



Clinical Leaders *Forum*

27-28 April 2026 | MEANJIN/BRISBANE

Summary Report

Acknowledgement

We acknowledge and wholly support all Traditional Owners for their continuing connection to this country and their communities. We recognise their continuing connection to these lands and waters and thank them for protecting this country and its ecosystems since time immemorial. We pay respect to them and to their Elders past, present and emerging.

This report highlights key presentations and discussions from the Queensland Aboriginal and Islander Health Council's (QAIHC) Clinical Leaders Forum of 2026. The well-attended forum was held at QAIHC in South Brisbane on 27-28 April 2026. Welcome to Country was delivered by Tribal Experiences.



DAY 1 – Monday 27 April 2026

QAIHCs Public Health Medical Director, A/Prof Sophia Couzos, opened the forum on behalf of the QAIHC Acting Chief Executive Officer, Ms Paula Arnol. Dr Georgia Haines, QAIHC Public Health Registrar, acted as Facilitator for the forum.



The forum was also delivered in webinar format to participants unable to attend in person in Brisbane. This was the first time that QAIHC has been able to host this forum as a webinar.

Dr Erin Waters, Clinical Director of the Institute for Urban Indigenous Health – **‘Staying professional yarn’**

Erin spoke about the role of the Australian Health Practitioner Regulation Agency (Ahpra) and the Office of the Health Ombudsman (OHO). She referred to the 153,000 medical practitioners in Australia, saying the workforce is growing, but not fast enough. About 1.3% of practitioners across all health disciplines identify as Aboriginal and/or Torres Strait Islander (figure below).



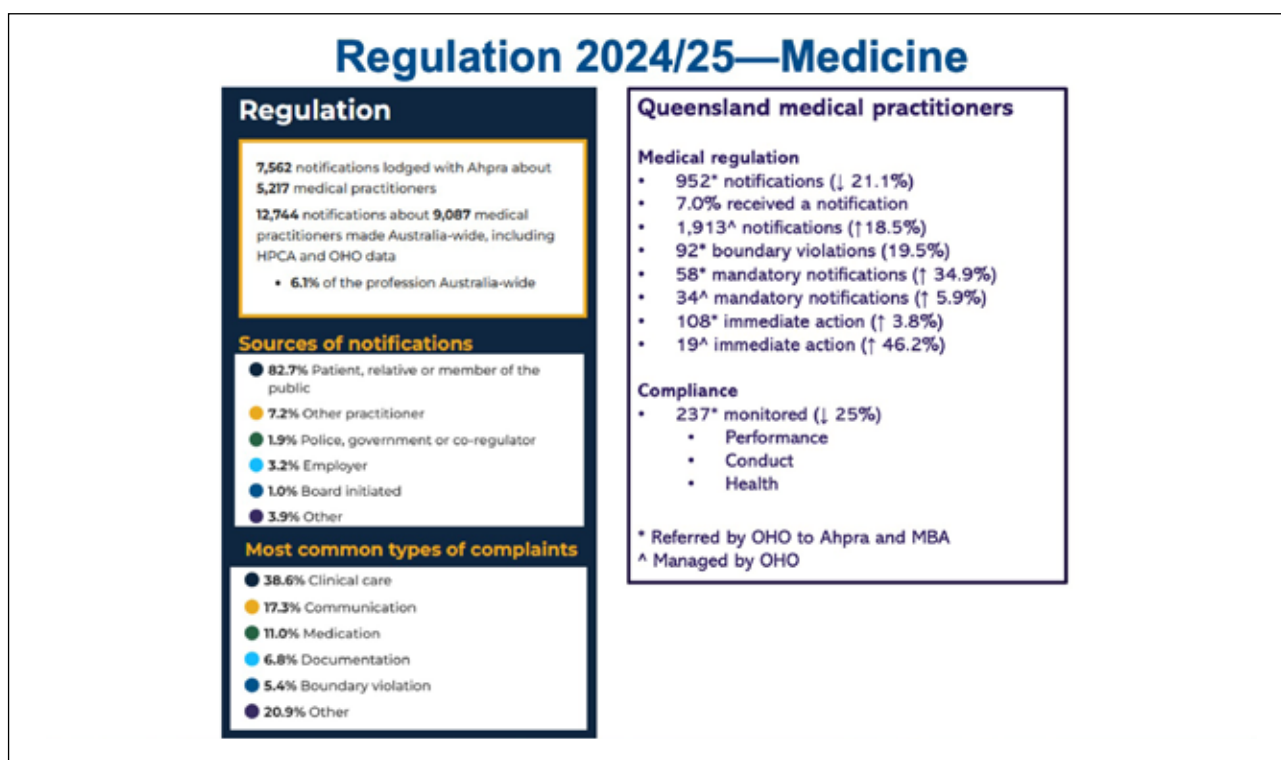
Practitioners who Identify as Aboriginal and/or Torres Strait Islander

Profession	ACT	NSW	NT	QLD	SA	TAS	VIC	WA	No PPP	Total	%
Aboriginal and Torres Strait Islander Health Practitioner	0	296	193	190	107	6	53	189	5	1,039	100.0%
Chinese Medicine Practitioner	0	9	1	12	1	0	2	1	1	27	0.5%
Chiropractor	0	15	0	14	1	1	10	6	0	47	0.7%
Dental Practitioner	3	51	4	53	14	3	18	12	2	160	0.5%
Medical Practitioner	12	389	43	237	45	27	126	90	4	973	0.6%
Medical Radiation Practitioner	9	67	5	31	9	5	15	5	0	146	0.7%
Midwife	12	78	8	93	18	2	16	14	0	241	2.6%
Nurse	74	2,643	149	2,412	397	381	843	597	69	7,545	1.5%
Nurse and Midwife	5	144	9	105	19	16	61	34	1	394	1.5%
Occupational Therapist	4	103	6	93	9	4	26	20	0	265	0.7%
Optometrist	2	4	1	3	2	1	1	0	0	14	0.2%
Osteopath	0	7	0	7	0	0	12	0	0	26	0.7%
Paramedicine	8	242	10	209	26	25	77	39	3	639	2.3%
Pharmacist	5	45	2	44	6	12	9	13	0	136	0.3%
Physiotherapist	2	148	9	91	22	12	39	20	6	349	0.7%
Podiatrist	0	23	0	9	3	1	11	4	0	51	0.8%
Psychologist	6	179	11	151	18	16	66	40	0	487	0.9%
Total	142	4,443	451	3,754	697	492	1,385	1,084	91	12,539	1.3%
% of all Registrants	0.8%	1.7%	4.9%	1.9%	1.0%	2.3%	0.5%	1.1%	0.2%	1.3%	

Ahpra has done great work on cultural safety and the Medical Board firmly believes that clinical safety only comes after cultural safety.

The new version of [Good Medical Practice: Professionalism, Ethics and Law](#) (5th edition) was released in March 2026. The Medical Board is guided by this when considering notifications

against medical practitioners. There were approximately 1000 notifications about medical practitioners in 2024-5. (Figure below).



Importantly, Erin referred to the *Expedited Specialist Pathway* to speed up access to an internationally trained workforce in Australia. This workforce includes nurses, GPs, obstetrics and gynaecology, general physicians and others. Most are expedited from the UK.

A small group discussion was held to discuss the challenge of treating colleagues within ACCHOs. The Medical Board code of conduct states that: *“Doctors should avoid treating colleagues and staff due to risks regarding objectivity, professional boundaries, and confidentiality. When treatment is necessary—primarily in emergencies **or isolated settings**—it must be treated as a formal, documented consultation with proper privacy protections, rather than ‘corridor consultations.’”*

Ms Samantha Townsend, QAIHC Communications Manager – QAIHC/RACP ACCHO Sector Orientation Learning Resource

Samantha Townsend referred participants to this new resource developed by QAIHC with the support of the RACP. The Learning Resource has been endorsed by the QAIHC Board of Directors after approval from the Governance Subcommittee for the Resource. The Learning Resource will have a public launch later in 2026 but is freely publicly accessible: acchosectororientation.com.au



Many clinicians entering ACCHOs lack understanding of the sector, as it is not covered in standard medical or clinical training. To address this, RACP and QAIHC developed a purpose built, free, online orientation resource for new clinical and allied health staff.

The program offers self-paced modules on ACCHO history, governance, funding and culture, supported by quizzes and original videos featuring interviews with ACCHO sector leaders and Elders, with strong governance oversight embedded throughout the project.

A formal Governance Committee provided strategic direction and cultural oversight throughout the project, meeting regularly to review content and guide key decisions. QAIHC led project management, with funding and partnership support from RACP, ensuring governance was embedded from the outset. Committee members included: Stevan Ober, Sheryl Lawton, Paula Arnol and Rachael Atkinson.

Content development focused on thematic modules, each with structured lessons and embedded video content:

- Module 1: History of the ACCHO Sector and the ACCHO Model of Care
- Module 2: Aboriginal and Torres Strait Islander Health Workers and Health Practitioners
- Module 3: Australian health system basics
- Module 4: Aboriginal Health Policy
- Module 5: Continuous Quality Improvement (CQI) and nKPIs for ACCHOs.

Voices that shaped the content

Les Collins AM
Founding Member
ATSICHS Brisbane

Dulcie Flower AM
Founding Member
AMS Redfern

Adrian Carson AM
Principal, Create Health
Former CEO, IUIH

Dr Mary Martin OAM
Founding Member
ATSICHS Brisbane

Their stories, knowledge and experience appear throughout the learning modules – in their own words.

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QAIHC

Dr Stephen Lambert and **Dr Olivia Williams**, Communicable Diseases Branch, Queensland Health — **Immunisation/vaccination update**



Dr Lambert introduced participants to the new FluMist™ vaccine available for children aged from 2 years to less than 6 years.* This live influenza virus grown in eggs is attenuated at lower temperatures meaning it does not grow in the lungs. Nasal swabs can pick up the FluMist™ virus up to 10 days after immunisation. *Since the forum, the QLD Government has expanded access to flu-mist vaccine to include children aged 6-17 years (inclusive) who struggle with getting a needle.

Childhood influenza vaccination (50%-60% coverage) can reduce general influenza virus transmission by 60%. FluMist™ has 50% efficacy. There is no evidence this virus reverts to wild-type new flu virus. The vaccine is not to be used in pregnancy, nor in immunocompromised people. It is not registered in people older than 50 years anywhere in the world. Adverse reactions are similar to injectable vaccine, except no injection site symptoms.

There was a brief discussion about LA Bicillin subcutaneous infusions (to reduce injection pain) with further investigations under way in Australia. Shingrix vaccine also appears to reduce the risk of new onset dementia by 20-30%, as well as death due to dementia. It is unclear why there are current diphtheria (cutaneous and respiratory) outbreaks in the NT and WA.

Mr Scott Brown, QAIHC Senior Manager Health Data and Analytics
QAIHC Health Information Team update



Mr Brown provided participants with a view of the nKPI performance reports for ACCHOs prepared by the QAIHC team. The completed reports will be circulated soon to provide a benchmark report against all ACCHOs that provide QAIHC access to their data. The MBS Optimisation Report is also due to be released to services in July.



Dr Sankalp Khanna, CSIRO National Digital Health Program — **Hospital risk stratification algorithm/report in PenCS tools**



The CSIRO have built a risk stratification tool for use in PHC settings. The tool initially aimed to assist with identifying patients at high risk of future hospitalisation over 12 months. The tool may also assist with PHC funding based on the burden of disease estimated from risk assessments. The dataset included demographics and disease groups, medications being prescribed and other chronic disease risk factors and was sourced from over 11,000 patients across Victorian general practices enrolled in the Health Care Home Trial. See Figure over page.

Primary Care brings its own unique set of challenges – The Health Care Homes experience

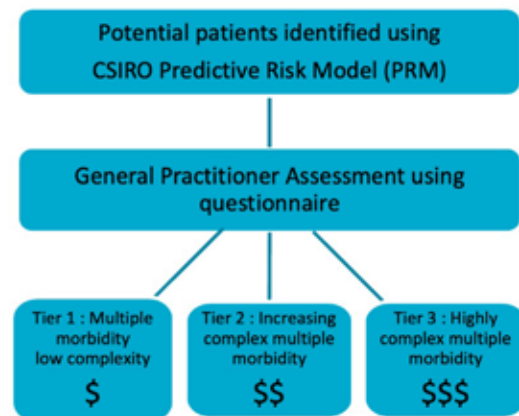
Recruit patients for the Australian Government Health Care Homes integrated care trial (Oct 2017 – Jun 2021)

Predictive Risk Model (PRM) developed by CSIRO

PRM identifies patients at high risk of **emergency admission or potentially preventable hospitalisation** within the next year

Identified patients invited for clinical assessment and assigned population tier based on complexity

11,334 patients enrolled across 165 GP practices



5 | Risk Stratification in Primary Care

The risk models were not applicable to remote locations, and Aboriginal and Torres Strait Islander populations. The social determinants of disease were not considered, nor were patient movement and previous hospitalisations recorded (yet this is the biggest predictor of future hospitalisation).

Dr Sankalp spoke about the algorithm subsequently developed, using different data sources. Its goal is to predict the probability of emergency admission or potentially preventable hospitalisation within one year, or urgent hospital admission within one year. The aim has been to build this algorithm into all medical record platforms to act as a data-driven clinical decision support system for healthcare providers. This is in the process of being released nationwide.

Anna Baccari & Elisabeth Cahill, Queensland Health RHD Clinical Nurse Consultants – RHD Program update

Anna presented an update on the Qld Rheumatic Heart Disease Program. This program supports the prevention, identification, treatment, and management of acute rheumatic fever (ARF) and RHD in Qld. There are 3874 active clients on the register (9 Feb 2026). 66% have established RHD. More than 80% of first cases of RHD are in First Nations people. The highest incidence of ARF are in 5-14 year olds. Of 1818 of the 3874 clients, 47% are recommended to receive secondary prophylaxis.


Unfortunately, the Qld ARF and RHD dashboard is only accessible to Qld health employees and not accessible to ACCHOs. However, the Register communicates information to the Viewer daily. All Qld health employees and other eligible healthcare providers can access the Viewer. When accessing the Viewer for patients, health staff were advised to use the 'care plan tab' to locate the patients care plans for RHD prevention and ECHO details.



Data from the Register can be requested so as to coordinate the care and follow-up of patients. To request data from the Register, services can contact ArfRhdRegister@health.Queensland.gov.au. ACCHOs can receive client summary reports (e.g., weekly/monthly) of any clients attending the service by reaching out to the registry.

An update was provided on the benzathine benzylpenicillin shortage. Shortages are expected to continue until November 2026. Lentocilin is an alternative product on the PBS. See Figure below.

BPG Shortage



- Pfizer's Bicillin L-A 600,000-unit prefilled syringe shortage is anticipated to continue until November 2026
- Bicillin L-A 1.2-million-unit prefilled syringe is available to order through wholesalers; supply disruptions are expected from May.
- Lentocilin S 1200 is an alternative BPG product, listed on the PBS.
- To order stock call the approval holder, **Neon Healthcare, on (02) 7255 8455.**

- Benzathine benzylpenicillin products should be prioritised for use in high-priority patient groups where oral therapy is not acceptable or the likelihood of non-adherence is high, including:
 - Treatment for Strep A infection in those at high risk of ARF or RHD
 - Treatment and Secondary prophylaxis of ARF and RHD

Queensland Health Rheumatic Heart Disease Program

A range of new resources were mentioned. These include:

Resources:

- [Queensland Health Resources](#)
- [Healthy Skin Handbook – English](#)
- [The Viewer](#)
- [Acute Rheumatic Fever and Rheumatic Heart Disease patient information](#)
- [Suspected Acute Rheumatic Fever Clinical Pathway](#)
- [Acute rheumatic fever \(ARF\) notification form for clinicians](#)
- [Rheumatic Heart Disease \(RHD\) notification form for clinicians](#)

Videos:

- [ARF and RHD in Queensland](#)
- [Think ARF](#)
- [BPG for ARF and RHD](#)
- [RHD and Pregnancy](#)
- [Queensland RHD Register](#)

Posters:

- [Preventing ARF](#)
- [ThinkAREF](#)
- [BPG for ARF and RHD](#)
- [RHD and Pregnancy](#)

Dr Ben Stute, Chief Dental Officer, QH — **Oral health update**

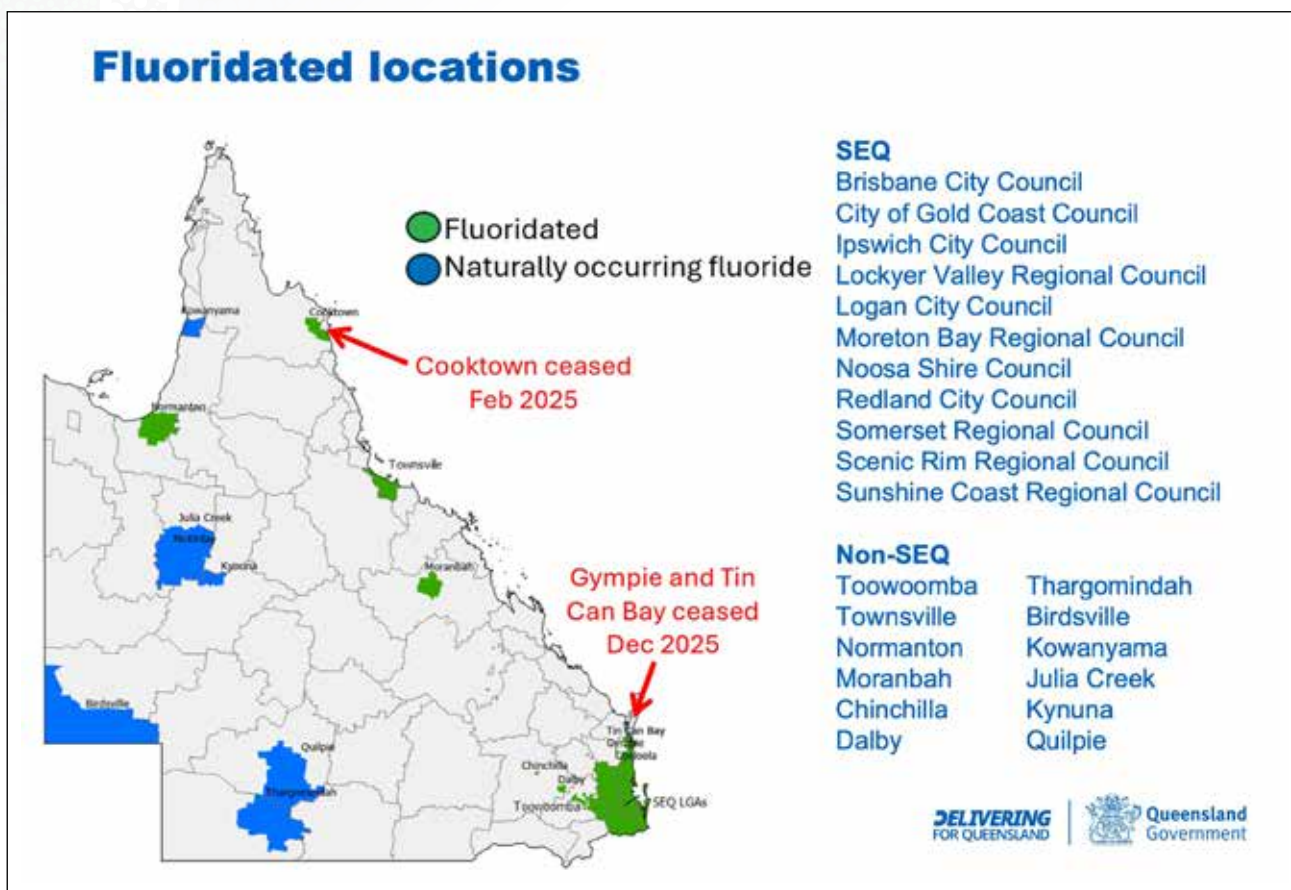


Queensland Health delivers public oral health services across the state through 15 Hospital and Health Services (HHSs), with performance monitored to support ongoing service improvements and targets to increase access for First Nations peoples.

Eligibility for free dental care includes adults holding a Pension Concession Card, Health Care Card, Commonwealth Seniors Card, or Queensland Seniors Card. All children from age 4 to Year 10 are eligible, along with those covered by the Child Dental Benefits Schedule and concession card holders.

Services are provided through community-based clinics, fixed school dental clinics, and mobile dental services. Some Aboriginal Community Controlled Health Organisations (ACCHOs), such as UIIH, also receive Queensland Health funding to deliver oral health services and may provide care supported by the Commonwealth Child Dental Benefits Schedule.

In 2013, the Queensland state government deferred water fluoridation (WF) decisions to local councils. There are now a significant number of geographic locations without naturally occurring or added fluoride. The grey areas in the figure below indicate geographical locations lacking fluoride water sources.



The variability in WF has supported a natural experiment to assess the impact of WF on oral health through the Qld Child Oral Health Study (University of Qld, Qld Health, and the Qld Department of Education). This study oversampled First Nations children (comprising 10% of children) out of a total of almost 8000 children 5-14 years of age who had a dental examination. Although the Report is yet to be released (likely June 2026), some findings were presented in terms of locations with no WF, new WF, and long-term WF.

The findings showed that 38.8% of children aged 5-10 years had at least one tooth decay experience with the primary teeth, a drop compared to previous numbers, primarily in areas with new WF. Almost 51% of children in regions without WF had untreated tooth decay. In summary, the study found that:

- First Nations children had a higher prevalence of decay experience than the general population, especially in primary teeth.
- First Nations children living in non-fluoridated areas had a higher decay experience and untreated decay than children living in other locations.

The presentation referred to QAIHCs engagement with Qld Health in the development of oral health resources for ACCHOs and support to understand the importance of water fluoridation in oral health. The establishment of a working group with QAIHC, OCDO and HHS oral health services has led to resources scoping exercises and the proposed development of resources on several oral health topics, including:

- Water fluoridation
- Use of fluoride varnish
- Maintaining oral health through life stages

QAIHC will continue to work with Qld Health to ensure that the ongoing failure to close the gap in dental check access for First Nations children is given more attention. Using the release of the child health study will be an important mechanism to argue for more oral health funding for ACCHOs from the State Government.

Dr Luke Wainwright, Mulungu Chief Dental Officer — Mulungu's experience of providing a dental service

Mulungu Aboriginal Corporation Primary Healthcare Service is located in Mareeba about one hour's drive from Cairns. In addition to the central clinic, services are also provided in Atherton, Kuranda, and elsewhere on the Tablelands through further outreach. Approximately 14.3% of the region's population is Aboriginal/Torres Strait Islander.



The dental service Luke described, commenced in July 2025 when Mareeba partnered with James Cook University (provided some funding) to host two final-year dental students. The focus of the service is to provide preventive dental care, chronic disease support, as well as the relief of pain and acute dental issues. A focus on child oral health has led to Deadly Smiles Celebration Days, first-visit confidence boosting, as well as a focus on early detection and prevention. The program has adopted a 5 by 5 focus, where Mulungu aims to enhance mums' oral health skills and ensure 5 child dental visits by 5 years of age. Opportunistic care is encouraged for siblings, and fluoride varnish is applied when possible.

Funding is sourced from the Commonwealth Child Dental Benefits Scheme (CDBS), although it doesn't pay for everything. In particular, MBS item 715 health checks are encouraged as a source of revenue (such as for periodontal exams), holistic exams, and treatment planning. The MBS item 715 helps to cross subsidise the dental service. Emergency care, including extractions and pain relief, is vital. Health Care Card holders attract no fees. Others pay \$20 per appointment. Dentures, crowns and bridge work attract their own fees as they include denture making machines that operate on-site.

The fact that Mulungu's earnings do not cover all the costs was emphasised. Funding is fragmented and there is no adult dental scheme. Moreover, the CDBS is not designed for the ACCHO model of care. This makes long-term planning challenging.

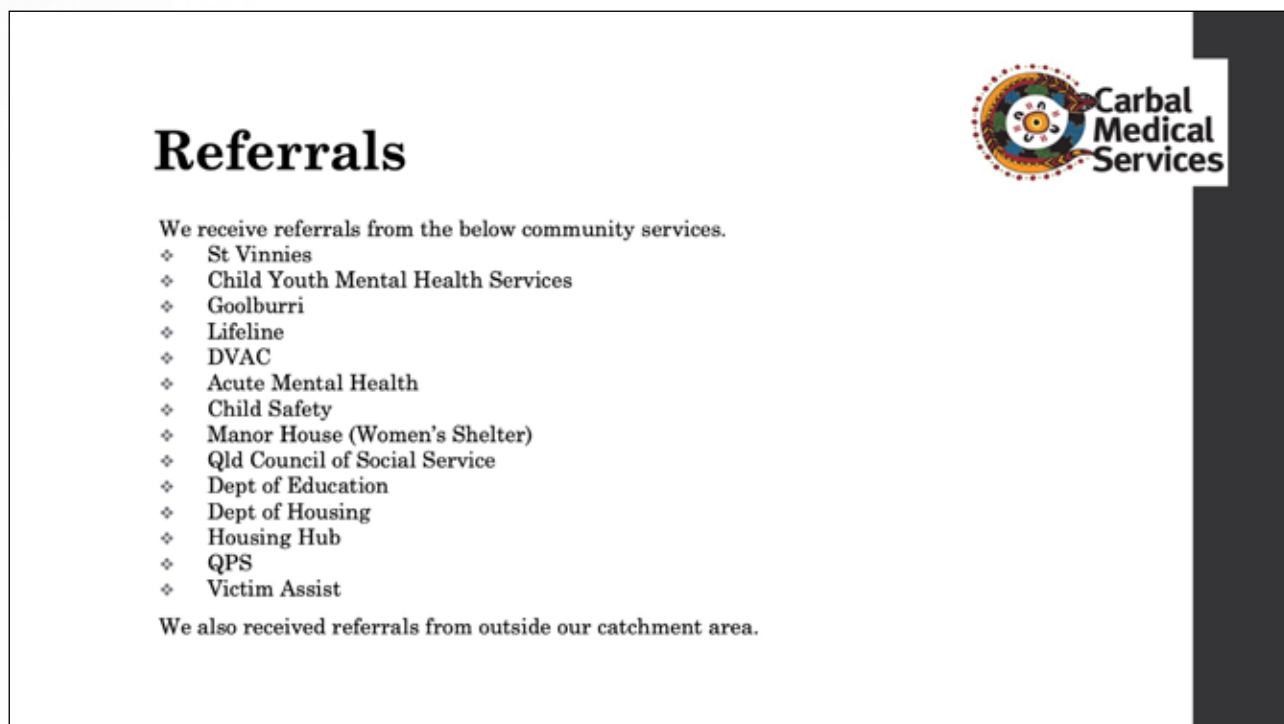
Importantly, the Mulungu dental clinic is integrated within the broader health service model, being an example of comprehensive primary health care. Health promotion is also a core component delivered through Deadly Smiles community days.

Ms Kim Passante, MBS National Coordinator, NACCHO — Carbal Medical Services domestic violence program and NACCHO MBS program



Ms Passante spoke on the 'coordination model' (called the Healing Pathways program), operating within Carbal Medical Service. The program aims to foster community resilience and prevent family, domestic and sexual violence. One clinical program staff member running the program is supported by an administrative officer, due to the demanding program reporting requirements.

To date, the program has supported 184 clients who have attended 2,187 sessions of support. Carbal receives client referrals from a range of services, as shown in the figure below.



Services provided by Carbal include:

- Mentoring and group sessions to keep families together if it is safe.
- The safe use of non-Indigenous services and referral to other services.
- Case management (coordinating of all referral agencies), home visits, transport support.
- Triple P — Positive Parenting Program.

Funding for this program was sourced from the Commonwealth Dept of Social Services and is funded to June 2027.

Kim also described the **NACCHO MBS Optimisation Program** which helps ACCHOs to develop financial sustainability through the MBS and support a community of practice. Several courses and resources have been developed and are available free on the NACCHO website. Courses include Medicare in ACCHOs; PIP in ACCHOs; and ACCHO nKPIs. Unfortunately, the program is unlikely to have future ongoing funding and will cease in June 2026.

Sean O'Connor, Townsville PHU — **STI Molecular POCT and update on START (Strep A) testing program**

This [First Nations Point of Care Testing Program](#) is managed in partnership by the Kirby Institute (University of New South Wales) and the Flinders University International Centre for Point-of-Care Testing (ICPOCT), in collaboration government and ACCHOs across Australia.



Molecular Point of Care Testing (POCT) has been in operation since 2016, scaled up, and is now integrated within the local clinical pathways of approximately 80 primary health care services. These services are in regional and remote areas across six jurisdictions: Western Australia, South Australia, the Northern Territory, Queensland, New South Wales, and Victoria.

There is 99% accuracy with POCT for sexually transmissible infections when compared with laboratory testing. Over 1000 health professionals have been trained, 21% being Aboriginal and Torres Strait Islander health practitioners.

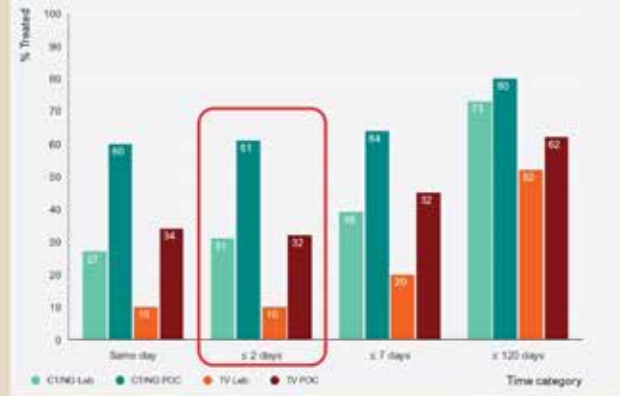
The testing includes chlamydia, gonorrhoea and trichomonas as well as respiratory assays for COVID-19, Flu A/B, and RSV.

A recent evaluation has outlined the impact of the POCT program, demonstrating the substantial reduction in the time to treatment when compared with laboratory based testing, reductions in onward disease transmission, and a reduction in long-term complications. Over a 10-year period, molecular STI point-of-care testing was found to be cost-effective compared to standard lab testing. It improves detection and treatment of chlamydia, gonorrhoea, and trichomoniasis, while reducing long-term complications such as PID (by 30%) and adverse birth outcomes (by 19%). Cost savings are driven by less staff time needed for follow-up and fewer complications for women and babies. Acceptability of testing was also demonstrated (shown below).

Clinical and Public Health Impact;

- Reduced time to treatment compared to lab-based testing
- 61% of CT/NG treated within 2 days compared with 31% for lab test
- The improved time to treatment was most pronounced in women
- Increased STI testing rates, particularly among young people
- No reduction in HIV or syphilis testing rates following POC testing introduction

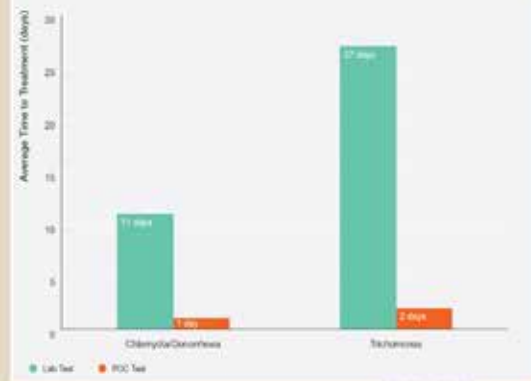
Figure 1. Time to treatment following a positive STI test (2016-2024)



Clinical and Public Health Impact

- More rapid and curative treatment lead to reductions in the number of days in the community and therefore fewer onward transmissions. Supports earlier contact tracing
- 8,800 CT/NG/TV infections were found between 2016 and 2024
- Patients with positive POC tests were treated earlier (from 11 to 1 day for CT/NG and from 27 to 2 days for TV)
- When a person was informed of their results and treated promptly, they have less time to pass on the infection. Modelling showed that as a result 118,000 infectious days were averted

Figure 2. Time to treatment following a positive STI test





Acceptability among healthcare workers

- High acceptability of STI POC testing technology in the community setting.
- Clinicians appreciated its effectiveness as a "one-stop shop" for STI management.
- Operator confidence and managing workload were critical factors for implementation
- High confidence from Managers, Nurses and Aboriginal and Torres Strait Islander Health Practitioners



Testing is also rebateable on the MBS (item 73813 and 73825 from 1 Nov 2024) and there have been nearly 4000 claims made, the majority from Queensland.

Group A Strep POCT (START Project)

This project is led by the Telethon Kids Institute and works in collaboration with the Kirby Institute at UNSW Sydney and the National Aboriginal Community Controlled Health Organisation (NACCHO).

START (Strep A Throat Assessment and Rapid Treatment) is a research project evaluating a test-and-treat model using point-of-care testing (POCT) for Group A Streptococcus (GAS) throat infections. While the POCT itself is already validated, the study is assessing the effectiveness, accessibility, and clinical impact of combining rapid testing with early treatment.

The project aims to improve detection of both symptomatic and subclinical infections, which are often missed but can lead to acute rheumatic fever (ARF). By enabling earlier and more targeted treatment, the model seeks to reduce the incidence of ARF. GAS skin infections are not included in this study.

The program is pending ethics approval in Queensland, with rollout planned through the FNM POCT program and additional sites being recruited.

START targets a key driver of ARF and rheumatic heart disease (RHD), conditions that are preventable with timely antibiotics but remain prevalent in resource-limited settings. The burden is highest among Aboriginal and Torres Strait Islander children aged 5–15 years in remote areas, influenced by factors such as overcrowded housing, limited health infrastructure, and reduced access to care.

START Strep A Project

- **Aim:** to assess the clinical effectiveness, acceptability, barriers/facilitators, and cost-effectiveness of a new test and treat strategy to increase the detection and timely treatment of Strep A throat infections and prevent ARF
- **Study design:** before-after (2 years retrospective, 2 years implementation)
- **Primary Objectives: to determine;**
 - Number and proportion same day treatments suspected/confirmed Strep A throat infections
 - Number and proportion sore throats detected and real-world incidence
- **Secondary Objectives; to determine/ evaluate**
 - Strep A positive throat swabs among those with sore throat symptoms
 - Unnecessary treatment avoided
 - ARF presentations
 - Acceptability, barriers and facilitators
 - Long-term effectiveness and cost-effectiveness vs standard care

START Strep A- Model of Care

New targeted approach involving sore throat check list and POC testing

Benefits

- Aligns with guidelines
- Finds more Strep A cases (16x compared to now)
- More sore throats are identified in 5-15yos presenting for other reasons
- Studies show 3% of children present with sore throat as primary reason for visit but when sore throat checklist was given to those presenting for other reasons 38% had some form of sore throat even if mild symptoms*
- Treatment is targeted
- Only 20mins to result (lab culture 5-10 days?)
- Increases on the spot or same day treatments
- Aim over time to decrease incidence of ARF and RHD

Considerations

- Regular sore throat checks needed

Checklist

- (1) Throat pain or sore throat?
- (2) Hard to swallow?
- (3) Not eating as much?
- (4) Not drinking as much?
- (5) Croaky voice?
- (6) Feeling hot or cold?

*Barth DD, Mullane MJ, Sampson C, Chou C, Pickering J, Nicol MP, et al. Missing Piece Study protocol: prospective surveillance to determine the epidemiology of group A streptococcal pharyngitis and impetigo in remote Western Australia. *BMJ Open*. 2022;12(4):e0057296.

Anecdotal feedback from WA and NT services indicates that testing is not onerous in terms of workload, and that it has helped identify GAS that may have been missed. The project combines a sore throat checklist (see above) with Strep A point of care testing to promote active screening, including mild cases that may be unnoticed, supporting timely, targeted treatment and potentially reducing unnecessary treatment.

The study will continue for 2 years of participant follow-up with all sore throat presentations treated for GAS in line with protocols for high ARF prevalence settings.

DAY 2 — Tuesday 28 April 2026

Kate Armstrong, NACCHO Medical Advisor — HPV POCT



The Australian Government, supported by NACCHO, is funding a national roll-out of a Human Papillomavirus (HPV) POCT program for the prevention of cervical cancer. The goal is to embed testing into routine clinical care in primary health care services.

Dr Dawn Casey is the overall co-lead with A/Prof Lisa Whop. NACCHO has reported this **is not a research project**, rather it is an implementation initiative.

The working theory is if all eligible women are screened for HPV at least once by 2030, cervical cancer would be eliminated by 2036. The PREVENT Project HPV POCT trial in the Kimberley region saw 108 women participate in the intervention, a 36% response rate. Among participants, 22 (21%) of 108 tested positive for oncogenic HPV, with 21 (95%) of these completing the same day colposcopic assessment. No high-grade cervical abnormalities were detected.

Ms Armstrong's discussion progressed to the Pathways to Accelerated Cervical Cancer Elimination (PACE) Project run by the Kirby Institute, Flinders University, Australian National University, Melbourne University, NACCHO, etc, to scale up the PREVENT Project.

A planned national roll-out is to build on the learnings of both these projects, train health professionals as well as share tools and resources. ACCHOs in all jurisdictions will be invited to take part. The intention is to link results with the National Cancer Screening Register.

The objectives are outlined below:

- Building on learnings from the PREVENT and PACE Projects, support remote and rural ACCHOs to: provide high quality HPV PoC testing for cervical screening to Aboriginal and Torres Strait Islander women and people with a cervix; link results to the National Cancer Screening Register (NCSR); and facilitate timely and appropriate follow-up.
- Provide cervical screening that is easily accessible and culturally safe for Aboriginal and Torres Strait Islander communities.
- Provide, or facilitate referral to, culturally safe treatment services for precancerous abnormalities, in people who are found to have high grade lesions.

The intended outcomes are:

- Increased cervical screening coverage in Aboriginal and Torres Strait Islander women and people with a cervix.
- Enhanced follow-up rate amongst Aboriginal and Torres Strait Islander women and people with a cervix in whom HPV is detected.
- PoC HPV testing for cervical screening is undertaken as a part of the NCSP, in a National Association of Testing Authorities (NATA) accredited service, eligible for Medicare rebates and linked to the NCSR.

Various models of roll-out are being proposed, including mobile colposcopy services that Queensland Health may agree to support. Clinical and referral pathways need to be developed, including their data collection and monitoring.

The results will go straight to the Australian Centre for the Prevention of Cervical Cancer (a world-leader in the prevention and control of cervical cancer – ACPC in Victoria was previously known as the Victorian Cytology Service).

Dr Casey sent a letter to all member services with information about PACE and who to contact. It is currently at the EoI stage for ACCHOs.

**Dr Jason King, Medical Director of Clinical Services —
Gurriny Yealamucka's new Public Health Unit**

Gurriny Yealamucka found “public health was done to us and not with us or by us”, resulting in multiple communicable disease outbreaks: mumps outbreak (2018), APSGNP (2019), COVID-19 (2020-22) and meningococcal (2024). Outbreak responses were only handled by the HHS's public health teams and were therefore not optimally effective.



Gurriny believes:

“Public health cannot sit outside of community control... ACCHOs are often required to act before formal systems are activated... State PHUs are essential but structurally distant from daily community life... Decision making is informed by lived experience not just surveillance dashboards.”

The PHU formalises work that Gurriny was already doing. This includes communicable disease outbreak management, sexual health, RHD, immunisation program, health checks, healthy skin (Moo Goo supply for washing). Gurriny built structures around these activities and then the funding followed.

Greg Richards, former QAIHC General Manager, Sector Development – Impact of global conflict and fuel shortages on delivery of care



Greg reported that some Member services have been required to cut outreach due to fuel costs. As a result, QAIHC is having opportunistic and informal discussions with Members on what impact energy price rises may have on services. QAIHC is particularly interested in what the impact may be if the fuel shortage and increased costs persist. This issue was opened to the floor.

One Member service reported airfares to Palm Island have risen by 50%. Some essential workers may need support to get to work. There is potential for the situation to pose prolonged difficulties. However, others reported the crisis has prompted them to investigate long-term savings through ecological sustainability measures.

Sandy Robertson, Senior Coordinator Medicare Benefits – MBS Update



Sandy provided an update via Teams, with her slides sent to all clinical leaders immediately after the presentation.

Sandy referred to the MyMedicare changes regarding chronic disease management plans. Whilst a patient does not need to be registered with MyMedicare (MM) to access a chronic disease management plan, for an ACCHO to claim the MBS service, the patient may not be registered with MM at another clinic. Several issues have been identified with the MM requirements, including reduced MBS revenue, since the measure was introduced. These issues were communicated by [QAIHC in a submission to the Australian Government Inquiry on Medicare access and funding in rural, regional and remote locations](#) [March 2026]. There were 151 submission including QAIHC Member services such as the [Apunipima Cape York Health Council](#), and [Gidgee Healing](#).

MyMedicare Overview

It is voluntary and free to register in MyMedicare.

- When you patients register with MyMedicare, it will notify your general practice or ATSI CCHS that the patient has chosen them as your regular care team.

MyMedicare patients will have access to:

- greater continuity of care with your registered practice, which has been demonstrated to improve health outcomes
- longer Medicare Benefit Scheme (MBS) funded telehealth consultations with your GP
- triple bulk billing incentive for longer MBS telehealth consultations for all Medicare-eligible patients registered with MyMedicare
- the General Practice in Aged Care Incentive program that provides more regular visits from a GP and better care planning for people living in a residential aged care home

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Health Assessment Items for Persons of Aboriginal and Torres Strait Islander Descent

- From 1 March 2026, aged-based clinical activities will be removed from the item requirements for health assessment items for persons of Aboriginal and Torres Strait Islander descent.
- The changes will support the delivery of holistic patient care, tailored to meet a patient's individual health needs and clinical circumstances throughout their life.
- The changes will also support the ongoing alignment of item requirements with clinical guidance.
- These changes are relevant to medical practitioners and other practice staff who assist in delivering health assessment services.
- Related items 715, 92004, 228 & 92011

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Other updates were provided on preventive health checks (MBS item 715) where the age-based descriptors for claiming have been removed (see below).

Health Assessment Items for Persons of Aboriginal and Torres Strait Islander Descent

Professional attendance by a general practitioner, at consulting rooms or in a place other than a hospital or a residential aged care facility:

- (a) for a health assessment of a patient who is of Aboriginal or Torres Strait Islander descent; and
- (b) that includes the following:
- (i) recognising the patient's health priorities
 - (ii) taking the patient's medical history
 - (iii) undertaking any relevant physical examinations
 - (iv) undertaking or arranging any required investigations
 - (v) assessing the patient using the information gained in the health assessment
 - (vi) initiating any necessary interventions and referrals
 - (vii) developing and documenting a plan to manage the patient's health, including for follow up, based on the health assessment and the patient's priorities
 - (viii) offering the patient (or the patient's carer (if any) if the practitioner considers it appropriate and the patient agrees) a written report of the health assessment, with recommendations on matters covered by the health assessment and a strategy for the patient's good health
 - (ix) if the offer referred to in subparagraph (viii) is accepted—giving the report to the patient or the patient's carer (as applicable)
 - (x) adding a record of the health assessment to the patient's medical records

Applicable only if a service to which this item or item 228, 92004 or 92011 applies has not been provided to the patient in the preceding 9 months

Note: For items 92004 and 92011, see the Telehealth Attendance Determination.

- Item age delineations (currently 0–14, 15–54, and 55+ years) and associated age specific clinical activities will be replaced with general preventative health and assessment activities and guidance.
- The revised item descriptors have included the clinical activities required to bill the items.
- Providers should refer to clinically and culturally appropriate guidelines when delivering health assessments for persons of Aboriginal and Torres Strait Islander descent.
- This includes (but is not limited to) the National Guide to preventive healthcare for Aboriginal and Torres Strait Islander people and its associated templates, the Central Australian Rural Practitioners Association (CARPA) Standard Treatment Manual, and the Guidelines for preventive activities in general practice (Red Book).

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Clinical Leaders informal showcase

Mention was made of the Australian Government House of Representatives Standing Committee on Health, Aged Care and Disability announcement of a new inquiry into access to and affordability of medical specialists in Australia. The deadline for submissions is 16 October 2026. The terms of reference are:

- Current access to **medical specialists in cities, regional and rural communities**, including workforce distribution, shortages, waiting times, and barriers to recruitment, retention and training;
- The **effectiveness, transparency and equity of referral pathways** from the perspectives of patients, primary health care practitioners and medical specialists across the public and private health sectors;
- The **affordability of specialist services**, including out of pocket costs for consultations, diagnostics and procedures, access through public health services, and factors influencing fee setting;
- The **impacts of delays** caused by cost, distance and waiting times on patient outcomes and on the wider health system, including primary care, emergency departments, public hospitals and chronic disease management, as well as impacts on people due to deferred or missed care; and
- **Innovative and emerging models of care that may improve access** to medical specialists.

Clinical leaders referred to poor access to paediatric developmental assessments. Referrals to child development services are rejected due to age restrictions of those transitioning after age 16 years.

Psychiatry access is also a huge barrier. The public health system is overstretched, and the GP is often the only person who is able to manage these issues. Telehealth options are sometimes bulk billed but come with a long wait. It is common for the referral to be declined even when the patients have complex issues. In some regions the federally funded ITC program (Integrated Team Care) will not cover psychiatry.

Clinical leaders will be contacted by QAIHC to seek further anecdotal evidence of challenges with access to specialists. This information will help form the planned QAIHC submission to the standing committee.

Day 2 ended with informal updates from the Member representatives present, highlighting some of the wins and challenges from their services.

Key highlights from the Member's showcase:

- Wuchopperen highlighted that several ACCHO CEOs in North Queensland have been participating in a secondment arrangement with NATSIHA which has generated new ideas for regionalisation and improved coordination of services, including more effective collaboration with partners like Gurriny. They are undertaking a major model of care review in the second half of this year to ensure they continue to meet community needs as their 50th anniversary approaches in 2029.
- Kambu also spoke about the benefit of a Nurse Practitioner at their service and the benefit this is having on chronic disease plans.
- IWC have recently become affiliated with QAIHC and attended their first forum this year. They spoke about upcoming expansion of their service and a review into their model of care with support from other ACCHOs in SE Queensland.
- Carbal Medical Services spoke about the benefit of the relationship between NACCHO and their service and the impact this is having on RHD programs, lung screening and staffing.

Some other themes that emerged from the showcase:

- The importance of access to timely data and information to guide decisions in primary care. This includes access to My Health Record and delays in clinical correspondence for complex cases. Some services highlighted a lack of access to this information and a significant impact this is having on their ability to provide appropriate and continuous care to their patients who have recently been hospitalised or reviewed by other medical specialists.

We thank all our presenters and attendees for making this a great event.

For any questions about the Forum, please contact:

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