local clinical capability
- Enable more equitable care
- Evaluate feasibility and acceptability of delivering VWRs via telehealth

Methods
Implementation study involving multiple regional 8-week pilots delivered by RMH and Austin across several specialties utilising telehealth. Two 3-hour sessions/week. Inclusion: patients admitted regionally, requiring specialist input not available onsite. Exclusion: urgent review or imminent tertiary transfer. Specialists conducted VWRs jointly with regional clinicians and patients/families.

Results
In the Wangaratta Haematology pilot and Albury Neurology pilot (n=41, 62 consultations), median referral-to-review time was 0 days, with 1.9 consultations/session. Median LOS was 6 days, and median time to discharge after VWR was 2 days. Four patients (9.8%) required transfer to a tertiary hospital for investigations or care unavailable locally. Management plans changed in 85% of consults. Without VWRs, clinicians estimated 85% of patients would have required tertiary transfer or urgent advice. Of those seen, 32% were planned for another review, 24% for RMH outpatient follow-up and 65% discharged from VWRs. Patient experience (n=15) was “good-very good”. Clinician feedback (n=15) highlighted stronger regional–metropolitan partnerships and improved decision-making, although workflow integration remained a challenge.

Conclusions
- VWRs were acceptable to clinicians and patients
- Simple technology utilising an iPad and telehealth is effective for VWR delivery
- Models of care must optimise resource use while ensuring timely specialist access

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A virtual health treatment and management service for cancer patients to reduce the impact and cost for patients in rural areas.

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Residents in regional and remote areas of Australia are proportionately older (≥65 years), have a higher prevalence of health risk factors, and record higher rates of hospitalisation, injury and death, all while having poorer access to primary health care services. A diagnosis of cancer often impacts household income due to change in employment and the 'cost' of care, placing an added burden on patients. Commencing 2018, a hybrid virtual Nurse/NPC led education and supervision model of care was introduced for oncology patients, initially for oral cancer therapies, but extending to include patients receiving any regionally administered therapy.

This study aimed to build on previous work by identifying and measuring the barriers and facilitators for patients who reside in regional and rural areas on accessing and receiving virtual care services.

Using a convergent mixed methods approach, patients completed surveys detailing digital literacy, telehealth satisfaction and health economics. A subset also completed an interview. Staff completed the telehealth satisfaction scale. Quantitative survey data were analysed descriptively. Qualitative data were analysed using reflexive thematic analysis.

Between 4-7% of all patients in the medical oncology stream of the health service were managed through the regional hospital using telehealth. Two-thirds of patients approached completed either survey, interview or both. A majority were female (68%), of mean age 68 years, and highest level of education was senior certificate (93%). For all but one, telehealth was accessed at the regional hospital. "Because I live in a poor reception zone and off grid I travel to Gympie to do Telehealth". Impact of treatment on costs was not a problem for half of respondents with remainder having financial concern. After 8 years of this nurse-led hybrid telehealth model, a majority of patients travel to a regional centre to access virtual health. A workflow of possible improvement has been created.

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Reflections on the development of a Virtual Community of Practice Approach to Paediatric Brain and Spinal Cord Injury Mental Health Care

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Children with brain or spinal cord injury and their families commonly experience stress, grief and trauma as they adapt to potential changes in their child or themselves. In addition, these children are at a higher risk of developing mental health problems, such as depression, anxiety, and behavioural issues compared to their peers, which affects their quality of life, relationships and school performance. Community based mental health professionals are best placed to offer mental health support but may not have the knowledge or confidence in therapeutic techniques specific to this cohort, nor the opportunity to connect with other professionals to discuss best practice and collaborative care.

The aim of the SHARE (Supporting Health, Adjustment, Recovery and Empowerment for children and adolescents with brain or spinal cord injuries) Community of Practice (CoP) is to connect leading health professionals and health researchers focused on facilitation of best practice for mental health support of children and adolescents with brain or spinal cord injury and their families. We have used the Project ECHO model to deliver tele-mentoring services to a range of professionals and sectors including health, mental health, disability, rehab and education.

The SHARE ECHO CoP offers monthly virtual sessions focused on case discussions, presentations and sharing of ideas, information and best practice. Since the program commenced in July 2025, 14 one-hour ECHO sessions have been delivered. From the 175 participants registered for the program, 84 have actively attended from more than 50 locations around Australia, with an average of 22 participants per session. Each session has a different case and topic focus including for example “Mental Health and ABI and SCI - when to refer to Psych?” and “Acceptance and Commitment Therapy Values for Parents”. Survey feedback from SHARE ECHO participants shows perceived increases in skills, knowledge, and confidence, as well as exposure to new techniques and connection with colleagues. Our presentation will describe the evolution of the SHARE ECHO program, key challenges, and an interim summary of feedback from participants.

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Measuring Trust and Confidence in Telehealth modalities in Australia: a nation-wide validation study of the trust and confidence in telephone and video consultation scales

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Introduction
Trust and confidence are essential for successful adoption of telehealth. Recent declines in telehealth utilisation highlight the need for a clearer understanding of these constructs and reliable tools for their measurement.

Aims
To evaluate the psychometric properties of scales measuring Trust and Confidence in Telephone and Video Consultation (TCTVC) across Australia.

Methods
Data were collected through online survey across Australia. Four exploratory factor analyses (EFA) with oblique rotation Promax were conducted to re-evaluate psychometric properties and factor structure of four validated scales, given their prior validation was limited to a smaller metropolitan group. Parallel analysis was used for factor retention and items with factor loadings ≥0.50 and without substantive cross-loadings were maintained. Confirmatory Factor Analysis (CFA) were applied independently to each scale, using multiple criteria to assess structural validity. Cronbach's alpha (α) and inter-item correlations measured the internal consistency reliability.

Results
EFA results (N=803) for the trust scales were both unidimensional: (1) 12-item trust in telephone consultations (α=0.95, r=0.59); (2) 11-item trust in video consultations (α=0.96, r=0.67). One item from the trust in video scale was excluded due to low factor loading. EFA resulted in two factors for each of the confidence scales: (3) Confidence in using telephone consultations (α = 0.87, r=0.50), comprising 4-item ‘competence & capability’ factor (α = 0.88, r=0.65) and 3-item ‘social & technical support’ factor (α=0.88, r=0.70); (4) Confidence in using video consultations (α=0.92, r=0.63) comprising 4-item experience ‘competence & capability’ factor (α=0.90, r=0.70) and 3-item ‘social & technical support’ factor (α=0.90, r=0.70).

Conclusion
All scales demonstrated strong psychometric properties, with high internal consistency and clear factor structures. The validated TCTVC scales provide reliable tools for measuring trust and confidence in telehealth within the Australian population. Their application can guide evidence-based policy and support targeted investments and future research to priority areas for trust-building.

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Beyond Data Breaches: A Cross-Sectional Analysis of the Human, Experiential and System-Level Factors Shaping Trust in Telehealth Modalities in Australia

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Introduction
Trust is essential for telehealth uptake and sustainability, yet it is shaped by a complex interplay of individual, experiential, and system-level factors. This study examined how demographic characteristics, experience, confidence, data sharing concerns, and transferable trust influence trust in telephone and video consultations.

Methods
A cross-sectional online survey was administered to Australian adults, yielding 803 complete responses. Trust and confidence scores for telephone and video consultations were derived from validated scales. Non-parametric tests (Wilcoxon signed-rank, Kendall's Tau-b, Mann–Whitney U) assessed trust in different modalities and bivariate associations, and multivariable linear regression examined the relative influence of demographic, experiential, and attitudinal predictors on trust.

Results
Participants were predominantly women (66.6%) and highly educated (42% held university degree). Trust was higher for telephone (median 3.75) than video consultations (median 3.45; $p<0.001$). Trust in telephone consultations showed no significant association with age, income, or education, whereas trust in video consultations was negatively associated with age and positively associated with income and education (all $p<0.001$). Gender differences were significant for both modalities, with women reporting higher trust. Confidence showed the strongest positive correlation with trust (telephone $\tau=0.566$; video $\tau=0.645$; both $p<0.001$). Personal or health data-sharing concerns were negatively associated with trust, particularly for telephone consultations, and trust in both modalities was more sensitive to personal data-sharing concerns. Frequency of use, better internet quality, and choice in the appointment modality were all positively associated to trust in both modalities. Transferable trust, especially trust in regular healthcare providers, was a stronger positive predictor compared to advice from family, friends or social media.

Conclusion
Trust in telehealth is multifactorial. Telephone trust is relatively stable across demographic groups, whereas video trust is more sensitive to age, education, and income. Confidence, choice, positive experiences, and trust in healthcare providers are key levers for strengthening trust in telehealth modalities.

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Telemedicine in medical education after COVID-19: a convergent mixed-methods study of medical students in Peru

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Aim
To evaluate the knowledge, perceptions, and experiences related to telemedicine among clinical-year medical students and to identify gaps between everyday digital literacy and clinical digital competence relevant to telemedicine practice.

Methods
A convergent mixed-methods study was conducted in 2024 among clinical-year medical students at a private university in Lima, Peru. A cross-sectional survey of 302 students using the Alvarado-Villa questionnaire assessed telemedicine knowledge and self-perceived competence. Descriptive statistics and exploratory association analyses were performed using SPSS. In-depth interviews involved 11 students, and the data were analysed using thematic analysis. Quantitative and qualitative findings were integrated through triangulation.

Results
Although 72.2% of students reported high self-perceived technological capacity, telemedicine-specific clinical knowledge was predominantly low. Low knowledge levels were observed for telemedicine tools (50.0%) and medical applications (48.0%). Only 8% of students demonstrated high knowledge. Prior telemedicine experience was reported by 72.8% of participants, mainly as service users; among these, 53.6% reported technical difficulties and 45.9% reported discomfort during virtual consultations. Exploratory analyses showed higher telemedicine knowledge among students with prior telemedicine experience ($p = 0.002$) and extracurricular training ($p < 0.001$). Integrated analysis indicated that low clinical digital knowledge co-occurred with concerns about data privacy, perceived technical failures described as depersonalising, and fragmented or uncomfortable prior telemedicine experiences. Acceptance of telemedicine varied according to prior exposure, digital literacy, and structured academic support.

Conclusion
In a post-COVID-19 context of increased telehealth exposure, general digital literacy and user-level experience do not equate to clinical digital competence. Structured integration of telemedicine into undergraduate medical education is required, including digital clinical simulation, ethical-legal training on confidentiality and digital consent, standardised virtual consultation protocols, and supervised teleconsultations with formative feedback. Adapting clinical communication skills to virtual care is also essential to support safe, effective, and humanised telemedicine practice.

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Teledermatology models of care: A snapshot of services in Australia

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Aim
Understand how teledermatology is used in Australia and summarise models of care.

Methods
Teledermatology service representatives were interviewed by phone, video-conference, and in-person. Services were identified through academic literature, online searches, recruitment notices in The Australasian College of Dermatologists' (ACD) newsletter, and snowball sampling.

Results
Twenty-six teledermatology services were included. All interview participants were dermatologists. Service models included asynchronous consultant advice (n=8), synchronous patient appointments (n=14) and triage services (n=4). Teledermatology services delivered care at jurisdictional (n=19) and national (n=5) levels. Teledermatology was mostly used for inflammatory skin conditions (n=19). Many perceived teledermatology was inappropriate for skin cancer referrals, however, certain models screened for skin cancer. Nine services billed privately, 15 were publicly funded, and two hired private providers to deliver public models of care. Service operation length ranged from 1 month to 25 years. Most models used a "technology stacking" approach where multiple third-party tools (e.g., referral and consultation platforms, appointment scheduling systems, imaging solutions, videoconferencing platforms, e-prescribing applications) were layered on an EMR. Enablers included systems interoperability, hybrid models, skilled workforce, thorough prework-up, leadership support, funding, and relationships between primary providers and specialists. Impediments to models were lack of support staff, inefficient data entry processes, cross jurisdictional issues, poor image quality, and lack of awareness of teledermatology models.

Conclusion
Diverse models of public and private teledermatology care exist in Australia, with hybrid workflows enhancing viability. While teledermatology services require adequate staff resources and efficiently integrated workflows to succeed, the relationships between primary care and specialists are critical, as well as remunerating both sides for their time. Shared learnings across teledermatology services are important to inform evidence-based, sustainable teledermatology models. This work was funded by the ACD through the Commonwealth Department of Health, Disability and Ageing, Flexible Approach to Training in Expanded Settings (FATES) program.

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Implementation of a virtual health navigator to support new virtual model of outpatient care in a tertiary hospital allied health department

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Background
Virtual care delivery can transform healthcare; however, key implementation challenges remain including insufficient staff skills and time to provide consumer support. We aimed to evaluate the development and implementation experience of a new Virtual Health Navigator (VHN) role, from role conception through to operationalisation.

Methods
This project utilised a pragmatic, prospective pre-post evaluation design over a six-month period (September 2025 – February 2026), to implement a VHN role (0.4FTE) to support virtual outpatient care within a Nutrition and Dietetics department of an Australian metropolitan tertiary hospital. A dedicated structured VHN log was used to record time, activities and interactions. Detailed meeting notes for planning, implementation and iterative role requirements throughout implementation were kept. A consumer researcher with lived experience in virtual care interviewed the VHN to understand how the role could be enhanced and integrated into the service post-implementation.

Results
The VHN role was utilised to support consumers (1-15 minutes/interaction), clinicians (5-45 minutes/interaction), and service improvements (10-150 minutes/interaction). Overall, consumers generally demonstrated engagement with virtual care with minimal VHN intervention required. Common tasks included confirming appointment details and technology logistics and offering consumer technical assistance if needed, to avoid failing to attend and late modality changes. During implementation, the VHN's predominant time shifted to building clinician competence and confidence in utilising the new virtual care model, rather than providing direct patient-facing technical support. Over time, the role evolved from its initial focus on increasing video consultation appointment activity through one-on-one support to more administrative support of the department's new virtual model of care.

Conclusion
A VHN role can support the implementation of a virtual model of care. Consumers may need less technical assistance to engage in these models, but more prompting and confirming of

appointment logistics supported its uptake. Clinician support is an important function of a VHN.

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Whole-of-System Ownership for program implementation: Lessons from the Australian Teletrial Program

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Clinical trial participation improves patient outcomes, strengthens health systems, and generates substantial economic returns. Despite these benefits, rural, regional, remote, and First Nations communities continue to experience inequitable access to clinical trials. To address this disparity, the Australasian Teletrial Model (ATM) was developed to enable decentralised clinical trial delivery through telehealth-enabled partnerships between metropolitan and regional centres. Following successful pilot studies, the Australian Government invested AUD $75 million to establish Teletrial Programs across six jurisdictions.

This presentation analyses the implementation of the Australian Teletrial Program through implementation science frameworks including PARIHS and CFIR, with a focus on “whole-of-system ownership” as a critical determinant of sustainable health system transformation. Key program components included establishment of Regional Clinical Trial Coordinating Centres, harmonisation of policies and templates, workforce education, and development of governance and evaluation structures.

The program demonstrated that decentralised clinical trials are feasible, scalable, and capable of improving access to research participation for underserved populations. More than 2,500 patients participated in teletrials, approximately 1,000 staff received training, and multiple clinical trial clusters were established across disease streams. Several jurisdictions successfully embedded teletrial infrastructure into routine health service operations.

However, implementation outcomes varied considerably across jurisdictions and health services. Key barriers included inconsistent leadership ownership across system layers, fragmented governance, variable sponsor engagement, workforce shortages, inconsistent satellite activation processes, and limited accountability mechanisms. These findings suggest that innovation and funding alone are insufficient to achieve sustained system transformation.

Using the “System Lasagne” model, this presentation illustrates how successful decentralised clinical trial implementation requires alignment across all system layers, enabling processes, governance mechanisms, and continuous quality improvement systems. The lessons from the Australian Teletrial Program are applicable internationally and provide a practical framework for embedding decentralised clinical trials and broader health equity initiatives as routine business within complex health systems.

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Policy evolution in digital health education and training: a scoping review

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The rapid expansion of telehealth and digital health technologies following the COVID-19 pandemic has highlighted the urgent need for a digitally competent healthcare workforce. While substantial investment has occurred in digital infrastructure and virtual care delivery, policy attention toward digital health education and workforce training remains fragmented across countries. This scoping review is examining the evolution of policies relating to digital health education and training, with a particular focus on workforce preparedness for telehealth and digital health implementation.

A preliminary scoping review methodology was adopted to map and synthesise policies relating to digital health education and workforce development. Literature searches were conducted across academic databases and grey literature sources, including policy documents published by governments, professional bodies, and international organisations. Policies and frameworks published primarily after 2010 were reviewed across high, middle, and low-income countries. Data were analysed thematically to identify major policy trends and recurring domains in digital health education and training.

Preliminary findings suggest that earlier policies focused mainly on electronic health records and information technology competencies, whereas recent policies emphasise telehealth capability, artificial intelligence, digital professionalism, interoperability, cybersecurity, data governance, and equitable access to care. Countries including Australia, the United Kingdom, the United States, Canada, and Singapore have introduced workforce capability frameworks addressing digital literacy, interdisciplinary training, leadership, ethics, and continuing professional development. However, substantial gaps remain in policy implementation, evaluation, accreditation standards, and integration of digital competencies into health professional curricula. Low- and middle-income countries continue to face challenges relating to infrastructure, financing, workforce capability, and governance. The findings suggest that sustainable digital health implementation depends not only on technology adoption but also on coherent workforce education policies.

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Increasing the Use of Video Telehealth in Residential Aged Care Homes: Evaluation of a Practical Telehealth Training Program

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Aim
To evaluate the impact of a tailored telehealth training program on residential aged care home (RACH) staff knowledge, skills, confidence, and uptake of video telehealth, as well as to identify barriers and requirements for sustainable implementation.

Methods
A quasi-experimental mixed-methods study was conducted across RACHs in Australia. A customised onsite telehealth training program was delivered, including workflow integration, policy guidance, and simulated video consultations. Pre- and post-training surveys assessed self-reported knowledge, skills, and confidence (0–100 scale), analysed using independent t-tests. Qualitative data were collected from consultant diaries and follow-up interviews with senior staff, with inductive thematic analysis. Telehealth activity was assessed using follow-up surveys and platform usage data.

Results
Forty-one RACHs and 377 staff participated (88% nurses). Significant improvements were observed in telehealth knowledge and skills (mean 41.0 to 77.3) and confidence (46.8 to 79.0; $p<0.001$).
Post-training, 77% of sites reported conducting video consultations, including with general practitioners, specialists, and allied health providers.
Key motivators included enabling family involvement, improving access to care, and reducing travel burden. Major barriers included limited engagement from external health providers, infrastructure challenges, and workforce constraints. Follow-up data indicated increased telehealth activity and staff confidence; however, sites identified the need for ongoing training, improved connectivity, and stronger engagement with external providers to sustain use.

Conclusion
A practical, tailored training program can significantly improve RACH staff capability and initial uptake of video telehealth. However, sustainable implementation requires ongoing support, system-level engagement—particularly with external providers—and integration into routine care pathways. Training alone is insufficient; a coordinated, multi-stakeholder approach is essential to embed telehealth into aged care practice.

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From Promise to Practice: Scaling Telepharmacy in New Zealand

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Telepharmacy has moved from possibility to practice, but its long-term place in pharmacy services remains uncertain. While much telepharmacy research has focused on early implementation, less attention has been given to how services can be mainstreamed and sustained at the system level. This study explored opportunities and challenges related to scaling and sustaining telepharmacy in New Zealand.

A sequential mixed-methods design was used.

This presentation reports findings from the quantitative phase, a national cross-sectional survey of 142 stakeholders across micro, meso, and macro levels of the pharmacy system. Survey items were informed by the NASSS framework (Non-adoption, Abandonment, Scale-up, Spread, and Sustainability of health and care technologies), which is widely used to predict and evaluate the success of technology-supported programmes at scale.

Findings showed strong support for telepharmacy in principle. Respondents perceived telepharmacy as valuable for patients (88.7%) and pharmacists (71.9%), and suitable for common conditions encountered in pharmacy practice. However, this support was tempered by concerns about equity, including social, cultural, and language barriers that could affect the quality of care. Major implementation challenges centred on underdeveloped funding models and limited organisational capability and capacity, reinforced by wider system-level barriers, such as an unsupportive regulatory and policy environment. Notably, 61% of respondents were uncertain about the role of professional bodies in advocating for telepharmacy. Despite these constraints, 91.4% of respondents expressed confidence in telepharmacy's future potential for wider adoption and growth.

Telepharmacy in New Zealand appears supported in principle but constrained in practice. Sustainable scale-up will require more than sector enthusiasm; it will depend on viable funding, organisational readiness, equity safeguards, and clearer policy and professional leadership.

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Would you like a side of AI with that? An organisational journey implementing AI in a national telehealth environment.

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Whakarongorau Aotearoa delivers New Zealand's National Telehealth Service, staffed by nurses, paramedics, counsellors, and social workers across physical health, mental health, and crisis lines.

Like many health services, it faces a demand and capacity mismatch. In late 2024, Whakarongorau began a phased AI implementation with a clear purpose: release clinical capacity, improve the waiting experience for people in distress, and give staff a head start before connecting.

The journey started internally. AI tools were introduced to senior leaders, then rolled out to reduce administrative burden and build capability. An internal AI chatbot helped staff locate policies and build knowledge. Alongside this, frameworks for ethical and culturally appropriate AI use were developed, recognising that in a bicultural health context, AI carries specific obligations to Māori and Pacific communities. The organisation participated in a longitudinal University of Canterbury study examining how AI affects staff wellbeing, trust, and workload over time - findings that helped shape a people-first approach to rollout.

In May 2026, Whakarongorau launched Welcome, its first public-facing AI tool, at the front of the contact flow for 1737, New Zealand's national mental health and wellbeing line.

Planning for failure was as deliberate as planning for success. Before go-live, clinical staff participated in structured red teaming across nine testing areas, including Privacy Impact Assessments, systematically attempting to break the tool; probing whether it could be prompted to give clinical advice, respond unsafely to disclosures of harm, or behave outside its approved boundaries. It could. Those failures were the point: finding them before service users did meant guardrail design, escalation pathways, and crisis planning could all be strengthened before the service went live.

This presentation takes a warts-and-all look at what the organisation learned: about guardrails, cultural safety, staff hesitation, and the complexity of deploying AI responsibly in high-stakes care environments.

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Does clinician AI use undermine trust in physiotherapy delivered in-person or via telerehabilitation? An online randomised experiment

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Aim
Despite growing interest in artificial intelligence (AI) supported healthcare, there is limited evidence on how clinician use of AI affects consumer perceptions of in-person or telerehabilitation physiotherapy consultations. The aim of this study is to explore how clinician use of AI influences consumer perceptions of physiotherapy delivered in-person versus via telerehabilitation.

Methods
Australian adults (n=729) were recruited via a paid Qualtrics panel and randomised to one of four hypothetical physiotherapy scenarios in a 2×2 design (delivery mode: in-person vs telerehabilitation; clinician use of AI vs no AI). Participants rated perceived warmth, competence, trust (service provider and emotional), working alliance, intention to use, and perceived safety on 7-point Likert scales. Outcomes were analysed as composite means using ordinary least squares regression with Heteroskedasticity Consistent Type 3 robust standard errors.

Results
Mean (SD) of consumer perceptions of physiotherapy care in the no-AI, in-person condition ranged between 4.8 (1.4) for emotional trust and 5.8 (0.9) for both perceived warmth and competence. AI use was associated with lower ratings for perceived warmth (−0.3, 95% CI −0.4 to −0.1), competence (−0.4, −0.6 to −0.2), service provider trust (−0.5, −0.7 to −0.3), intention to use (−0.8, −1.0 to −0.5), and perceived safety (−0.8, −1.1 to −0.6). Interaction effects were small, suggesting similar reductions associated with AI use in both delivery modes.

Conclusion
Clinician use of AI reduced consumer perceptions of the physiotherapist and service across multiple relational and evaluative domains. Services introducing AI should emphasise physiotherapist oversight, explain how AI supports (rather than replaces) clinical judgement, and address safety and privacy concerns to maintain trust and willingness to access physiotherapy care.

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The mediating role of telehealth trust between AI knowledge and patient comfort across the AI-HCP involvement spectrum

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Background
Artificial intelligence (AI) has been increasingly integrated into virtual care, yet whether patient comfort with AI-supported care varies across levels of AI involvement remains unclear. This study examined whether trust in telehealth mediated the association between AI knowledge and patient comfort across four scenarios with increasing AI integration.

Methods
An online cross-sectional survey was conducted in Australia in March 2025 (n=803). Self-reported data included AI knowledge, validated telehealth trust scales, and comfort across four scenarios with increasing AI involvement: L1: AI-free (HCP-only); L2: AI-assisted (HCP-led); L3: AI-led (HCP-oversight); L4: AI-autonomous (HCP-free). Spearman's correlation tests examined associations among AI knowledge, telehealth trust, and comfort with AI-supported care. Covariate-adjusted ordinal mediation models were conducted, controlling for age, gender, and education.

Results
Comfort differed significantly across all four AI scenarios ($p < 0.001$), with the highest comfort reported in the AI-free (L1) scenario (median=4.00, IQR=2.00) and the lowest in the AI-autonomous (L4) scenario (median=2.00, IQR=2.00). AI knowledge was positively associated with comfort across all AI-integrated scenarios (L2-L4), with the strongest association observed in the AI-assisted (L2) scenario ($\rho = 0.32$, $p < 0.001$). Trust in both telephone and video consultations significantly mediated the association between AI knowledge and comfort in all AI-integrated scenarios. Video-consultation trust showed consistently larger mediated proportions than telephone trust, particularly in the AI-autonomous (L4) scenario (43.28% vs 37.64%).

Conclusion
Trust in telehealth mediated the association between AI knowledge and comfort with AI-supported care. AI knowledge mattered most when AI was actively involved, and its association with comfort was partly explained by trust in telehealth. Patient comfort was strongest when AI supported, rather than replaced healthcare professionals, highlighting the importance of human interaction. Models that combine AI education, trusted telehealth modalities, and clinician oversight should be promoted for increased uptake.

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Understanding patient distress from speech: Lessons for AI in telehealth

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This talk explores how a patient's voice can help AI models estimate distress and why this matter for telehealth. Clinicians may not have the same cues available during remote consultations, so understanding whether AI can interpret patient speech could inform additional support. The talk examines whether adding audio improves existing AI models' estimates of distress compared with text alone, and when audio helps most. It then discusses why we need evaluation methods that consider both what patients say and how they say it.

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Oral Poster Presentations

The Virtual Neurologist: Transforming Regional Care Through Telehealth Diagnosis of Functional Neurological Disorder

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This case highlights the impact of telehealth in delivering timely specialist neurological care to an inpatient regional setting, demonstrating both the opportunities and evolving models of virtual consultation. A 33-year-old female presented to a regional hospital with a one-month history of progressive neurological symptoms, including gait disturbance, weakness, tremor, incoordination, visual impairment, and cognitive changes. The clinical picture prompted concern for serious neurological disease, with differential diagnoses including motor neuron disease and spinocerebellar ataxia, and plans were underway for extensive and invasive investigations.

A virtual neurological consultation was conducted via a telehealth ward round with a tertiary specialist. Through detailed history-taking and real-time observation of objective assessment supported by local medical and physiotherapy staff. Including the Hoover's technique, learned through prior virtual teaching, a confident diagnosis of Functional Neurological Disorder (FND) was established. This enabled immediate redirection of care, avoiding unnecessary investigations and prolonged hospitalisation.

For the patient, telehealth facilitated rapid access to specialist expertise, eliminating the need for transfer or delayed outpatient review. Diagnostic clarity provided significant reassurance, particularly in excluding serious structural pathology, and allowed initiation of a patient-centred management plan incorporating physiotherapy, psychological support, and education. Early diagnosis is particularly critical in FND, where delays can exacerbate symptom severity and prolong disability.

From a health service perspective, this model improved resource utilisation by preventing costly transfers and invasive testing, while enhancing regional clinician capability through real-time education and skills transfer. It also strengthened collaboration between metropolitan and regional services. This case demonstrates telehealth not only as a substitute for in-person care, but as an enabler of high-value, efficient, and educational clinical practice, underscoring its role in improving equity of access and reshaping neurological service delivery.

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Teletrials Transforming Clinical Trial Access Across Queensland

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The Queensland Regional Clinical Trials Coordinating Centre (QRCCC) was established under the Australian Teletrial Program to address a long-standing reality: people living in regional, rural and remote (RRR) communities often face fewer treatment options and poorer health outcomes simply because of where they live. Using the Australasian Teletrial Model, the QRCCC facilitates access to clinical trials by bringing clinical trials closer to home and ensuring that geography is not a barrier to accessing innovative care.

This model supports a coordinated, networked approach to trial delivery. Through a hub-and-spoke cluster model utilising secure telehealth technologies, Primary Sites partner with Satellite Sites across Queensland, working as one clinical team. This approach strengthens communication between clinicians, supports shared decision-making, and ensures participants receive safe, high-quality trial care within their own communities.

By 31 March 2026, QRCCC had enabled 51 teletrials, enrolling 1,474 participants across public and private health services. Importantly, 6.4% of participants at Satellite Sites identified as First Nations peoples, reflecting a commitment to culturally safe, equitable research participation. The model also empowers regional clinicians, offering upskilling opportunities that build capability and confidence in settings where such experience is rarely accessible.

Key lessons learned include the importance of embedding health equity from the outset, investing in strong communication pathways, and fostering genuine collaboration between trial sites, sponsors, and local teams. Above all, the teletrial model demonstrates the power of connected networked care – a system where distance no longer dictates opportunity.

QRCCC’s experience highlights the critical role of telehealth-enabled clinical trials in improving equity and strengthening research participation for geographically dispersed populations. By reducing travel, financial strain, and family disruption, QRCCC’s teletrial service is reshaping what equitable access to research looks like. It shows that when care is designed around people, not postcodes, better outcomes follow.

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Bringing the ward home: early outcomes of a virtual care model

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Virtual care models are increasingly used within hybrid Hospital-at-Home (HaH) services, with telehealth and remote monitoring technologies augmenting acute in-person bed substitution care at home. We report on early outcomes of a cardiac-focused virtual HaH program in Melbourne, Australia.

A retrospective observational evaluation of the pilot program was conducted over 15 weeks (5th February to 30th April 2026). The program focused on patients with heart failure and those recovering from cardiac surgery. Patients received cardiac rhythm monitoring, had equipment for measuring vital signs at home, and underwent daily multidisciplinary telehealth assessments. Data on patient outcomes, demographics, length of stay and referral patterns were analysed to assess performance and identify implementation barriers.

97 patients were safely managed in the community, no patient died. Ages ranged from 20-97 years (mean 69.98 years); more were male (n=55; 56.7%). 287 telehealth assessments were conducted over 85 days, with an average length of stay of 5.6 days. Overall readmission rate was 14.4% (14/97), with a higher proportion of heart failure patients (11/63, 17.4%).

Accepted referrals were primarily from cardiac surgery (n=34), cardiology (n=26), followed by general medicine (n= 20). Not all received referrals were suitable for virtual care, with barriers related to high clinical acuity requiring intensive treatment, functional limitations, and restricted access to telehealth. A small proportion declined participation.

Patient-reported experience questionnaires demonstrated positive feedback. While 15% reported some anxiety with technology, all patients felt safe receiving care virtually, and 95% reported feeling involved in making decisions regarding their care alongside their families. This evaluation suggests that virtual care is a feasible and effective approach for managing selected patients beyond the hospital setting. Optimising patient selection and addressing accessibility barriers will be key to maximising impact and scalability of this hybrid HaH care model.

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The Hybrid Telehealth Model in Physiotherapy - Training Wheels or the Finish Line?

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Remember learning to ride a bike? We started with training wheels - what if we never took them off? Kids today use balance bikes, learning independence faster without the intermediate step. This raises a question for physiotherapy: is hybrid telehealth model a comfortable middle ground we've settled into, or the best practice?

Since COVID-19, hybrid models have shown promising results, extending funding and service reach. However, we didn't choose telehealth; it was forced upon us, revealing its potential. This prompts an uncomfortable question: is hybrid model driven by client needs or by clinician bias that views telehealth alone as insufficient? Are we projecting our own discomfort onto clients and calling it clinical reasoning?

What if, where clinically indicated, we took the training wheels off entirely?

In my role as Virtual Health Coordinator at Mobile Rehab, I manage a predominantly telehealth caseload. Transitioning long-term face-to-face clients to remote care revealed unexpected outcomes. While some disengaged, others, when faced with remote continuity, realised they didn't need ongoing physiotherapy, feeling independent and confident. I argue this is a positive outcome, not a loss. The clients who remained are largely thriving, reporting meaningful progress.

Crucially, resistance is minimal when expectations are clearly set upfront. Many clients, particularly older adults already managing full schedules of home services, expressed genuine relief and a preference for fewer home visits, challenging the assumption that elderly clients always need and want constant human presence. Another body through the door isn't always welcome; it requires energy and coordination.

Before booking the next visit, we must ask: is this appointment for the client, or for the clinician?

Telehealth-only delivery, when clinically appropriate and expectation-managed well, is quality physiotherapy. We've already proven we can ride the bike. It might be time to find out what we can do without the training wheels.

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Experiences implementing telemedicine for heart-failure patients: A Case from a Danish department of Cardiology

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In Denmark, a nationwide program for telehealth services for patients with COPD and ischemic heart disease was launched in 2024. As being a part of this program, our department have needed to reorganize. Including change workflows and reset the mindset of the involved staff to capture the value of the national programs intended at a local level. The service consists of remote monitoring and virtual consultations.

From the beginning, the initiative with telemedicine aimed to improve remote monitoring for patients with heart failure, ensuring timely interventions while supporting a greater sense of safety in their everyday lives. Throughout the process, we gained a deeper understanding of the opportunities and challenges associated with integrating telemedicine into routine practice.

From a workflow perspective, Telemedicine forced us to rethink traditional care pathways. The introduction of remote monitoring required clear protocols for the nurses, shared responsibilities, and alignment across professional groups. While the initial learning curve was steep for some nurses, ongoing training and peer to peer support helped build confidence in the new system.

Initially, technical and organizational challenges required continuous adjustments ensuring reliable data transmission, support of patients with low digital health literacy, and consistent documentation standards, governed by a strong collaboration of clinicians, management and a project group responsible for the implementation. Over time, virtual consultations were considered to be an important extension to future practice to strengthen both patient engagement and clinical efficient workflows.

In conclusion, telehealth can meaningfully enhance patient care when supported by robust structures, adequate training, and a willingness to adapt, but cannot replace nurses in-person contact with patients. It rather expands their provision of timely, personalized, and accessible care. These insights will help us in scaling up and refining cardiac telehealth services to benefit even more patient groups.

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Use of telehealth for Australian regional patients to improve access to specialized stereotactic radiosurgery in a post-pandemic era: A single institution study and literature review

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Introduction
Australian regional and rural cancer patients face inherent challenges when accessing timely subspecialised care. This study examines the adoption and impact of modern telehealth strategies to deliver subspecialised radiation oncology services to those disadvantaged by living in regional and remote Australia, with emphasis on the changes driven by the COVID-19 pandemic.

Methods
This was a single-institution retrospective analysis of outpatient appointments at the Gamma Knife Centre of Queensland (GKCQ) from 2018 to 2023 covering periods before, during and after the pandemic. The primary objective was to analyse the trends of telehealth uptake over time in respect to rural and regional status, particularly examining the use of videoconferencing.

Results
Over the six-year study period, 8512 outpatient appointments were conducted at GKCQ, with videoconference appointments comprising 29% by the end of 2023. Most of the videoconference appointments (72.7%) were used for those in regional or remote areas. The number of in-person appointments steadily fell during the pandemic and remained low at only 19.2%, with telephone appointments increasing to 51.8% over the same time period. In general, the literature reports high patient satisfaction with telehealth overall, with significant benefits such as reduced travel, cost savings and improved access for those in rural areas. However there remain challenges, such as technological barriers and inability to conduct physical examination.

Conclusion
Telehealth services at GKCQ, which expanded during the COVID-19 pandemic, have proven essential for geographically isolated patients by improving access to subspecialized care, maintaining high patient satisfaction and minimizing disruptions to other treatments. These benefits warrant further cost-benefit research and investment into telemedicine infrastructure.

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Restoring capsule endoscopy through a remote reporting model: what worked, and what got stuck downstream

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Aim
To re-establish capsule endoscopy access at Mackay Hospital and Health Service after a two-year service gap following private provider withdrawal, using a remote-reporting model that placed the procedure locally and the reporting specialist remotely.

Methods
From January to October 2024, MHHS and Telecare co-designed a remote reporting pathway. Local clinical nurse consultants were upskilled in patient preparation, capsule administration and on-site recorder management. Data transfer used a protected platform; remote Telecare gastroenterologists reported studies and fed findings directly back to the local team. New patient information sheets, a local workplace instruction manual, and a credentialled procedural pathway were developed. Service commenced October 2024.

Results
Within the first nine months: 32 capsule endoscopy procedures performed locally; longest wait time reduced from 1,085 days to as low as 2 days for inpatients; inpatient turnaround as short as 12 hours, outpatient average 4–5 days. Diagnostic yield included three active gastrointestinal bleeds, one previously undetected caecal carcinoma, Crohn’s disease, vascular lesions and gastritis/duodenitis. Patient experience: 100% rated overall experience ‘good’ or ‘excellent’.

What we learned (successes and failures). Successes: equipment procurement and on-site staff training were completed in approximately two months; the model required no new local gastroenterologist FTE. Failures and unresolved issues: the protocol build-out and credentialling took two months and was repeatedly underestimated in early planning; small-bowel bleed management still required transfer to Brisbane or Townsville; governance overhead (procedure forms) was higher than anticipated; follow-up pathways needed to be redesigned mid-pilot when it became clear that diagnostic detection had outpaced local downstream therapeutic capacity.

Conclusion
Remote diagnostic reporting can restore access where workforce-based services have failed, but the value of finding pathology depends on the capability of the local system to act on it. The next phase is upskilling local endoscopy capacity so that detection and treatment can both happen locally.

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Poster Display

Waiting is acceptable, Unacknowledged waiting is not: Patient-reported experiences of telehealth virtual waiting

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Background
Telehealth outpatient services have expanded rapidly across public health systems. While prolonged waiting is an accepted feature of in-person outpatient care, telehealth removes the visual and social cues that typically reassure patients that care is ongoing. The experience and safety implications of virtual waiting remain under-examined.

Aim
To understand why patients disengage from telehealth virtual waiting areas before being seen, how long they wait beforehand, whether that waiting is perceived as being acknowledged, and the potential patient safety implications.

Methods
A mixed-methods quality improvement study followed identification of higher-than-expected telehealth call abandonment in routine reporting. A voluntary survey was administered to patients exiting telehealth waiting areas prior to clinician pick-up. Responses from 400 patients across 80 clinics (April 2026 - October 2026) were analysed to understand why patients disengaged before being seen. Findings were compared with telehealth platform monitoring data and free-text comments were analysed using inductive thematic coding.

Results
"Waiting too long" was the predominant reason for disengagement (237/400), reported across all durations: 9 patients had waited under 15 minutes, 68 for 15 - 30 minutes, 72 for 30 - 60 minutes and 88 for an hour or more. This occurred despite an 11-slide carousel of patient information running continuously in the waiting area, where 271 of 400 patients did not perceive the carousel content as communication or acknowledgement of their wait, including 189 of the 237 who left because of the wait and acknowledgement did not increase as delays lengthened.

Disengagement accumulated through the day: 171 surveys were completed before midday and 229 afterwards, with 85 and 152 respectively citing waiting too long, and 69 of the 88 longest waits occurring after midday. Cross-referencing survey responses against abandonment records held in a separate platform source suggested that some patients who had been present in the waiting area may subsequently have been recorded as did-not-attend (DNA), creating a potential risk of missed or delayed care. Free-text responses described uncertainty and loss of reassurance rather than impatience.

Conclusion and next steps
Passive visual content alone does not reliably convey acknowledgement. In a physical waiting room patients receive continuous reassurance through environmental and social cues; telehealth removes these cues unless they are deliberately recreated.
Unacknowledged waiting may therefore represent an emerging patient safety risk that is distinct from wait duration.
The findings have informed redesign of the virtual waiting experience, including introduction of audio, investigation of additional patient communication options and ongoing evaluation of patient engagement and appointment outcomes. Survey feedback is also being used to support speciality-level review of patients who were present in the waiting area but subsequently recorded as did not attend (DNA).

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From Satisfaction to Attendance Burden: A Consumer Centred Lens for Telehealth First Care

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Consumer satisfaction with telehealth, particularly video consultations, is now well established. However, less attention has been paid to the effort required to attend healthcare appointments, and how that differs between in person and telehealth delivery.

This study reports findings from an ongoing Bayside Health Peninsula Care Group consumer survey examining experiences of video telehealth appointments, alongside reported barriers to attending in person appointments. The survey was intentionally designed using a burden of attendance lens, informed by a structured framework encompassing psychological, physical, logistical, caring, employment, and economic factors. Where applicable, barrier items were aligned across appointment types to enable comparison of reported consumer effort. Consumers were also asked about modality preference when in person care was not required.

Consumers reported positive experiences with video telehealth and high perceived quality of care. Video appointments were the most preferred modality when in person care was not required, few consumers preferred telephone, some reported no strong preference. Barriers to attending in person appointments were commonly reported and multifactorial, including impacts related to work or education, planning and coordination, transport, waiting, and health-related difficulty attending. In comparison, barriers to video telehealth were reported less frequently and were more concentrated around technology, appointment setup, and online waiting. Where negative telehealth experiences were reported, these were more often associated with system processes such as delays or communication rather than clinical care quality.

While consumer satisfaction with telehealth is not novel, this work demonstrates the value of intentionally measuring attendance burden from the consumer perspective. By designing the survey to capture and align effort across appointment types, the findings highlight clear differences in attendance burden between in person and video telehealth care. This approach provides a practical consumer centred evidence base to support more deliberate telehealth first decision making where in person care is not clinically required.

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Recent developments in telehealth education and training: A systematic review of curricula from the past five years

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Aim
Identify telehealth training and education programs developed since 2020 and describe development, implementation, learning objectives, and content.

Methods
Seven databases were searched (2020-2024) for articles describing video or phone consultation education and training initiatives and listing content or learning objectives. Any educational level, health professionals or health-related students could be included. Two authors independently screened and divided data extraction. Article quality was assessed against SQUIRE 2.0. Quantitative data was summarised using frequencies and percentages, learning objectives and content were mapped across the six Association of American Medical Colleges (AAMC) telehealth competency domains, and qualitative categories were thematically synthesised.

Results
Fifty-one articles were included of 7,547 identified. Most programs were delivered in the USA (82%) and targeted undergraduate students (51%). Articles published per year increased over time. Universities most often developed the programs (53%) and sometimes collaborated with health services, with content often across multiple specialties. Training ranged from short multi-day workshops to telehealth modules embedded in long courses (e.g., 18 months). Around one-quarter of studies (n=14, 27%) were solely theoretical and did not have any practical application or experiential learning. Participants usually evaluated the courses (90%). Domains mapped were: Patient safety and appropriate use (n=27, 53%), collecting data and assessment (n=22, 43%), communication (n=21, 41%), ethical practices and legal requirements (n=17, 33%), technology (n=19, 37%), and access and equity (16, 31%). Only four (8%) articles listed all six AAMC telehealth domains.

Conclusion
Telehealth training courses have been increasing every year, but many programs still lack experiential learning. Training generally covered assessment and technology use, however, more programs could include medico-legal requirements and address access or equity issues. For better use of resources, educators should consider standardised training programs applicable across disciplines and add site or speciality-specific modules as needed.

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Designing and implementing a nurse-led telehealth RPM Model of Care: Successes, Failures and Lessons Learnt.

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The advancement of telehealth has created new opportunities for nurse-led models of care, however, the design, testing and implementation processes of remote patient monitoring (RPM) services within traditionally structured health systems remain underreported throughout literature.

The safe@home (ACTRN12623001125617) project is a research study looking to see if people with chronic conditions experience reduced hospital utilisation when remotely monitored by nurses at home. The study aims to support individuals to manage their health conditions through technology. The safe@home project outlines the design and implementation of a novel nurse-led telehealth RPM model developed within a local health network and delivered through a randomised controlled trial focused on decreasing hospital readmissions. As part of a broader hospital avoidance project, we set out to document the challenges, learnings, and evolution of the model of care through implementation and beyond.

The safe@home model of care was led by nurses as the primary coordinators of service admission, assessment, monitoring, escalation and patient education. Its design centred on patient-led observation upload, nurse-led review, and nurse initiated interdisciplinary collaboration and escalation. Development occurred within an ecosystem not designed for telehealth, requiring iterative redesign to address digital limitations, governance constraints, and variable patient digital literacy. Furthermore, referral pathways were restricted by research protocols, resulting in inconsistent demand and heightened challenges in clinician engagement with a nurse-led telehealth approach. The model evolved through adaptive nursing workflows and ongoing refinement. As a nurse-led initiative, one significant challenge was around obtaining modifications to patient usual observation parameters. Despite the challenges, iterative adaptation supported service improvement. Early findings indicate benefits in hospital avoidance, strong therapeutic nurse-patient relationships, and enhanced patient self-management capabilities.

This experience highlights the central role of nursing leadership in designing adaptable telehealth models of care and provides practical insights into the complexities of implementing nurse-led RPM services within health systems.

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Investigating the relationship between nurses' work-life balance and their knowledge and attitudes toward artificial intelligence in hospitals affiliated with Behbahan University of Medical Sciences, Iran.

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Background and aim
Nurses are more exposed than many other occupational groups to disruptions in their work-life balance. The achievements of artificial intelligence (AI) can reduce nurses' workload and improve the quality of care. Therefore, the present study aims to examine the relationship between nurses' work-life balance and their level of knowledge and attitudes toward AI.

Methods
This descriptive-analytical study was conducted with the participation of 219 nurses working in hospitals affiliated with Behbahan University of Medical Sciences. Cluster sampling was used, and data were collected using a demographic information questionnaire, Wong's Work-Life Balance Scale, and the Hamedani Knowledge and Attitude Toward AI Scale. Data were analyzed using SPSS version 23, employing descriptive statistics and Pearson correlation tests. A significance level of 0.05 was considered.

Results
The average age of participants was 36.28 years, with an average work experience of 11.79 years and an average of 1.49 children. The mean score for work-life balance was 79.01. The mean scores for knowledge and attitude toward AI were 8.86 and 30.76, respectively. Pearson correlation results showed a significant relationship between nurses' work-life balance and their knowledge ($r = 0.224$, $p = 0.049$) and attitude ($r = 0.758$, $p = 0.031$) toward artificial intelligence.

Conclusion
Based on the results of this study, greater knowledge and positive attitudes toward AI are associated with a better work-life balance among nurses. Familiarity with emerging technologies may reduce workload and enhance professional well-being. Targeted AI education could serve as an effective strategy to support nurses' mental health.

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Virtual Emergency Departments and Domestic Violence: a new frontier for healthcare

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Emergency Departments (EDs) are critical components of the healthcare system, providing immediate care for acute conditions, injuries, and trauma. Individuals who experience domestic violence (DV) face barriers accessing care in traditional EDs. These include fear of retaliation from an abuser, shame, isolation, and logistical challenges. Virtual Emergency Departments have emerged as potential solutions to these challenges. Providing emergency care through telehealth offers an innovative way to meet the needs of patients who may otherwise hesitate or be unable to seek help.

This presentation explores the intersection of Virtual EDs and DV, examining the potential benefits and challenges of using telemedicine to support survivors, as well as the ethical, legal, and clinical considerations. Specific cases will be discussed. By focusing on this emerging field, we seek to highlight how Virtual services could enhance the way DV survivors access care and the broader implications for healthcare delivery.

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Establishing government-led telemedicine services in Indonesia: lessons learned

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Background
With the implementation of the National Strategy of e-Health in 2017, the Indonesia Ministry of Health (MOH) launched the telemedicine platform “TEMENIN” to facilitate telemedicine activities including teleconsultation, teleradiology, tele-ECG, and tele-USG. In 2022, this platform was replaced by the KOMEN platform which enabled structured teleconsultation involving registered healthcare facilities. This study aims to examine the lessons learned from a government-led national telemedicine journey in Indonesia.

Methods
Secondary data of aggregated indicators published at the KOMEN dashboard from January 2018 to April 2026 were analysed, complemented by a descriptive review of literature.

Results
The telemedicine utility shows a steady growth in use from 268 consultations in 2018 to 16,977 in 2025. A significant increase in telemedicine uptake was observed pre-COVID up to 253 consultations/month and post COVID up to 2357 consultations/month. As of April 2026, 2,491 healthcare facilities are using the KOMEN platform (501 hospitals, 1654 primary healthcare centres (PHCs), 42 private clinics and 294 auxiliary PHCs). In total 40,287 patients have been consulted via telemedicine, of whom 55% were males, 75% consultations were financed by national insurance, while 24% were out-of-pocket. Teleconsultations have been used for a wide range of health problems from cardiovascular to broader acute and chronic diseases including acute respiratory infections, diabetes and gastrointestinal.

Discussion
The findings indicate the steady growth of telemedicine activities within Indonesia’s health system. MOH Indonesia reported telemedicine services provide better access to specialists’ advice and reduced physical referral from rural healthcare facilities. Nonetheless, quantitative evidence remains limited. The adoption of the KOMEN platform varies across facilities. The availability of digital infrastructure, organisational readiness, financing mechanism and workforce capacity have been the main challenges.

Conclusion
Similar to many experiences around the world, Indonesia’s experience in telemedicine use shows positive impact on the access of health services. However, challenges cannot be overlooked.

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myChildHealth TeleHealth Clinic

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New Service with Pilot April 2024. Part of the clinical support team for the Child Health Service (CHS). Is a child health nurse (CHN) telehealth clinic that offers parent/caregivers the opportunity to have a brief consultation, in partnership with the family using a strengths based approach. Small team consisting of Registered Nurses with a Clinical Nurse Consultant and Nurse Manager overseeing. Nurse led but requiring admin support.

Opportunities
Promote early engagement and opportunity to build relationships and connection to the CHS. CHN can explain the purpose of any future local CHS appointments. Able to respond to any general information that can support parenting e.g. development, feeding, immunisations and safe sleep. Identify risk factors that may impact parenting e.g. perinatal mental health. Advise of evidenced based resources to support parenting, complete referrals (GP) if needed. Respond to emergent issues that require immediate response e.g. Child Safety concerns. Clinic was business as usual by August 2024. Occasions of services range from 150-200 per month.

Lessons learnt
Preparation when internet is down, flexibility to use phone if telehealth not suitable for family, need to educate the wider service on the role, use of Interpreters in telehealth, training admin and continuing this, escalation process for CHNs, targeted appointments (for Breastfeeding) not utilised. Support quality clinical practice by development of a reflective tool suitable for Telehealth-PORT (Peer, Observation, Reflection, Tool), completed monthly.

Evaluation report
Telehealth has increased engagement to CHS, families are seen earlier by the CHS. Future thinking; Expansion of service to include case management of families, Antenatal contact.

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Bridging Distance Differently: Telerehabilitation Models of Care for Spinal Cord Injury in Low- and Middle-Income Countries

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Rehabilitation is essential for people living with spinal cord injury (SCI) as it helps maximise wellbeing and quality of life and reduces secondary complications such as pressure ulcers. However, health system inequities in low- and middle-income countries (LMICs) mean that many do not receive the rehabilitation they need to live well and participate meaningfully in their local communities. Telerehabilitation offers a potential way to overcome barriers created by geography, workforce shortages and weak health systems. Yet, what works in high income countries does not necessarily translate well to low-resource settings, and optimal models of care may differ across these contexts. Understanding the range of telerehabilitation models for SCI for LMICs could help researchers and service providers design health services that best meet local needs.

Aim
To conduct a scoping review to identify (a) models of care, (b) outcome measures, (c) factors affecting acceptability and feasibility, and (d) reported outcomes of telerehabilitation for people with SCI in LMICs.

Methods
This scoping review followed the Joanna Briggs Institute methodology. Searches were conducted in PubMed, CINAHL, and Scopus. Inclusion criteria were (a) studies or protocols published in English that focused on (b) people with SCI living in LMICs and/or their healthcare providers, and (c) rehabilitation delivered via technology over a distance.

Results
Telerehabilitation models were diverse, utilising both specialised and everyday technologies and involving various rehabilitation partners including rehabilitation specialists, people with SCI, family members, and local health workers. Although approaches using low-cost technologies were generally feasible and acceptable, deep-rooted challenges such as poverty, education, and workforce development undermined some implementation efforts.

Conclusion
Diverse telerehabilitation options exist for SCI in LMICs. Yet, careful attention to the needs of the local context is essential to ensure that telerehabilitation effectively bridges existing health inequities.

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Integrated Nurse Practitioner and Pharmacist Cardiology Telehealth for Underserved Communities.

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Background and service gap: Post-discharge care following acute coronary syndrome (ACS) or heart failure (HF) admissions has progressed, with major city centres providing cardiac rehabilitation, and dedicated HF services that support safe transition to community care and improved outcomes. In contrast, rural and remote regions continue to face limited access to cardiovascular services, structured recovery programs, and general practitioner (GP) support. To address this inequity, an integrated Nurse Practitioner (NP)–Pharmacist cardiology telehealth service was established for patients with HF and complex cardiac follow-up needs.

Service model and delivery: Referrals were received from cardiology discharge summaries or directly from a cardiology outreach clinic within the Metro South Hospital and Health Service. Telehealth consultations focused on optimisation of HF guideline-directed medical therapy, symptom and pathology monitoring, cardiovascular risk reduction, and patient education within a shared-care framework.

Collaborative telehealth benefits and outcomes: A NP–Pharmacist model enabled parallel workflows, improving efficiency and responsiveness. While the NP conducted clinical assessment, the pharmacist performed medication reconciliation, resolved prescribing issues, coordinated supply, and provided counselling. Video-based consultations enabled direct visual confirmation of medicines, improving accuracy compared with telephone reviews and supporting deeper adherence discussions. The service delivered timely advice to GPs managing complex HF, with cardiologist input where needed, and clear management plans communicated to primary care. This supported earlier intervention, reduced outpatient failure-to-attend rates, and helped to mitigate unnecessary emergency department presentations.

Failures, limitations and lessons learnt: Telehealth suitability was not universal; older patients and those with limited digital literacy were often excluded, risking increased inequity. Telehealth infrastructure in rural settings was sometimes unreliable. Dependence on GP-facilitated telehealth created vulnerability, with cancellations occurring due to GP workforce shortages. These limitations highlight the need for hybrid care pathways, alternative access models independent of GP availability, and targeted digital support to ensure telehealth strengthens continuity of cardiac care.

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Utilisation of Telehealth for Mavacamten Monitoring to Reduce Cardiology Outpatient Burden

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Mavacamten therapy for obstructive hypertrophic cardiomyopathy is associated with a substantial monitoring burden, requiring intensive, protocol-driven follow-up. Patients require four-weekly cardiac monitoring for the first 12 weeks, followed by three-monthly monitoring until six months of stable therapy is reached. This includes regular clinical review, serial echocardiography, and timely medication dose adjustments. These requirements often necessitate frequent cardiologist outpatient department (OPD) visits, contributing to clinic congestion and limiting capacity for new cases. In addition, coordinating investigations, reviewing results within strict timeframes, and managing medication access further increases the workload for cardiology services.

To address this, we implemented a telehealth-enabled mavacamten monitoring service using a Nurse Practitioner (NP)–Pharmacist collaborative model. Following cardiologist initiation of therapy, patients are transitioned to structured telehealth reviews aligned with the required cardiac monitoring schedule. These consultations include symptom assessment, adherence support, safety monitoring, and evaluation of echocardiography results against prescribing thresholds. All medication changes are discussed with and authorised by the treating cardiologist, ensuring ongoing specialist oversight while reducing the need for routine in-person visits. The NP–pharmacist team also coordinates echocardiogram scheduling, tracks results, and facilitates medication supply.

This model has enabled routine monitoring and logistical coordination to be shifted away from cardiologist OPD clinics, reducing appointment demand and administrative burden. Telehealth reviews have been well accepted by patients, improving convenience and access while maintaining timely, protocol-adherent care. Key lessons learnt include the importance of clear governance frameworks, strong communication pathways with cardiologists, and robust systems to track echocardiography requirements. Careful patient selection and defined escalation processes remain critical to maintaining safety.

Overall, telehealth-enabled NP–pharmacist monitoring provides an effective strategy to reduce cardiology clinic burden while preserving high-quality, specialist-led care.

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Consumer needs and design preferences for video-based systemic anti-cancer treatment education

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Background/Aims
Patients commencing systemic anti-cancer treatment (SACT) are often given complex information at diagnosis, when understanding and recall may be limited by distress and cognitive overload. Existing resources are frequently generic and predominantly written, contributing to unmet information needs. Video-based information offers an opportunity to improve accessibility, understanding and person-centered care. This study aimed to understand patient and carer challenges with SACT education and identify needs and preferences for video-based resources.

Methods
A qualitative needs assessment, part of a broader participatory design project, was undertaken. Adults with a living experience of cancer or caregiving participated in focus groups or semi-structured interviews. Sessions were recorded, transcribed verbatim and analysed inductively using reflexive thematic analysis. Consolidated Criteria for Reporting Qualitative Research (COREQ) guided the reporting of results.

Results
Five focus groups and two individual interviews were conducted with 13 participants (7 patients; 6 caregivers): The majority of participants were female (n=10) and aged between 51–75 (n=7). Four were living with cancer and three had completed treatment; two were current caregivers and four past caregivers. Three participants had a first language other than English and eight were from regional/remote areas. Five themes were identified: (1) Access and delivery: flexible formats needed to accommodate digital and geographic barriers; (2) Comprehension and inclusivity: plain language, reduced jargon, and cultural/linguistic sensitivity; (3) Timing: staged, modular, on-hand education to manage overload at diagnosis and treatment start; (4) Shared understanding: caregiver/family access and shareability to support safety and reduce patient/caregiver burden; and (5) Trust and sustainability: credible, current and version controlled content.

Conclusion
Participants prioritised accessible, plain-language, modular SACT education that can be shared with support networks and updated as treatments change over time. These findings will guide the next participatory design stage, solution focused workshops, to develop video resources, and a pathway for delivery and testing.

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Exploring factors associated with safe recall of medication side effects

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Background
Accurate recall of medication side effects is a critical determinant of medication safety, yet little is known about the extent to which patients can readily report these details from brief telehealth settings.
AIM: Across two studies, we aim to explore factors that are associated with higher memory accuracy for medication side effects, including side effect likelihood and age.

Methods
We analyzed data from two Australian samples—156 adults aged 40-65 and 181 adults aged 18-44—both key user age-groups for telehealth. In Phase 1, participants listened to 12 individual recordings of a GP describing medication side effects drawn from one of four likelihood categories (with likelihoods ranging from very rare, occasional, may occur, to very likely). After a two-day delay, in Phase 2, participants were asked to report side effects from Phase 1 in a free recall test.

Results
We examined recall accuracy for each item and across participants, while accounting for the role of age, gender, and subjective health literacy (second sample only). Overall, items varied in how accurately they were recalled, which was not consistently explained by side effect likelihood. We also found that individuals differed in their memory accuracy, which was not explained by age, gender, or subjective health literacy. Participants also made intrusion errors—items that were not presented in Phase 1 but were recalled by participants during Phase 2—which we also explore.

Conclusion
These initial findings suggest that simply testing recall for presented side effects may not be sufficient for safety thresholds, where an understanding of intrusions may also contribute to a broader conceptualization of medication safety.

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Resolving Diagnostic Uncertainty in Suspected Encephalitis Through Telehealth Neurology Review

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This case illustrates the critical role of telehealth-enabled specialist review in supporting diagnostic uncertainty for complex neurological presentations in regional hospitals. An 88-year-old woman was admitted to Goulburn Valley Health with acute confusion, slurred speech, and headache. She remained an inpatient without clear diagnosis and minimal clinical improvement, initially managed as hypertensive encephalopathy. The geriatrics team questioned the working diagnosis, arranged a lumbar puncture, and referral to the newly commenced Royal Melbourne Hospital neurology virtual ward round (VWR) for an inpatient consultation.

Following virtual neurological assessment, a diagnosis of probable autoimmune encephalitis, most consistent with LGI-1 encephalitis, was made. This was based on the clinical syndrome, inflammatory cerebrospinal fluid findings, normal brain MRI, and associated hyponatraemia. Immunotherapy with intravenous methylprednisolone followed by oral prednisone was commenced promptly after the virtual review. The patient demonstrated marked clinical improvement, transitioning from florid confusion, paranoia, and severe agitation—previously requiring consideration of general anaesthesia for repeat MRI—to being oriented, conversational, and near her cognitive baseline. She subsequently tolerated MRI without sedation and achieved a Mini-Mental State Examination score of 25/30, having previously been unable to participate. Retrospective history revealed possible blackout episodes and unilateral hand tremor for several months prior, consistent with a prolonged prodromal phase of autoimmune encephalitis.

From the patient’s perspective, the VWR was pivotal in ending a period of diagnostic uncertainty and enabling timely, effective treatment without tertiary transfer, allowing her to remain close to home. From a health service perspective, this case demonstrates the value of virtual specialty input in overcoming diagnostic delays, optimising investigation pathways, avoiding tertiary transfer and expediting appropriate therapy in regional settings. Follow-up will continue via telehealth through a tertiary neuroimmunology clinic, reinforcing the role of virtual care to provide equity of access to regional patients across the diagnostic and longitudinal management continuum.

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Supporting Non-Clinical Referrers in Virtual Urgent Care: Lessons From a Statewide Disability Pathway

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The South Australian Virtual Care Service (SAVCS) established a direct referral pathway for people living with disability in December 2022 to improve access to virtual urgent care. The aim was to deliver the right care in the right location through virtual clinical assessment, care navigation, and escalation support, while complementing existing primary care and emergency care services.

While the pathway was modelled on a referral process used by Residential Aged Care (RACH) nurses, referrals from disability support workers differ because they are not clinically trained. A co-design workshop was conducted with consumers and their families, disability service providers, and other stakeholders to review the RACH process and consider what would need to change for it to work in the disability support setting. A key need identified was a decision support tool to help differentiate care needs - whether ambulance response, the virtual service, or the person's primary care provider.
It was also important for organisations to understand the utility and limitations of the virtual care service. Therefore, onboarding was intentionally developed as a collaborative and adaptive process, with tailored education and some customisation becoming central to implementation. Engagement focused on understanding and reducing technological and workflow barriers for disability support workers, while ensuring alignment with existing processes.

Since establishment, more than 30 disability providers have been onboarded and now regularly and appropriately access the virtual care service. Referral volumes have steadily increased to more than 10 per day. Consumer experience measures for both referrers and consumers remain strong, with Net Promoter Scores consistently above 80, and over 75% of consumers managed without requiring emergency department presentation.
This presentation will explore lessons learned in supporting non-clinical referrers within virtual urgent care environments, highlighting how adaptive onboarding, capability development, and simplified implementation processes have supported safe integration within disability services.

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Your Home Gets You: Building the Care Economy's Invisible Infrastructure with Predictive IoT

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Australia’s aged care system is transitioning from a reactive crisis-management model to a proactive, person-centered approach under the Support at Home (SAH) program. Central to this shift is the "care economy" concept—an interconnected ecosystem where health data flows seamlessly to support independent living, delay residential care admission, and optimize workforce capacity. This case study presents the Australian adaptation of Archangel.cloud, a proven UK middleware platform serving as the "invisible infrastructure" for this care economy.

Unlike siloed telecare devices, Archangel.cloud is a universal Health OS that aggregates data from diverse IoT sensors, connected medical devices (e.g., blood pressure, blood sugar monitors), and third-party systems. By establishing individual behavioral baselines, its predictive AI detects subtle deviations—such as increased nocturnal bathroom visits or slowing gait—2 to 48 hours before critical events like falls or acute infections occur.

We present validated outcomes from UK deployments across 20,000+ individuals, which achieved a 4.4:1 return on investment, a 40-60% reduction in emergency interventions, and prevented costly hospital admissions. In Inverclyde Council, the platform enabled a system-wide transformation, keeping vulnerable elderly safe while reducing unnecessary welfare checks by 50%.

As we replicate this model in Australia, we emphasize its alignment with clinical governance and the SAH framework. By integrating seamlessly with existing clinical software, NDIS platforms, and telehealth providers, the system empowers care teams with actionable, objective insights rather than relying solely on subjective reporting. This presentation will detail the operational realities, risks, and lessons learned from deploying a data-led, proactive strategy that safeguards dignity and independence while delivering scalable, board-ready efficiencies across the broader healthcare ecosystem.

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Economic and workforce benefits of a telehealth training and telementoring program for Northern Australia

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Aim
The University of Queensland's Centre for Online Health partnered with the Cooperative Research Centre for Developing Northern Australia to strengthen telehealth capability and mental health service delivery across Northern Australia. This three-year initiative aimed to build workforce capacity, reduce professional isolation, and improve access to care closer to home through digitally enabled education and telementoring.

Methods
We conducted a retrospective review of the telementoring and training program which included service metrics, participant feedback, and potential cost savings related to alternative forms of education delivery.

Results
From Jan 2023-Dec 2025, two accredited Project ECHO® programs were implemented: Telehealth Skills ECHO and Health eMinds ECHO. Over the project period, 25 Telehealth Skills ECHO sessions (916 participants) and 22 Health eMinds ECHO sessions (615 participants) were delivered, attracting more than 1,500 attendances overall. An additional nine telehealth training workshops engaged 69 participants across Queensland, Western Australia and the Northern Territory. Fifty-three partner organisations were involved in the program.

Evaluation findings demonstrate strong impact. More than 85% of survey respondents reported improved knowledge and skills in telehealth or mental health practice, and 68% reported reduced professional isolation. Workshop participants reported very high satisfaction (mean 5.2/6), highlighting the relevance and practical value of the training.

An economic analysis compared the cost of delivering education online with equivalent in-person delivery in Brisbane. Estimated savings from the ECHO programs ranged from $3.6 million to $12.9 million, depending on travel assumptions. Telehealth workshop delivery generated a further estimated $335,000 in avoided travel-related costs.

Conclusion
Telementoring health professionals in urban, regional and remote locations is a valuable way of creating a community of practice, and ensuring shared learning can take place between specialist service providers and health workers in primary care settings. Strategies to reduce professional isolation are important for maintaining a sustainable health workforce.

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A Simplified Workflow for Multi-Institutional Live Endoscopy Transmission Using Zoom Breakout Rooms

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Aim
Live endoscopy demonstrations are widely used educational methods in international medical congresses. Conventional multi-institutional live transmission generally requires separate video conferencing sessions for each site, resulting in complicated system settings, repeated reconnections, and risk of connection errors. This study evaluated the feasibility and operational advantages of a centralized workflow using a single Zoom meeting with breakout rooms for multi-institutional live endoscopy transmission.

Methods
During an international endoscopy congress, live endoscopy procedures from three Asian medical institutions were transmitted in full high-definition quality (1920 × 1080 pixels). A single Zoom meeting was used to receive audiovisual feeds from all institutions, and three breakout rooms were created, with one assigned to each institution. The Zoom feed was routed to a browser-based live-streaming platform for online participants and displayed at the onsite venue. Remote moderators were moved between breakout rooms by host operation without reconnecting to separate meetings. Transmission bitrate and questionnaire-based evaluations were assessed.

Results
Simultaneous live endoscopy transmission from three institutions was successfully managed within a single Zoom meeting using breakout rooms. Unified system settings were applied across all institutions, and moderators could move between institutions through breakout room transfers without reconnecting, reducing operational complexity and risk of connection errors. Stable full high-definition transmission was achieved with an average bitrate of 4620 kbps and a maximum of 6548 kbps. More than 90% of participants rated audiovisual quality as good or very good, and over 80% rated the educational experience positively.

Conclusion
A single-meeting Zoom breakout-room workflow successfully enabled stable multi-institution live endoscopy transmission while simplifying operational management and minimizing reconnection-related errors. This is the first report to manage simultaneous multi-institutional live endoscopy transmission within a single Zoom meeting using breakout rooms. This novel approach may be useful for future large-scale hybrid medical congresses and remote medical education programs.

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Trust in AI-Enabled Digital Healthcare for Cardiovascular-Kidney-Metabolic Self-Management: A Systematic Review

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Background
Consumer-facing artificial intelligence (AI) digital health tools are rapidly emerging in Cardiovascular-Kidney-Metabolic (CKM) self-management. However, understanding consumers' trust in these tools, a key precursor of uptake, remains limited.

Methods
We conducted a systematic review of trust-related outcomes in consumer-facing AI-supported digital health tools for CKM self-management. Searches were conducted across seven databases (up to February 2026) following PRISMA guidelines. Data were extracted on AI functions; trust measurement, facilitators and barriers; and downstream outcomes, which were synthesised thematically.

Results
From 3,158 records, 26 studies across 13 countries were included, involving used AI-supported tools (n=14, 53.8%), prototypes (n=3, 11.5%), or hypothetical/scenario-based tools (n=9, 34.6%). Interventions predominantly featured conversational or coaching AI (n=14) or health data–driven analytics AI which provided alerts and recommendations (n=3). Trust was rarely measured using validated, AI-specific instruments, relying instead on indirect proxies (n=18, 69.2%). Six themes were identified as influencing trust: personal relevance and self-management fit, perceived clinical reliability, task-specific autonomy boundaries, explanations and information sources, healthcare authority and oversight, and data privacy and governance. Downstream implications of trust mainly focused on attitudes and behavioural intentions, lacking evidence for sustained CKM health outcomes and cost.

Conclusion
Consumer trust in AI-supported CKM self-management is multidimensional, shaped by personal relevance, clinical risk, role boundaries, healthcare assurance, transparency, and data governance. Balancing the consumer-provider-AI relationship is crucial to support patient trust and safety without increasing clinical workload.

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Virtual geriatric in-reach across rural residential aged care: partnering nurse practitioners with remote geriatricians and aged psychiatrists

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Aim
To address specialist workforce shortages in rural residential aged care by combining on-site nurse practitioner (NP) assessment with remote geriatrician and aged psychiatrist consultation, with the goal of proactive frailty management and reduced avoidable hospitalisation.

Methods
The model was piloted at Barrabill House and expanded across Seymour, Yea, and Nagambie through the Hume Health Service Partnership. NPs (or local GPs) conducted on-site assessments. Telecare geriatricians and aged psychiatrists joined via secure video, having access to records and investigations prior. Residents, families and local staff participated together. Care plans were documented and disseminated immediately via the Telecare platform.

Results
Approximately 110 consultations were delivered across multiple Hume facilities in the first 11 months. Clinicians estimate that the service prevented deterioration or avoided hospital admission for at least 10 residents in that period. In some facilities, 100% annual geriatric review has been achieved — previously unattainable due to workforce constraints. Staff and family acceptability has been high.

What we learned (successes and failures)
Successes: NPs were excellent ‘eyes and hands’ on-site, and the partnership preserved their clinical leadership rather than displacing it.
Failures and limitations: digital literacy was uneven across facilities; the avoided-admission count is a clinician estimate, not a controlled measure; model expansion was limited by NP or GP workforce.

Conclusion
A virtual specialist–on-site NP partnership can deliver structured geriatric review at a frequency that on-the-ground specialist visits cannot match.

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Virtual subspecialist inpatient support: co-designed access to subspecialties in regional Queensland

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Aim
To embed virtual subspecialist consultation capacity into the inpatient workflow of a regional referral hospital facing chronic subspecialist shortages, with a measurable impact on inpatient decision-making, length of stay, and inter-hospital transfers.

Methods
MHHS general medicine teams were given a structured referral pathway to request real-time subspecialist input across dermatology, hepatology, haematology, rheumatology, inflammatory bowel disease, endocrinology, neurology, and geriatrics. Requests were lodged through existing hospital pathways and allocated by Telecare to an appropriate subspecialist, typically returning a consultation within 24 hours. Registrars and junior doctors presented cases live to enable joint decision-making, continuity, and on-the-job learning.

Results
More than 120 inpatient subspecialty consultations have been delivered. Median turnaround under 24 hours. Positive indicators include inferred reduced length of stay (40% of patients discharged within 48 hours of a consult), fewer transfers to metropolitan tertiary hospitals, and qualitative reports of strengthened clinician confidence. Registrar feedback consistently highlights upskilling as a primary benefit.

What we learned (successes and failures). Successes: a single referral pathway rather than seven specialty-specific portals; reduced length of stay; capability building for local team.

Failures and constraints: requires significant coordination input to ensure smooth operations of the inpatient subspecialist model.

Conclusion
Embedding a virtual subspecialist consult service into an existing referral workflow can deliver rapid input across multiple disciplines without a local FTE, but uptake is not automatic — it is a behaviour change project as much as a workforce one.

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Virtual inpatient care as a foundation for rural hospital recovery: three years of lessons from a paper-hospital pilot to a multi-site Victorian model

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Aim
To describe the implementation, scaling, and ongoing operation of a virtual inpatient (admitting officer) model across multiple Victorian rural health services, with explicit reflection on what enabled and constrained replication beyond the original pilot site.

Methods
A virtual admitting officer model was piloted at NCN Health (Nathalia, Cobram, Numurkah; 32 acute beds total) from December 2022 in response to a 75% reduction in local GP VMO availability between 2017 and 2023. FRACP-qualified physicians conducted virtual ward rounds, admissions, discharges and after-hours on-call cover. Services were delivered into a paper-based hospital environment, prompting in-house development of a lightweight inpatient management platform (IPAU) to digitise charting, ordering and handover. The University of Melbourne Department of Rural Health led an independent mixed-methods evaluation. The model has subsequently been extended to additional Victorian rural health services and used to support reopening of a flood-affected hospital in 2025.

Results
Across initial 18 months: 831 on-call shifts, 2,951 consults, 49 ward rounds, with a transfer-to-admission ratio of 1:18. Independent University of Melbourne evaluation described the model as ‘safe, effective, scalable’. The model has since extended to low-risk drug-and-alcohol detox admissions, post-operative admissions, acute admissions for aged care patients, and HITH. A flood-affected hospital was successfully reopened with virtual inpatient cover as a structural enabler.

Successes
Stakeholder co-design from the outset; building software around the model; conservative inclusion criteria for the first six months.

Failures and constraints
Under-estimating onboarding burden for rural nursing teams.

Conclusion
Virtual inpatient care can underwrite the survival of rural acute services where on-the-ground workforce has collapsed, but only with disciplined patient selection, locally-codesigned digital tooling and models of care. The model is replicable; it is not effortless.

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Bridging the dermatology care gap: a fully virtual specialist model in a region with no resident dermatologist

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Aim
To establish a sustainable virtual dermatology model in a region with no resident dermatologist, replacing inter-hospital transfer to centres approximately 400km distant as the only access pathway.

Methods
Mackay Hospital and Health Service (MHHS) and Telecare co-designed a three-component model: (1) virtual triage of referrals by a remote dermatologist; (2) virtual outpatient consultations facilitated by local junior doctors operating as in-room clinical proxies; and (3) virtual inpatient dermatology support. Standardised photography protocols, secure imaging review, governance pathways and escalation criteria were defined collaboratively. The service was the sole dermatology pathway within MHHS at go-live.

Results
Between May 2024 and June 2025, long-wait patients fell by 89% (168 to 19), new referrals reduced by 77% (202 to 47), and review consultations increased by 25% (99 to 124) — a pattern consistent with successfully working through historical backlog while sustaining capacity for ongoing care. Junior doctor feedback was strongly positive regarding learning opportunity. The service is fully virtual and the dermatologist has not visited Mackay in person.

What we learned (successes and failures)
Successes: longer consult slots gave room for image review, education and dictated clinical letters; local junior doctor presence preserved the value of physical examination and good clinical photography. Failures and limitations: dependence on local junior doctor availability; patients with surgical lesions still required onward referral.

Conclusion
A fully virtual dermatology service can become the principal pathway for a region without a resident specialist, but the design must include the local clinician as an integral part of the model, not as optional support.

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GEM-R HITH: embedding a virtual geriatrician in a Hospital-in-the-Home model where no local specialist exists

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Aim
To evaluate the implementation of a Geriatric Evaluation and Management Hospital-in-the-Home model (GEM-R HITH) supported by a remote geriatrician, in a regional Queensland catchment with no resident public geriatrician despite a population of approximately 180,000.

Methods
From February 2025, eligible patients were admitted under the SMO bed card and received care at home from local HITH nursing and allied health teams, with virtual geriatrician review and case conferences delivered via secure video. Pre-visit MRI/CT and cognitive screening were completed where required. Medical registrars participated in consultations as a deliberate teaching strategy. Shared clinical records and standardised referral pathways were used. Case conferences supplemented individual reviews.

Results
Across the first months: 215 home visits, 41 virtual geriatric consultations, more than 20 MDT case conferences, and approximately 644 inpatient bed-days freed. Staff capability self-rating: over 80% reported increased capability. Patient feedback: 86% of patients indicated they would not otherwise have accessed specialist geriatric input at home. A representative case (80-year-old woman with arm fractures) was discharged on day 2 with combined nursing, allied health and virtual geriatrician input, enabling her daughter to return to work and avoiding inpatient deconditioning.

What we learned (successes and failures)
Successes: the SMO bed card pathway resolved governance ambiguity from day one; in-home video review combined with nurse facilitation was more effective than either alone. Failures and limitations: the model depends on a functional local HITH service, and is not suitable for catchments without that foundation.

Conclusion
GEM-R HITH demonstrates that specialist geriatric care can be safely decentralised into the home, expanding hospital capacity while improving patient experience and registrar training — provided the underlying HITH chassis already exists. It is a layer on top of an existing service, not a replacement for one.

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Culturally safe paediatric care for Aboriginal communities: a co-designed virtual specialist model with Armajun Aboriginal Health Service

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Aim
To co-design and deliver a culturally safe, community-led virtual paediatric model that improves access, continuity, and cultural appropriateness of care for Aboriginal children in rural northern NSW, where only 20 of 167 NSW paediatricians work outside metropolitan Sydney.

Methods
A 12-month co-design process was undertaken with Aboriginal Health Workers (AHWs), Armajun AHS senior clinicians, and Telecare. The model established weekly virtual paediatric clinics and facilitated on-site by AHS teams acting as cultural brokers. Infrastructure included a secure booking platform, culturally trained administrative coordination, and integration into existing AHS primary care workflows. A dedicated Senior Medical Officer oversees the program across Inverell, Armidale, Tenterfield and Glen Innes hubs.

Results
Since launch in November 2024, more than 150 paediatric consultations have been delivered in 6 months. Post-April 2025, monthly consultation volumes are approximately 50% higher than pre-April levels and have sustained. Activity is concentrated across two main hubs — Armidale (45%) and Inverell (43%). Reported benefits include reduced patient travel (some families previously travelled five to seven hours), improved access to developmental and behavioural assessments, and high family acceptability.

Successes
AHWs and the broader AHS as cultural brokers was an important enabler; community-led design from month one (not a clinical model retrofitted with consultation) produced something families trusted.

Failures and limitations
Lack of “corridor consults” or “tea-room consults” as an avenue for local staff upskilling; use of a non-local phone number caused significant numbers of families to not respond to calls.

Conclusion
Co-designed, AHW-facilitated virtual specialist care can meaningfully address paediatric access inequity for Aboriginal communities.

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Determinants of Digital Health Maturity in Low- and Middle-Income Countries: Scoping Review

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Introduction
Digital health maturity refers to the extent to which a healthcare system effectively adopts, integrates, and utilizes modern digital technologies to achieve better health outcomes.

Aim
This scoping review synthesizes evidence on the determinants of digital health maturity in low- and middle-income countries.

Methods
A systematic search of PubMed, CINAHL, Embase, and Cochrane Library identified relevant peer-reviewed records published from 2016 to 2026. Screening was conducted in two stages using the Covidence platform by three reviewers. Grey literature and hand-searched study findings were included where appropriate. Thematic analysis was employed to synthesis the findings

Results
The study identified a total of 2,345 records following removal of 1,181 duplicates. Subsequently, 256 full-text articles were reviewed in detail, of which 43 studies were included in the study. Among these, 76.7% (n=33) discussed infrastructure, 53.5% (n=23) emphasized workforce capacity, and 60.5% (n=26) highlighted governance and policy, while 46.5% (n=20) and 39.5% (n=19) discussed sustainable financing and interoperability as the primary drivers of digital health maturity. Further, 18.6%(n=8) discussed institutional readiness and scalability, and 14.0% (n=6), described contextual factors. Only 11.6% (n=5) discussed trust and security, while 7.0% (n=3) and 4.7% (n=2) described progress evaluation and user acceptance, respectively.

Previous reviews indicate that research on determinants of digital health in high-income countries has primarily focused on areas such as interoperability, artificial intelligence, cybersecurity, and equity. In contrast, the findings of our review suggest that lower-income countries place greater emphasis on factors including infrastructure, governance and policy, workforce capabilities, and financing mechanisms.

Conclusion
The study recognized digital health maturity is complex and multifaceted. The advancement of digital health maturity is shaped by a complex interplay of institutional, structural, technological, and socio-cultural determinants. Therefore, coordinated strategic approaches are mandatory to achieve expected healthcare digital transformation along the continuum of digital health maturity through all-inclusive regulatory frameworks.

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